AN ACT

relating to the administration and operation of Medicaid, including Medicaid managed care and the delivery of Medicaid acute care services and long-term services and supports to certain persons.

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

SECTION 1. Section 531.001, Government Code, is amended by adding Subdivision (4-c) to read as follows:

(4-c) "Medicaid managed care organization" means a managed care organization as defined by Section 533.001 that contracts with the commission under Chapter 533 to provide health care services to Medicaid recipients.

SECTION 2. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.021182, 531.02131, 531.02142, 531.024162, and 531.0511 to read as follows:

Sec. 531.021182. USE OF NATIONAL PROVIDER IDENTIFIER NUMBER. (a) In this section, "national provider identifier number" means the national provider identifier number required under Section 1128J(e), Social Security Act (42 U.S.C. Section 1320a-7k(e)).

(b) The commission shall transition from using a state-issued provider identifier number to using only a national provider identifier number in accordance with this section.

(c) The commission shall implement a Medicaid provider management and enrollment system and, following that

implementation, use only a national provider identifier number to enroll a provider in Medicaid.

(d) The commission shall implement a modernized claims processing system and, following that implementation, use only a national provider identifier number to process claims for and authorize Medicaid services.

Sec. 531.02131. GRIEVANCES RELATED TO MEDICAID. (a) The commission shall adopt a definition of "grievance" related to Medicaid and ensure the definition is consistent among divisions within the commission to ensure all grievances are managed consistently.

(b) The commission shall standardize Medicaid grievance data reporting and tracking among divisions within the commission.

(c) The commission shall implement a no-wrong-door system for Medicaid grievances reported to the commission.

(d) The commission shall establish a procedure for expedited resolution of a grievance related to Medicaid that allows the commission to:

(1) identify a grievance related to a Medicaid access to care issue that is urgent and requires an expedited resolution; and

(2) resolve the grievance within a specified period.

(e) The commission shall verify grievance data reported by a Medicaid managed care organization.

(f) The commission shall:

(1) aggregate Medicaid recipient and provider grievance data to provide a comprehensive data set of grievances;

and

(2) make the aggregated data available to the legislature and the public in a manner that does not allow for the identification of a particular recipient or provider.

Sec. 531.02142. PUBLIC ACCESS TO CERTAIN MEDICAID DATA. (a) To the extent permitted by federal law, the commission in consultation and collaboration with the appropriate advisory committees related to Medicaid shall make available to the public on the commission's Internet website in an easy-to-read format data relating to the quality of health care received by Medicaid recipients and the health outcomes of those recipients. Data made available to the public under this section must be made available in a manner that does not identify or allow for the identification of individual recipients.

(b) In performing its duties under this section, the commission may collaborate with an institution of higher education or another state agency with experience in analyzing and producing public use data.

Sec. 531.024162. NOTICE REQUIREMENTS REGARDING DENIAL OF COVERAGE OR PRIOR AUTHORIZATION. (a) The commission shall ensure that notice sent by the commission or a Medicaid managed care organization to a Medicaid recipient or provider regarding the denial of coverage or prior authorization for a service includes:

(1) information required by federal law;

(2) a clear and easy-to-understand explanation of the reason for the denial for the recipient; and

(3) a clinical explanation of the reason for the

denial for the provider.

(b) To ensure cost-effectiveness, the commission may implement the notice requirements described by Subsection (a) at the same time as other required or scheduled notice changes.

Sec. 531.0511. MEDICALLY DEPENDENT CHILDREN WAIVER PROGRAM: CONSUMER DIRECTION OF SERVICES. Notwithstanding Sections 531.051(c)(1) and (d), a consumer direction model implemented under Section 531.051, including the consumer-directed service option, for the delivery of services under the medically dependent children (MDCP) waiver program must allow for the delivery of all services and supports available under that program through consumer direction.

SECTION 3. Section 533.00253(a)(1), Government Code, is amended to read as follows:

(1) "Advisory committee" means the STAR Kids Managed Care Advisory Committee described by [~~established under~~] Section 533.00254.

