By:  Klick H.B. No. 4561

A BILL TO BE ENTITLED

AN ACT

relating to the system redesign for delivery of Medicaid acute care services and long term services and supports to persons with an intellectual or developmental disability and a pilot for certain populations with similar functional needs receiving services in managed care.

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

SECTION 1.  Section 534.001, Subchapter A, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.001.  DEFINITIONS. In this chapter:

(3)  [~~"Department" means the Department of Aging and Disability Services.~~] "Commission" means the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program, as appropriate.

(4)  "Comprehensive long term services and supports provider" is defined as a provider of long term services and supports specified under this chapter that ensures the coordinated, seamless provision of the full range of services as approved in participants' program plans as described under Section 534.1045 (b), (b-2),(c), and (d). A comprehensive service provider includes:

(A)  an ICF/IID program provider who is authorized to deliver services in the program defined under Section 534.001 (8), and

(B)  a Medicaid waiver program provider who is authorized to deliver services in the programs specified under Section 534.001 (12) and certified in accordance with 534.301 (b).

[~~(4)~~] (5)  "Functional need" means the measurement of an individual's services and supports needs, including the individual's intellectual, psychiatric, medical, and physical support needs.

[~~(5)~~] (6)  "Habilitation services" includes assistance provided to an individual with acquiring, retaining, or improving:

(A)  skills related to the activities of daily living; and

(B)  the social and adaptive skills necessary to enable the individual to live and fully participate in the community.

[~~(6)~~] (7)  "ICF-IID" means the program under Medicaid serving individuals with an intellectual or developmental disability who receive care in intermediate care facilities other than a state supported living center.

[~~(7)~~] (8)  "ICF-IID program" means a program under Medicaid serving individuals with an intellectual or developmental disability who reside in and receive care from:

(A)  intermediate care facilities licensed under Chapter 252, Health and Safety Code; or

(B)  community-based intermediate care facilities operated by local intellectual and developmental disability authorities.

[~~(8)~~] (9)  "Local intellectual and developmental disability authority" has the meaning assigned by Section 531.002, Health and Safety Code.

[~~(9)~~] (11)  "Managed care organization," "managed care plan," and "potentially preventable event" have the meanings assigned under Section 536.001.

(10)  Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 2.287(17), eff. April 2, 2015.

[~~(11)~~] (12)  "Medicaid waiver program" means only the following programs that are authorized under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) for the provision of services to persons with an intellectual or developmental disability:

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

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

(C)  the deaf-blind with multiple disabilities (DBMD) waiver program; and

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

(13)  "Residential Services" means services provided for an individual with intellectual or developmental disability in a community-based ICF/IID, a three or four persons home and host home/companion service offered through the 1915(c) home and community-based waiver services program, or a group home in the Deaf Blind Multiple Disabilities program.

[~~(12)~~] (14)  "State supported living center" has the meaning assigned by Section 531.002, Health and Safety Code.

SECTION 2.  Section 534.051, Subchapter B, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.051.  ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. In accordance with this chapter, the commission [~~and the department~~] shall [~~jointly~~] design and implement an acute care services and long-term services and supports system for individuals with an intellectual or developmental disability that supports the following goals:

(1)  provide Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to the individuals' needs and preferences in the most integrated and least restrictive setting;

SECTION 3.  Section 534.052, Subchapter B, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.052.  IMPLEMENTATION OF SYSTEM REDESIGN. The commission [~~and department~~] shall, in consultation and collaboration with the advisory committee, [~~jointly~~] implement the acute care services and long-term services and supports system for individuals with an intellectual or developmental disability in the manner and in the stages described in this chapter.

SECTION 4.  Section 534.053, Subchapter B, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.053.  INTELLECTUAL AND DEVELOPMENTAL DISABILITY SYSTEM REDESIGN ADVISORY COMMITTEE. (a) The Intellectual and Developmental Disability System Redesign Advisory Committee shall advise the commission [~~and the department~~] on the implementation of the acute care services and long-term services and supports system redesign under this chapter. Subject to Subsection (b), the executive commissioner [~~and the commissioner of aging and disability services~~] shall [~~jointly~~] appoint members of the advisory committee who are stakeholders from the intellectual and developmental disabilities community, including:

(b)  To the greatest extent possible, the executive commissioner [~~and the commissioner of aging and disability services~~] shall appoint members of the advisory committee who reflect the geographic diversity of the state and include members who represent rural Medicaid recipients.

(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:~~

~~(1)  the advisory committee is abolished ; and~~

~~(2)  this section expires~~].

(g)  On the [~~one year]~~ two-year anniversary of the date the commission completes implementation of the transition required under Section 534.202:

(1)  the advisory committee is abolished; and

(2)  this section expires.

SECTION 5.  Section 534.054, Subchapter B, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.054.  ANNUAL REPORT ON IMPLEMENTATION.