SECTION 4. Section 533.00253, Government Code, is amended by amending Subsection (c) and adding Subsections (f), (g), and (h) to read as follows:

(c) The commission may require that care management services made available as provided by Subsection (b)(7):

(1) incorporate best practices, as determined by the commission;

(2) integrate with a nurse advice line to ensure appropriate redirection rates;

(3) use an identification and stratification

methodology that identifies recipients who have the greatest need for services;

(4) provide a care needs assessment for a recipient [~~that is comprehensive, holistic, consumer-directed, evidence-based, and takes into consideration social and medical issues, for purposes of prioritizing the recipient's needs that threaten independent living~~];

(5) are delivered through multidisciplinary care teams located in different geographic areas of this state that use in-person contact with recipients and their caregivers;

(6) identify immediate interventions for transition of care;

(7) include monitoring and reporting outcomes that, at a minimum, include:

(A) recipient quality of life;

(B) recipient satisfaction; and

(C) other financial and clinical metrics determined appropriate by the commission; and

(8) use innovations in the provision of services.

(f) Using existing resources, the executive commissioner in consultation and collaboration with the advisory committee shall determine the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under:

(1) an accountable care organization model in accordance with guidelines established by the Centers for Medicare and Medicaid Services; or

(2) an alternative model developed by or in

collaboration with the Centers for Medicare and Medicaid Services Innovation Center.

(g) Not later than December 1, 2022, the commission shall prepare and submit a written report to the legislature of the executive commissioner's determination under Subsection (f).

(h) Subsections (f) and (g) and this subsection expire September 1, 2023.

SECTION 5. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00254 and 533.0031 to read as follows:

Sec. 533.00254. STAR KIDS MANAGED CARE ADVISORY COMMITTEE. (a) The STAR Kids Managed Care Advisory Committee established by the executive commissioner under Section 531.012 shall:

(1) advise the commission on the operation of the STAR Kids managed care program under Section 533.00253; and

(2) make recommendations for improvements to that program.

(b) On December 31, 2023:

(1) the advisory committee is abolished; and

(2) this section expires.

Sec. 533.0031. MEDICAID MANAGED CARE PLAN ACCREDITATION. (a) A managed care plan offered by a Medicaid managed care organization must be accredited by a nationally recognized accreditation organization. The commission may choose whether to require all managed care plans offered by Medicaid managed care organizations to be accredited by the same organization or to allow for accreditation by different organizations.

(b) The commission may use the data, scoring, and other information provided to or received from an accreditation organization in the commission's contract oversight processes.

SECTION 6. Section 534.001, Government Code, is amended by amending Subdivision (3) and adding Subdivisions (3-a) and (11-a) to read as follows:

(3) "Comprehensive long-term services and supports provider" means a provider of long-term services and supports under this chapter that ensures the coordinated, seamless delivery of the full range of services in a recipient's program plan. The term includes:

(A) a provider under the ICF-IID program; and

(B) a provider under a Medicaid waiver program

[~~"Department" means the Department of Aging and Disability Services~~].

(3-a) "Consumer direction model" has the meaning assigned by Section 531.051.

(11-a) "Residential services" means services provided to an individual with an intellectual or developmental disability through a community-based ICF-IID, three- or four-person home or host home setting under the home and community-based services (HCS) waiver program, or a group home under the deaf-blind with multiple disabilities (DBMD) waiver program.

SECTION 7. Sections 534.051 and 534.052, Government Code, are 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;

(2) improve individuals' access to services and supports by ensuring that the individuals receive information about all available programs and services, including employment and least restrictive housing assistance, and how to apply for the programs and services;

(3) improve the assessment of individuals' needs and available supports, including the assessment of individuals' functional needs;

(4) promote person-centered planning, self-direction, self-determination, community inclusion, and customized, integrated, competitive employment;

(5) promote individualized budgeting based on an assessment of an individual's needs and person-centered planning;

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

(7) improve acute care and long-term services and supports outcomes, including reducing unnecessary institutionalization and potentially preventable events;

(8) promote high-quality care;

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

(10) ensure the availability of a local safety net provider and local safety net services;

(11) promote independent service coordination and independent ombudsmen services; and

(12) ensure that individuals with the most significant needs are appropriately served in the community and that processes are in place to prevent inappropriate institutionalization of individuals.

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 8. Sections 534.053(a) and (b), Government Code, are amended to read as follows:

(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:

(1) individuals with an intellectual or developmental disability who are recipients of services under the Medicaid waiver programs, individuals with an intellectual or developmental disability who are recipients of services under the ICF-IID program, and individuals who are advocates of those recipients, including at least three representatives from intellectual and developmental disability advocacy organizations;

(2) representatives of Medicaid managed care and nonmanaged care health care providers, including:

(A) physicians who are primary care providers and physicians who are specialty care providers;

(B) nonphysician mental health professionals; and

(C) providers of long-term services and supports, including direct service workers;

(3) representatives of entities with responsibilities for the delivery of Medicaid long-term services and supports or other Medicaid service delivery, including:

(A) representatives of aging and disability resource centers established under the Aging and Disability Resource Center initiative funded in part by the federal Administration on Aging and the Centers for Medicare and Medicaid Services;

(B) representatives of community mental health and intellectual disability centers;

(C) representatives of and service coordinators

or case managers from private and public home and community-based services providers that serve individuals with an intellectual or developmental disability; and

(D) representatives of private and public ICF-IID providers; and

(4) representatives of managed care organizations contracting with the state to provide services to individuals with an intellectual or developmental disability.

(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.

SECTION 9. 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, is reenacted and amended to read as follows:

(g) On the second [~~one-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 10. Section 534.054(b), Government Code, is amended to read as follows:

(b) This section expires on the second anniversary of the date the commission completes implementation of the transition required under Section 534.202 [~~January 1, 2026~~].

SECTION 11. The heading to Subchapter C, Chapter 534, Government Code, is amended to read as follows:

SUBCHAPTER C. STAGE ONE: PILOT PROGRAM FOR IMPROVING [~~PROGRAMS TO IMPROVE~~] SERVICE DELIVERY MODELS

SECTION 12. Section 534.101, Government Code, is amended by amending Subdivision (2) and adding Subdivision (3) to read as follows:

(2) "Pilot program" means the pilot program established under this subchapter [~~"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~~].

(3) "Pilot program workgroup" means the pilot program workgroup established under Section 534.1015.

SECTION 13. Subchapter C, Chapter 534, Government Code, is amended by adding Section 534.1015 to read as follows:

Sec. 534.1015. PILOT PROGRAM WORKGROUP. (a) The executive commissioner, in consultation with the advisory committee, shall establish a pilot program workgroup to provide assistance in developing and advice concerning the operation of the pilot program.

(b) The pilot program workgroup is composed of:

(1) representatives of the advisory committee;

(2) stakeholders representing individuals with an intellectual or developmental disability;

(3) stakeholders representing individuals with similar functional needs as those individuals described by

Subdivision (2); and

(4) representatives of managed care organizations that contract with the commission to provide services under the STAR+PLUS Medicaid managed care program.

(c) Chapter 2110 applies to the pilot program workgroup.

SECTION 14. Sections 534.102 and 534.103, Government Code, are amended to read as follows:

Sec. 534.102. PILOT PROGRAM [~~PROGRAMS~~] TO TEST PERSON-CENTERED MANAGED CARE STRATEGIES AND IMPROVEMENTS BASED ON CAPITATION. The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall [~~and the department may~~] develop and implement a pilot program [~~programs~~] 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 a managed care strategy based on capitation to deliver~~] long-term services and supports [~~under Medicaid~~] to individuals participating in the pilot program [~~with an intellectual or developmental disability~~].

Sec. 534.103. STAKEHOLDER INPUT. As part of developing and implementing the [~~a~~] pilot program [~~under this subchapter~~], the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, [~~department~~] shall develop a process to receive and evaluate:

(1) input from statewide stakeholders and stakeholders from a STAR+PLUS Medicaid managed care service area [~~the region of the state~~] in which the pilot program will be implemented; and

(2) other evaluations and data.

SECTION 15. Subchapter C, Chapter 534, Government Code, is amended by adding Section 534.1035 to read as follows:

Sec. 534.1035. MANAGED CARE ORGANIZATION SELECTION. (a) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop criteria regarding the selection of a managed care organization to participate in the pilot program.

(b) The commission shall select and contract with not more than two managed care organizations that contract with the commission to provide services under the STAR+PLUS Medicaid managed care program to participate in the pilot program.