(b)  On the two-year anniversary of the date the commission completes implementation of the transition required under Section 534.202 this [~~This~~] section expires [~~January 1, 2026~~].

SECTION 6.  Section 534.101, Subchapter C, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.101.  Pilot Program Workgroup [~~DEFINITIONS~~]. In accordance with Section 534.053 (e-1), for puposes of [~~In~~] this subchapter the advisory committee shall establish a h Workgroup that includes representatives from the advisory committee, stakeholders representing individuals with an intellectual and developmental disability, individuals with similar functional needs, and the STAR+PLUS managed care organizations. [~~:~~]

~~[(1)  "Capitation" means a method of compensating a provider on a monthly basis for providing or coordinating the provision of a defined set of services and supports that is based on a predetermined payment per services recipient.~~]

~~[(2)  "Provider" means a person with whom the commission contracts for the provision of long-term services and supports under Medicaid to a specific population based on capitation.~~]

SECTION 7.  Section 534.102, Subchapter C, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.102.  PILOT PROGRAM [~~S]~~ TO TEST PERSON-CENTERED MANAGED CARE STRATEGIES AND IMPROVEMENTS BASED ON CAPITATION. The commission [~~and the department may]~~ ,in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall develop and implement a pilot program[~~s~~] in accordance with this subchapter to test, through the STAR+PLUS Medicaid managed care program, the delivery of [~~one or more service delivery models involving~~] long term services and supports [~~a managed care strategy based on capitation to deliver long-term services and supports under Medicaid~~] to individuals [~~with an intellectual or developmental disability~~]specified under Section 534.1065.

SECTION 8.  Section 534.103, Subchapter C, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.103.  STAKEHOLDER INPUT. As part of developing and implementing a pilot program under this subchapter, the [~~department~~] commission, in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall develop a process to receive and evaluate input from statewide stakeholders and stakeholders from the STAR+PLUS service area [~~region~~] of the state in which the pilot program will be implemented and other evaluations and data.

SECTION 9.  Chaoter 534, Government Code is amended to add new Section 534.1035, SELECTION OF MANAGED CARE ORGANIZATION VENDORS, to read as follows:

Sec.534.1035.  SELECTON OF MANAGED CARE ORGANIZATION PILOT VENDORS. (a) The commission shall select and contract with no more than two managed care organizations contracted to provide services under the STAR+PLUS Medicaid managed care program to participate in the pilot.

(b)  The commission, in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall develop criteria regarding the selection of managed care organizations to conduct the pilot program.

SECTION 10.  Section 534.104, Subchapter C, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.104.  PILOT DESIGN [~~MANAGED CARE STRATEGY PROPOSALS; PILOT PROGRAM SERVICE PROVIDERS~~].

[~~(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)  [~~A managed care strategy based on capitation developed for implementation through a~~] The 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 informed choice and meaningful outcomes by using person-centered planning, flexible consumer directed services, individualized budgeting, and self-determination, and promote community inclusion and engagement;

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

(5)  promote efficiency and the best use of funding based on the individual's needs and preferences;

(6)  promote [~~the placement of an individual in~~] housing stability through housing supports and navigation services that is the most integrated and least restrictive setting appropriate to the individual's needs and preferences;

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

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

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

(10)  promote the use of innovative technology and benefits, including telemonitoring and testing of remote monitoring for individuals participating in the pilot. The remote monitoring and telemonitoring is voluntary and shall ensure an individual's privacy and health and welfare and allow access to housing in the most integrated and least restrictive environment. Innovations may include transportation and other innovations that support community integration. If a pilot participant voluntarily decides to use telemonitoring or remote monitoring or other innovative technologies, the managed care organization providing the pilot services shall deliver the telemonitoring, remote monitoring and/or innovative technology services in a way that:

(A)  assesses individual needs and preferences in a manner that promotes autonomy, self-determination, consumer directed services, privacy and increases personal independence;

(B)  determines the extent in which remote monitoring, telemedicine and other innovative technologies will be used, including but not limited to, times of day, where the equipment can be used, what types of telemonitoring and/or remote monitoring, for what tasks;

(C)  is identified and agreed to through the person centered planning process;

(D)  ensures the staff overseeing remote monitoring, telemedicine and other innovative technologies review person-centered plans and implementation plans of each individual they are monitoring prior to monitoring that individual and demonstrate competency regarding the support needs of each individual they are monitoring; and

(E)  ensures an individual can request to remove the remote monitoring and other innovative technology equipment at any point during the IDD pilot and the managed care organizations must remove the equipment immediately.

(F)  ensures individuals can choose not to use telemedicine at any point during participation in the pilot and that the pilot participating managed care organization must arrange for services that do not require the use of telemedicine.