SECTION 16. Section 534.104, Government Code, is amended to read as follows:

Sec. 534.104. [~~MANAGED CARE STRATEGY PROPOSALS;~~] PILOT PROGRAM DESIGN [~~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 managed care strategy based on capitation developed for implementation through a~~] pilot program [~~under this subchapter~~] must be designed to:

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

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

(3) promote:

(A) informed choice and meaningful outcomes by using person-centered planning, flexible consumer-directed services, individualized budgeting, and self-determination;[~~,~~] and

(B) [~~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 an individual's needs and preferences;

(6) promote through housing supports and navigation services stability [~~the placement of an individual~~] in housing that is the most integrated and least restrictive based on [~~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 technologies and benefits, including telemedicine, telemonitoring, the testing of remote monitoring, transportation services, and other innovations that support community integration;

(11) ensure an adequate provider network that includes comprehensive long-term services and supports providers and ensure that pilot program participants have a choice among those providers;

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

(13) ensure that individuals with complex behavioral, medical, and physical needs are assessed and receive appropriate services in the most integrated and least restrictive setting based on the individuals' needs and preferences;

(14) increase access to, expand flexibility of, and promote the use of the consumer direction model; and

(15) promote independence, self-determination, the use of the consumer direction model, and decision making by individuals participating in the pilot program by using alternatives to guardianship, including a supported decision-making agreement as defined by Section 1357.002, Estates

Code.

(b) An individual is not required to use an innovative technology described by Subsection (a)(10). If an individual chooses to use an innovative technology described by that subdivision, the commission shall ensure that services associated with the technology are delivered in a manner that:

(1) ensures the individual's privacy, health, and well-being;

(2) provides access to housing in the most integrated and least restrictive environment;

(3) assesses individual needs and preferences to promote autonomy, self-determination, the use of the consumer direction model, and privacy;

(4) increases personal independence;

(5) specifies the extent to which the innovative technology will be used, including:

(A) the times of day during which the technology will be used;

(B) the place in which the technology may be used;

(C) the types of telemonitoring or remote monitoring that will be used; and

(D) for what purposes the technology will be used;

(6) is consistent with and agreed on during the person-centered planning process;

(7) ensures that staff overseeing the use of an

innovative technology:

(A) review the person-centered and implementation plans for each individual before overseeing the use of the innovative technology; and

(B) demonstrate competency regarding the support needs of each individual using the innovative technology;

(8) ensures that an individual using an innovative technology is able to request the removal of equipment relating to the technology and, on receipt of a request for the removal, the equipment is immediately removed; and

(9) ensures that an individual is not required to use telemedicine at any point during the pilot program and, in the event the individual refuses to use telemedicine, the managed care organization providing health care services to the individual under the pilot program arranges for services that do not include telemedicine.

(c) The pilot program must be designed to test innovative payment rates and methodologies for the provision of long-term services and supports to achieve the goals of the pilot program by using payment methodologies that include:

(1) the payment of a bundled amount without downside risk to a comprehensive 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 comprehensive long-term services and supports providers based on the completion of predetermined outcomes or quality metrics; and

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

(d) An alternative payment rate or methodology described by Subsection (c) may be used for a managed care organization and comprehensive long-term services and supports provider only if the organization and provider agree in advance and in writing to use the rate or methodology [~~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) In developing an alternative payment rate or methodology described by Subsection (c), the commission, managed care organizations, and comprehensive long-term services and supports providers shall consider:

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

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

(3) whether an alternative payment rate or methodology is sufficient to promote quality outcomes and ensure a provider's continued participation in the pilot program [~~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) An alternative payment rate or methodology described by Subsection (c) may not reduce the minimum payment received by a provider for the delivery of long-term services and supports under the pilot program below the fee-for-service reimbursement rate received by the provider for the delivery of those services before participating in the pilot program.

(g) The pilot program must allow a comprehensive long-term services and supports provider for individuals with an intellectual or developmental disability or similar functional needs that contracts with the commission to provide services under Medicaid before the implementation date of the pilot program to voluntarily participate in the pilot program. A provider's choice not to participate in the pilot program does not affect the provider's status as a significant traditional provider.

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

(i) [~~(g)~~] The commission [~~department~~], in consultation and collaboration with the advisory committee and pilot program

workgroup, shall analyze information provided by the managed care organizations participating in the pilot program [~~service providers~~] and any information collected by the commission [~~department~~] during the operation of the pilot program [~~programs~~] for purposes of making a recommendation about a system of programs and services for implementation through future state legislation or rules.

(j) [~~(h)~~] The analysis under Subsection (i) [~~(g)~~] must include an assessment of the effect of the managed care strategies implemented in the pilot program [~~programs~~] on the goals described by this section [~~:~~

[~~(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~~].

(k) Before implementing the pilot program, the commission,

in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop and implement a process to ensure pilot program participants remain eligible for Medicaid benefits for 12 consecutive months during the pilot program.