(11)  ensure an adequate provider network that includes comprehensive long term services and supports providers as described in Section 534.001 (4) and Section 534.107 (a)(2) and choice from among these providers;

(12)  ensure timely initiation and consistent provision of long term services and supports in accordance with an individual's person centered care plan;

(13)  ensure individuals with complex behavioral, medical and physical needs receive services based on assessed needs and in the most integrated, least restrictive setting according to the each individual's needs and preferences;

(14)  increase, expand flexibility and promote use of the consumer directed services model ; and

(15)  promote independence, self-determination, consumer directed services and decision making by using alternatives to guardianship, including supported decision-making agreements under Chapter 1357, Estates Code.

(b)  The pilot program shall be designed to test innovations and payment models for the provision of long-term services and supports to achieve the goals outlined in subsection (a) utilizing methods such as:

(1)  payment of a bundled amount without downside risk to a long term services and supports provider for some or all services delivered as part of a comprehensive array of long term services and supports;

(2)  enhanced incentive payments to providers of long term services and supports based on meeting pre-determined outcome or quality metrics; and

(3)  any other payment models approved by the commission.

(c)  The alternative payment rates or methodologies tested under subsection (b) must be agreed to in writing by the managed care organization and participating long term services and supports provider. In developing the alternative payment rates or methodologies, the parties must utilize:

(1)  the historical costs of long term services and supports, including Medicaid fee-for-service rates; and

(2)  reasonable cost estimates for new pilot program services; and

(3)  whether alternative payment rates or methodologies are sufficient to ensure the provider's continued participation in the pilot program and promote quality outcomes.

(d)  For long term services and supports delivered under the pilot, the alternative payment models tested under subsection (b) shall not reduce the minimum payment to providers below the current fee for service reimbursement rates.

(e)  The pilot program must allow existing providers of long-term services and supports for persons with intellectual and developmental disabilities, as defined in Section 534.001 (4), and providers of long term services and supports for persons with similar functional needs to voluntarily participate in one or more pilot projects. Failure to participate in a pilot project does not affect the contracting status of any provider as a significant traditional provider.

~~[(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.]~~

(f)  [~~For each pilot program service provider, the department\_\_shall develop and implement a pilot program.~~] Under a pilot program, the [~~pilot program service provider~~] the participating managed care organizations shall provide long-term services and supports under Medicaid to persons with an intellectual or developmental disability, and other individuals with disabilities with similar functional needs, to test its managed care strategy based on capitation.

(g)  The [~~department~~] commission, in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall analyze information provided by the [~~pilot program service providers~~] participating managed care organizations and any information collected by the [~~department~~] commission during the operation of the pilot program[~~s~~] 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 program[~~s~~] on the goals specified under Subsections (a), (b), (c) and (d). [~~:~~]

[~~(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.]~~

(i)  Prior to implementation of the pilot program, the commission, in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall develop a process to ensure 12 months continuous Medicaid eligibility for pilot participants.

SECTION 11.  Chapter 534, Government Code is amended to add new section 534.1045, PILOT BENEFITS AND PROVIDER QUALIFICATIONS as follows:

Sec. 534.1045.  PILOT BENEFITS AND PROVIDER QUALIFICATIONS. (a) The pilot program must ensure that participating managed care organizations provide:

(1)  all Medicaid state plan acute care benefits available under the STAR+PLUS program;

(2)  long term services and supports in the Medicaid state plan, including:

(A)  Community First Choice services;

(B)  Personal Assistant services;

(C)  Day Activity Health Services;

(D)  Habilitation services defined under Section 534/001 (6);

(3)  long term services and supports in the STAR+PLUS home and community-based services waiver, including:

(A)  assisted living

(B)  personal assistance services;

(C)  employment assistance;

(D)  supported employment;

(E)  adult foster care;

(F)  dental care;

(G)  nursing care;

(H)  respite care;

(I)  home-delivered meals;

(J)  cogniticve rehabilitative therapy;

(K)  physical therapy;

(L)  occupational therapy;

(M)  speech-language pathology;

(N)  medical supplies;

(O)  minor home modifcations;

(P)  adaptive aids;

(4)  long term services and supports available in the Medicaid waiver programs defined in Section 534.001 (12), including:

(A)  enhanced behavioral health services;

(B)  behavioral supports;

(C)  day habilitation;

(D)  community support transporation;

(5)  additional long term services and supports, including:

(A)  housing supports;

(B)  behavioral health crisis intervention;

(C)  high medical needs services; and

(6)  Other non-residential long term services and supports the commission, in consultation and coordination with the advisory committee and Pilot Program Workgroup, determines appropriate and consistent with the regulations governing the 1915 (c) waiver programs defined in Section 534.001 (12), person-centered approaches, home and community-based settings requirements, and the most integrated and least restrictive setting according to an individual's needs and preferences.

(b)  A comprehensive long term services and supports provider is authorized to deliver services listed under under subsections (a)(2)(A), (a)(2)(D), (a)(3)(B), (a)(3)(C), (a)(3)(D), (a)(3)(G), (a)(3)(H), (a)(3)(J), (a)(3)(K), (a)(3)(L), (a)(3)(M), and (a)(3)(4),if they also deliver the service in a Medicaid waiver defined under Section 534.001 (12).

(b-2)  A comprehensive long term services and supports provider may deliver services under subsections (a)(5) and (a)(6) if agreed to under contract with the pilot participating managed care organization.

(c)  Day habilitation services under (a)(4)(c) may be delivered by a provider who is contracted or subcontracted under a 1915 (c) Medicaid waiver as defined under Section 534.001 (12) or an ICF/IID program as defined under Section 534.001 (8).

(d)  A comprehensive long term services and supports provider works in consultation with the pilot participating managed care organization's care coordinators to ensure the seamless delivery of acute care and long term services and supports on a day-to-day basis in accordance with an individual's plan of care and may be reimbursed by the managed care organization for this coordination.

(e)  Prior to implementation of the pilot program, the commission, in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall:

(1)  develop recommendations to modify, for the pilot program only, the Adult Foster Care, Supported Employment and Employment Assistance benefits to ensure increased access to and availability of this service, and

(2)  as needed, definitions for services described under subsection (a)(4) and (5), and any services added under subsection (6).

SECTION 12.  Section 534.105, Subchapter C, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.105.  PILOT PROGRAM: MEASURABLE GOALS. (a) The [~~department~~] commission, in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall identify measurable goals using National Core Indicators, National Quality Forum LTSS measures and other appropriate CAHPS measures to be achieved by [~~each~~] the pilot program implemented under this subchapter. [~~The identified goals must:~~

~~(1)  align with information that will be collected under Section 534.108(a); and~~

~~(2)  be designed to improve the quality of outcomes for individuals receiving services through the pilot program.~~]

(b)  The [~~department~~] commission, in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall [~~propose~~] develop specific strategies and performance measures for achieving the identified goals. A proposed strategy may be evidence-based if there is an evidence-based strategy available for meeting the pilot program's goals.

(c)  The commission, in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall ensure that the mechanisms to report, track and assess the specific strategies and performance measures for achieving the identified goals are established prior to implementation of the pilot program.

SECTION 13.  Section 534.106, Subchapter C, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.106.  IMPLEMENTATION, LOCATION, AND DURATION. (a) The commission [~~and the department~~] shall implement [~~any~~] the pilot program[~~s~~] established under this subchapter [~~not later than~~] on September 1, [~~2017~~] 2023.

(b)  A pilot program established under this subchapter [~~may~~] shall operate for at least [~~up to~~] 24 months. [~~A pilot program may cease operation if the pilot program service provider terminates the contract with the commission before the agreed-to termination date.~~]

(c)  A pilot program established under this subchapter shall be conducted in [~~one or more~~] the STAR+PLUS service area [~~regions~~] selected by the [~~department~~] commission.

SECTION 14.  Section 534.1065, Subchapter C, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.1065.  RECIPIENT ENROLLMENT, PARTICIPATION AND ELIGIBILITY [~~IN PROGRAM VOLUNTARY~~]. (a) Enrollment [~~Participation~~]in a pilot program established under this subchapter by an individual [~~with an intellectual or developmental disability~~] shall occur using an opt-out process [~~is voluntary, and~~] with the decision whether to participate in a program and receive long-term services and supports from a provider through that program [~~may~~] to be made only by the individual or the individual's legally authorized representative.

(1)  The commission, in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall develop a timeline and process for and informational materials related to educating pilot participants about the pilot including its benefits, impact on current services and other related information to ensure prospective pilot participants are able to make an informed decision regarding participation. The process must ensure:

(A)  the timeline for development and distribution of the pilot informational materials allows for sufficient advance notification to and education of individuals eligible for pilot participation, their families and other individuals actively involved in their lives;

(B)  individuals eligible for pilot participation, including new and current STAR+PLUS enrollees and other individuals specified in subsection (a) (1) (A), receive oral and written information about the pilot prior to participation,

(C)  the information provided is written in clear, simple language and presented in a manner individuals are able to understand and, at a minimum, explains that:

(i)  upon conclusion of the pilot, individuals will be requested to provide input on their pilot participation experience, including whether the pilot was able to meet their unique support needs;

(ii)  participation in the pilot does not remove individuals from any Interest List or, in accordance with Section 534.1065 (c), the right to select an enrollment, transition or diversion offer; and

(iii)  individuals have choice among acute care and long term services providers, including the consumer directed services model and the comprehensive services model.