SECTION 17. Subchapter C, Chapter 534, Government Code, is amended by adding Section 534.1045 to read as follows:

Sec. 534.1045. PILOT PROGRAM BENEFITS AND PROVIDER QUALIFICATIONS. (a) Subject to Subsection (b), the commission shall ensure that a managed care organization participating in the pilot program provides:

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

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

(A) Community First Choice services;

(B) personal assistance services;

(C) day activity health services; and

(D) habilitation services;

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

(A) assisted living services;

(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) cognitive rehabilitative therapy;

(K) physical therapy;

(L) occupational therapy;

(M) speech-language pathology;

(N) medical supplies;

(O) minor home modifications; and

(P) adaptive aids;

(4) the following long-term services and supports under a Medicaid waiver program:

(A) enhanced behavioral health services;

(B) behavioral supports;

(C) day habilitation; and

(D) community support transportation;

(5) the following additional long-term services and supports:

(A) housing supports;

(B) behavioral health crisis intervention services; and

(C) high medical needs services;

(6) other nonresidential long-term services and supports that the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, determines are appropriate and consistent with applicable requirements governing the Medicaid waiver programs, person-centered

approaches, home and community-based setting requirements, and achieving the most integrated and least restrictive setting based on an individual's needs and preferences; and

(7) dental services benefits in accordance with Subsection (a-1).

(a-1) In developing the pilot program, the commission shall:

(1) evaluate dental services benefits provided through Medicaid waiver programs and dental services benefits provided as a value-added service under the Medicaid managed care delivery model;

(2) determine which dental services benefits are the most cost-effective in reducing emergency room and inpatient hospital admissions due to poor oral health; and

(3) based on the determination made under Subdivision (2), provide the most cost-effective dental services benefits to pilot program participants.

(b) A comprehensive long-term services and supports provider may deliver services listed under the following provisions only if the provider also delivers the services under a Medicaid waiver program:

(1) Subsections (a)(2)(A) and (D);

(2) Subsections (a)(3)(B), (C), (D), (G), (H), (J), (K), (L), and (M); and

(3) Subsection (a)(4).

(c) A comprehensive long-term services and supports provider may deliver services listed under Subsections (a)(5) and

(6) only if the managed care organization in the network of which the provider participates agrees to, in a contract with the provider, the provision of those services.

(d) Day habilitation services listed under Subsection (a)(4)(C) may be delivered by a provider who contracts or subcontracts with the commission to provide day habilitation services under the home and community-based services (HCS) waiver program or the ICF-IID program.

(e) A comprehensive long-term services and supports provider participating in the pilot program shall work in coordination with the care coordinators of a managed care organization participating in the pilot program to ensure the seamless delivery of acute care and long-term services and supports on a daily basis in accordance with an individual's plan of care. A comprehensive long-term services and supports provider may be reimbursed by a managed care organization for coordinating with care coordinators under this subsection.

(f) Before implementing the pilot program, the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall:

(1) for purposes of the pilot program only, develop recommendations to modify adult foster care and supported employment and employment assistance benefits to increase access to and availability of those services; and

(2) as necessary, define services listed under Subsections (a)(4) and (5) and any other services determined to be appropriate under Subsection (a)(6).

SECTION 18. Sections 534.105, 534.106, 534.1065, 534.107, 534.108, and 534.109, Government Code, are amended to read as follows:

Sec. 534.105. PILOT PROGRAM: MEASURABLE GOALS. (a) The commission [~~department~~], in consultation and collaboration with the advisory committee and pilot program workgroup and using national core indicators, the National Quality Forum long-term services and supports measures, and other appropriate Consumer Assessment of Healthcare Providers and Systems measures, shall identify measurable goals to be achieved by the [~~each~~] 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 commission [~~department~~], in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop [~~propose~~] 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 mechanisms to report, track, and assess specific strategies and performance measures for achieving the identified goals are

established before implementing the pilot program.

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

(b) The [~~A~~] pilot program [~~established under this subchapter~~] shall [~~may~~] 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) The [~~A~~] pilot program [~~established under this subchapter~~] shall be conducted in a STAR+PLUS Medicaid managed care service area [~~one or more regions~~] selected by the commission [~~department~~].