(b)  The commission, in consultation and coordination with the advisory committee and Pilot Program Workgroup, shall develop pilot program participant eligibility criteria. The criteria must ensure pilot participants include:

(1)  individuals with an intellectual and developmental disability including autism and individuals with significant complex behavioral, medical and physical needs receiving home and community-based services through STAR+PLUS or a STAR+PLUS member who is also on a Medicaid Waiver Interest List or is a STAR+PLUS member meeting criteria for intellectual disabilities. It does not include individuals who are receiving only acute care services under STAR+PLUS and enrolled in the community-based ICF/IID program or one of the Medicaid waiver programs defined under Section 534.001 (12).

(2)  individuals receiving services under the STAR+PLUS Medicaid managed care program who have a traumatic brain injury that occurred after the age of 22; and

(3)  other individuals with disabilities who have similar functional needs independent of age of onset or diagnosis.

(c)  Individuals participating in the pilot who, during the pilot's implementation, are offered enrollment in one of the 1915 (c) Medicaid waiver programs defined under Section 534.001 (12) shall be eligible to accept the enrollment, transition or diversion offer.

SECTION 15.  Section 534.107, Subchapter C, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.107.  [~~COORDINATING SERVICES~~] COMMISSION RESPONSIBILTIES. (a) [~~In providing long-term services and supports under Medicaid to individuals with an intellectual or developmental disability,~~] The commission [~~a pilot program service provider~~] shall require managed care organizations participating in the pilot program to:

(1)  ensure individuals participating in the pilot have choice among acute care and comprehensive long term services and supports providers and service delivery options including the consumer directed services model as specified under Section 534.109. [~~coordinate through the pilot program institutional and community-based services available to the individuals, including services provided through:~~

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

~~(B)  a Medicaid waiver program; or~~

~~(C)  a community-based ICF-IID operated by local authorities~~] ;

(2)  demonstrate to the satisfaction of the commission that their network of acute care, long term services and supports and comprehensive service providers have experience and expertise providing services for individuals with an intellectual or developmental disability and individuals with similar functional needs;

~~[collaborate with managed care organizations to provide integrated coordination of acute care services and long-term services and supports, including discharge planning from acute care services to community-based long-term services and supports];~~

(3)  have a process for preventing inappropriate institutionalizations of individuals; and

(4)  ensure timely initiation and consistent provision of services in accordance with an individual's person-centered plan ~~[accept the risk of inappropriate institutionalizations of individuals previously residing in community settings]~~.

(b)  For the duration of the pilot the commission must ensure that comprehensive long term services and supports providers as defined under Section 534.001(4) are deemed significant traditional providers and included in the provider network of the managed care organizations participating in the pilot.

SECTION 16.  Section 534.108, Subchapter C., Chapter 534, Government Code, is amended to read as follows:

Section 534.108.  Pilot Program Information. (a) The commission [~~and the department~~, in consultation and coordination with the advisory committee and Pilot Program Workgroup, shall determine the information to be collected from each managed care organization participating in the pilot for use in the evaluation and reports required under Section 534.121. [~~collect and compute the following information with respect to each pilot program implemented under this subchapter to the extent it is available:]~~

(b)  For the duration of the pilot each managed care organization participating in the pilot shall submit to the commission and the advisory committee a quarterly report on the services provided to each pilot participant that includes the following information:

(A)  the level of services requested, and the authorization and utilization rates of services for each pilot service;

(B)  timeliness of services requested, authorized, initiated, and number and duration of unplanned service breaks;

(C)  number of pilot participants using employment assistance and supported employment services;

(D)  number of service denials and fair hearings, and disposition of fair hearings;

(E)  number of complaints and inquiries received by the commission and managed care organizations participating in the pilot and the outcome of the complaints; and

(F)  number of participants who select the consumer directed services model and reasons participants did not select the service model.

(c)  The commission shall ensure that the mechanisms to report and track the information and data required in subsections (a) and (b) are established prior to implementation of the pilot program.

[~~(1)  the difference between the average monthly cost per person for all acute care services and long-term services and supports received by individuals participating in the pilot program while the program is operating, including services provided through the pilot program and other services with which pilot program services are coordinated as described by Section 534.107, and the average monthly cost per person for all services received by the individuals before the operation of the pilot program;~~

~~(2)  the percentage of individuals receiving services through the pilot program who begin receiving services in a nonresidential setting instead of from a facility licensed under Chapter 252, Health and Safety Code, or any other residential setting;~~

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

~~(4)  the difference between the average total Medicaid cost, by level of need, for individuals in various residential settings receiving services through the pilot program during the operation of the program and the average total Medicaid cost, by level of need, for those individuals before the operation of the program;~~

~~(5)  the difference between the percentage of individuals receiving services through the pilot program who obtain and maintain employment in meaningful, integrated settings during the operation of the program and the percentage of individuals receiving services through the program who obtained and maintained employment in meaningful, integrated settings before the operation of the program;~~

~~(6)  the difference between the percentage of individuals receiving services through the pilot program whose behavioral, medical, life-activity, and other personal outcomes have improved since the beginning of the program and the percentage of individuals receiving services through the program whose behavioral, medical, life-activity, and other personal outcomes improved before the operation of the program, as measured over a comparable period; and~~

~~(7)  a comparison of the overall client satisfaction with services received through the pilot program, including for individuals who leave the program after a determination is made in the individuals' cases at hearings or on appeal, and the overall client satisfaction with services received before the individuals entered the pilot program.~~

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

~~(c)  In addition to the information described by Subsection (a), the pilot program service provider shall collect any information specified by the department for use by the department in making an evaluation under Section 534.104(g).~~

~~(d)  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 17.  Section 534.109, Subchapter C, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.109.  PERSON-CENTERED PLANNING. The commission, in consultation and collaboration [~~cooperation]~~ with the [~~department]~~ advisory committee and Pilot Program Workgroup, shall ensure that each individual[~~with an intellectual or developmental disability~~] who receives services and supports under Medicaid through a pilot program established under this subchapter, or the individual's legally authorized representative, has access to a comprehensive facilitated, person-centered plan that identifies outcomes for the individual and drives the development of the individualized budget. The consumer directed services[~~direction~~] model, as defined by Section 531.051, [~~may be an outcome of the plan]~~ must be an available option for individuals to achieve self-determination, choice and control.

SECTION 18.  Section 534.110, Subchapter C., Chapter 534, Government Code, is amended to read as follows:

Sec. 534.110.  TRANSITION BETWEEN PROGRAMS; CONTINUITY OF SERVICES. (a) During the evaluation of the pilot required under Section 534.121,[~~The]~~ the commission may continue the pilot to protect continuity of care. If the commission determines not to continue the pilot during the evaluation, the commission, in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits provided to pilot participants to the services provided before the pilot. [~~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 19.  Section 534.111, Subchapter C, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.111.  CONCLUSION OF PILOT PROGRAM[~~S~~]; EXPIRATION. Contingent on the decision made under Section 534.110, [~~On~~] on September 1, [~~2019]~~ 2025:

(1)  [~~each~~] the pilot program established under this subchapter [~~that is still in operation~~] either continues or must conclude. ~~[; and~~

~~(2)  this subchapter expires.~~]

SECTION 21.  Chapter 534, Government Code,is amended to add new Subchapter C-1 to read as follows: SUBCHAPTER C-1. PILOT EVALUATION AND REPORT

Section 534.121.  EVALUATION OF AND REPORT ON PILOT PROGRAM. (a) The commission, in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall review and evaluate the progress and outcomes of the pilot program implemented under Subchapter C of this Chapter and submit, as part of the annual report required by Section 534.054, a report on the status of the pilot program. The report must include recommendations for program improvement.

(b)  Upon conclusion of the pilot program required under Subchapter C, the commission, in consultation and collaboration with the advisory committee and Pilot Program Workgroup, shall evaluate the pilot program and prepare and submit a report to the legislature based on a comprehensive analysis of the pilot.

(c)  The comprehensive analysis must:

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

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

(B)  informed choice and meaningful outcomes using person-centered planning, flexible consumer directed services, 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;

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

(F)  increasing use and flexibility of the consumer directed service model;

(G)  increasing use of alternatives to guardianship, including supported decision-making agreements under Chapter 1357, Estates Code;

(H)  achieving cost effectiveness and best use of funding based on individuals' needs and preferences; and

(I)  attendant recruitment and retention;

(2)  provide an analysis of the experience and outcome of the following systems changes:

(A)  the IDD assessment tool required under Chapter 533, Subchapter B, Section 533.0335, Health and Safety Code;

(B)  the 21st Century Cures Act;

(C)  implementation of the federal HCBS Settings regulations; and

(D)  the provision of basic attendant and habilitation services required under Section 534.152 of this Chapter, and

(E)  the benefits of providing STAR+PLUS services to persons based on functional needs;

(3)  include input from the individuals with intellectual and developmental disabilities and participants of similar functional needs, families and other individuals actively involved in the lives of the individuals; and providers of long term services and supports programs defined under Section 534.001 (8) and (12) who participated in the pilot about their experiences;

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

(5)  include recommendations about a system of programs and services for consideration by the legislature, including recommendations for needed statutory changes and whether to transition the pilot to a statewide program under the STAR+PLUS program for individuals who meet the eligibility criteria specified in Section 534.1065.

SECTION 22.  The heading to Subchapter E, Chapter 534, Government Code, is amended to read as follows: SUBCHAPTER E. STAGE TWO: TRANSITION OF ICF-IID PROGRAM RECIPIENTS AND LONG-TERM CARE MEDICAID WAIVER PROGRAM RECIPIENTS TO INTEGRATED MANAGED CARE SYSTEM

SECTION 23.  Section 534.201, Subchapter E, Chapter 534, Government Code, is repealed:

[~~Sec. 534.201. TRANSITION OF RECIPIENTS UNDER TEXAS HOME LIVING (TxHmL) WAIVER PROGRAM TO MANAGED CARE PROGRAM.~~] [(a)[~~This section applies to individuals with an intellectual or developmental disability who are receiving long-term services and supports under the Texas home living (TxHmL) waiver program on the date the commission implements the transition described by Subsection (b).]~~

~~[(b)  On September 1, 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 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).]~~

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

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

~~(2)  provide all or a portion of the long-term services and supports previously available under the Texas home living (TxHmL) waiver program through the managed care program delivery model selected by the commission.]~~

~~[(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.]~~

~~[(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.]~~

~~[(f)  In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission for the organization to provide Medicaid benefits under this section must contain a requirement that the organization implement a process for individuals with an intellectual or developmental disability that:~~

~~(1)  ensures that the individuals have a choice of providers;~~

~~(2)  to the greatest extent possible, protects those individuals' continuity of care with respect to access to primary care providers, including the use of single-case agreements with out-of-network providers; and~~

~~(3)  provides access to a member services phone line for individuals or their legally authorized representatives to obtain information on and assistance with accessing services through network providers, including providers of primary, specialty, and other long-term services and supports~~].

[(~~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 24.  Section 534.202, Subchapter E, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.202.  DETERMINATION TO TRANSITION [~~OF~~] ICF-IID PROGRAM RECIPIENTS AND CERTAIN [~~OTHER~~] MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM. (a) This section applies to individuals with an intellectual or developmental disability who

[ ~~, on the date the commission implements the transition described by Subsection (b),~~ ] are receiving long-term services and supports under:

(1)  a Medicaid waiver program as defined under Section 534.001 (12) [~~other than the Texas home living (TxHmL) waiver program~~]; or

(2)  an ICF-IID program.

(b)  After implementing the pilot [~~transition~~] required by Subchapter C of this Chapter, completing the evaluation required under Section 534.121, and subject to subsection (g)[~~on September 1, 2021~~], the commission, in consultation and collaboration with the advisory committee, shall develop a plan for the transition of all or a portion of the services provided through the programs defined in Sections 534.001 (8) and (12) which were not included in the pilot under Subchapter C. The plan must include:

(1)  The process for transitioning the services in the programs defined in Sections 534.001 (8) and (12) in a phased-in manner as follows:

(A)  Texas Home Living;

(B)  CLASS;

(C)  non-residential services provided through the 1915 (c) Home and Community-based Services and DBMD waivers; and

(D)  subject to subsection (b) (3), the residential services offered through the ICF/IID program and the HCS and DBMD waiver programs.

(2)  With the exception of the residential services provided through the programs specified in subsection (b) (1)(D), the schedule for transitioning the services and individuals into managed care must occur in the order specified under subsection (b)(1)beginning with TxHmL on September 1, 2027; CLASS on September 1, 2029,; and the non-residential services provided through the Home and Community-based services and DBMD waivers on September 1, 2031.

(3)  The process for evaluating the feasibility and cost efficiency of transitioning the residential services offered through the ICF/IID program and the HCS and DBMD waiver programs, and, as appropriate, transitioning to the managed care program.

(A)  The process for determining the transition of the residential services must be based on an evaluation of a two year pilot.

[~~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).]~~

(c)  [~~At the time of~~] Prior to the transition [~~described by~~] dates specified under Subsection (b) (2) and subject to subsection (g), the commission shall determine whether to:

(1)  continue operation of the Medicaid waiver programs only for purposes of providing, if applicable:

(A)  supplemental long-term services and supports not available under the managed care program delivery model selected by the commission; or

(B)  long term services and supports to Medicaid waiver program recipients who choose to continue receiving benefits under the waiver programs who choose to continue receiving benefits under the waiver program as provided by Subsection (g); or

(2)  subject to Subsection (g), provide all or a portion of the long-term services and supports previously available under the Medicaid waiver programs through the managed care program delivery model selected by the commission.

(d)  In implementing the transition described by Subsection (b)(2), the commission 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 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 and ensures individuals have a choice among acute care and comprehensive long term services and supports providers and service delivery options including the consumer directed services model as specified under Subsection (i).

(f)  Before transitioning the provision of Medicaid benefits for children under this section, a managed care organization providing services under the managed care program delivery model selected by the commission must demonstrate to the satisfaction of the commission that the organization's network of providers has experience and expertise in the provision of services to children with an intellectual or developmental disability. Before transitioning the provision of Medicaid benefits for adults with an intellectual or developmental disability under this section, a managed care organization providing services under the managed care program delivery model selected by the commission must demonstrate to the satisfaction of the commission that the organization's network of providers has experience and expertise in the provision of services to adults with an intellectual or developmental disability.

(g)  If the commission determines that all or a portion of the long-term services and supports previously available under the Medicaid waiver programs should be provided through a managed care program delivery model under Subsection (c)(1), the commission shall, at the time of the transition, allow each recipient receiving long-term services and supports under a Medicaid waiver program the option of:

(1)  continuing to receive the services and supports under the Medicaid waiver program; or

(2)  receiving the services and supports through the managed care program delivery model selected by the commission.

(h)  A recipient who chooses to receive long-term services and supports through a managed care program delivery model under Subsection (g) may not, at a later time, choose to receive the services and supports under a Medicaid waiver program.

(i)  In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission for the organization to provide Medicaid benefits under this section must contain a requirement that the organization implement a process for individuals with an intellectual or developmental disability that:

(1)  ensures that the individuals have a choice among acute care and comprehensive long term services and supports providers and service delivery options including the consumer directed services model;

(2)  to the greatest extent possible, protects those individuals' continuity of care with respect to access to primary care providers, including the use of single-case agreements with out-of-network providers; and

(3)  provides access to a member services phone line for individuals or their legally authorized representatives to obtain information on and assistance with accessing services through network providers, including providers of primary, specialty, and other long-term services and supports.

SECTION 25.  Section 534.203, Subchapter E, Chapter 534, Government Code, is amended to read as follows:

Sec. 534.203.  RESPONSIBILITIES OF COMMISSION UNDER SUBCHAPTER. In administering this subchapter, the commission shall ensure that upon a determination to transition services in the programs defined under Sections 534.001 (8) and (12):

(1)  that the commission is responsible for setting the minimum reimbursement rate paid to a provider of ICF-IID services or a group home provider under the integrated managed care system, including the staff rate enhancement paid to a provider of ICF-IID services or a group home provider;

(2)  that an ICF-IID service provider or a group home provider is paid not later than the 10th day after the date the provider submits a clean claim in accordance with the criteria used by the department for the reimbursement of ICF-IID service providers or a group home provider, as applicable; and

(3)  the establishment of an electronic portal through which a provider of ICF-IID services or a group home provider participating in the STAR + PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as appropriate, may submit long-term services and supports claims to any participating managed care organization [~~.~~ ] ; and

(4)  that each individual with an intellectual or developmental disability and the individual's legally authorized representative has access to a comprehensive facilitated, person-centered plan that identifies outcomes for the individual. The consumer directed services model must be promoted as an available option for individuals to achieve self-determination, choice and control.

SECTION 26.  Chapter 534, Government Code, is amended to add Subchapter F. to read as follows:

SUBCHAPTER F. OTHER IMPLEMENTATION REQUIREMENTS AND RESPONSIBILITIES UNDER THIS CHAPTER

Sec. 534.301.  IMPLEMENTATION AND RESPONSIBILITIES UNDER THIS CHAPTER. (a) The commission is authorized to delay implementation of this Chapter or its subchapters without further investigation or adjustments or legislative intervention, if it determines any provision under the Chapter or other related mandate or initiative integral to implementation adversely affects the system of services and supports to persons and programs to which the Chapter applies.

(b)  For purpose of the pilot under Subchpater C. of this Chapter and any subsequent transition of recipients receiving services under certain Medicaid waiver programs defined under Section 534.001 (12) to a managed care program as specified under Section 534.202 (c), the commission must:

(1)  maintain a certification process and regulatory oversight of Texas Home Living and Home and Community-based Services providers; and

(2)  require managed care organizations include in their network of qualified long term services and supports providers certified Texas Home Living and Home and Community-based Services providers that specialize in services for persons with intellectual disabilities.

(c)  Subject to Section 534.202 (b) and (c), upon a decision to transition the long term services and supports under a Medicaid waiver program defined under Section 534.001 (12), the commission shall ensure individuals do not lose the benefits they are receiving through these Medicaid waiver programs.

(d)  For purposes of the pilot under Subchapter C. and any future transition of services specified under Section 534.202 into the STAR+PLUS program, the comprehensive long term services and supports provider defined in Section 534.001 (4):

(1)  must report encounters of any directly contracted services to the managed care organization; provide quarterly reporting of coordinated services and timeframes to the managed care organization, and provide quarterly progress on goals and objectives set by an individual's person centered plan; and

(2)  will not be held accountable for the provision of services on an individual's service plan for which a managed care organization denies or does not authorize access to in a timely manner.

SECTION 27.  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 28.  If the Health and Human Services Commission determines that it is cost effective, the commission shall apply for and actively seek a waiver or authorization from the appropriate federal agency to allow the state to provide medical assistance under the waiver or authorization to medically fragile individuals;

(1)  Who are at least 21 years of age; and

(2)  Whose costs to receive care exceed cost limits under existing Medicaid waiver programs.

SECTION 29.  This act takes effect September 1, 2019.