Sec. 534.1065. RECIPIENT ENROLLMENT, PARTICIPATION, AND ELIGIBILITY [~~IN PROGRAM VOLUNTARY~~]. (a) An individual who is eligible for the pilot program will be enrolled automatically [~~Participation in a pilot program established under this subchapter by an individual with an intellectual or developmental disability is voluntary~~], and the decision whether to opt out of participation [~~participate~~] in the pilot [~~a~~] program and not receive long-term services and supports under the pilot [~~from a provider through that~~] program may be made only by the individual or the individual's legally authorized representative.

(b) To ensure prospective pilot program participants are able to make an informed decision on whether to participate in the pilot program, the commission, in consultation and collaboration

with the advisory committee and pilot program workgroup, shall develop and distribute informational materials on the pilot program that describe the pilot program's benefits, the pilot program's impact on current services, and other related information. The commission shall establish a timeline and process for the development and distribution of the materials and shall ensure:

(1) the materials are developed and distributed to individuals eligible to participate in the pilot program with sufficient time to educate the individuals, their families, and other persons actively involved in their lives regarding the pilot program;

(2) individuals eligible to participate in the pilot program, including individuals enrolled in the STAR+PLUS Medicaid managed care program, their families, and other persons actively involved in their lives, receive the materials and oral information on the pilot program;

(3) the materials contain clear, simple language presented in a manner that is easy to understand; and

(4) the materials explain, at a minimum, that:

(A) on conclusion of the pilot program, pilot program participants will be asked to provide feedback on their experience, including feedback on whether the pilot program was able to meet their unique support needs;

(B) participation in the pilot program does not remove individuals from any Medicaid waiver program interest list;

(C) individuals who choose to participate in the pilot program and who, during the pilot program's operation, are

offered enrollment in a Medicaid waiver program may accept the enrollment, transition, or diversion offer; and

(D) pilot program participants have a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model and comprehensive services model.

(c) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop pilot program participant eligibility criteria. The criteria must ensure pilot program participants:

(1) include individuals with an intellectual or developmental disability or a cognitive disability, including:

(A) individuals with autism;

(B) individuals with significant complex behavioral, medical, and physical needs who are receiving home and community-based services through the STAR+PLUS Medicaid managed care program;

(C) individuals enrolled in the STAR+PLUS Medicaid managed care program who:

(i) are on a Medicaid waiver program interest list;

(ii) meet the criteria for an intellectual or developmental disability; or

(iii) have a traumatic brain injury that occurred after the age of 21; and

(D) other individuals with disabilities who have similar functional needs without regard to the age of onset or

diagnosis; and

(2) do not include individuals who are receiving only acute care services under the STAR+PLUS Medicaid managed care program and are enrolled in the community-based ICF-IID program or another Medicaid waiver program.

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

(1) ensures that individuals participating in the pilot program have a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model [~~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) demonstrates to the commission's satisfaction that the organization's network of acute care, long-term services and supports, and comprehensive long-term services and supports providers have experience and expertise in 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) has [~~have~~] a process for preventing inappropriate institutionalizations of individuals; and

(4) ensures the 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 program, the commission shall ensure that comprehensive long-term services and supports providers are considered significant traditional providers and included in the provider network of a managed care organization participating in the pilot program.

Sec. 534.108. PILOT PROGRAM INFORMATION. (a) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, [~~and the department~~] shall determine which information will be collected from a managed care organization participating in the pilot program to use in conducting the evaluation and preparing the report under Section 534.112 [~~collect and compute the following information with respect to each pilot program implemented under this subchapter to the extent it is available:~~

[~~(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) For the duration of the pilot program, a managed care organization participating in the pilot program shall submit to the commission and the advisory committee quarterly reports on the services provided to each pilot program participant that include information on:

(1) the level of each requested service and the authorization and utilization rates for those services;

(2) timelines of:

(A) the delivery of each requested service;

(B) authorization of each requested service;

(C) the initiation of each requested service; and

(D) each unplanned break in the delivery of requested services and the duration of the break;

(3) the number of pilot program participants using employment assistance and supported employment services;

(4) the number of service denials and fair hearings and the dispositions of fair hearings;

(5) the number of complaints and inquiries received by the managed care organization and the outcome of each complaint; and

(6) the number of pilot program participants who choose the consumer direction model and the reasons why other participants did not choose the consumer direction model [~~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) The commission shall ensure that the mechanisms to report and track the information and data required by this section are established before implementing the pilot program [~~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~~].

Sec. 534.109. PERSON-CENTERED PLANNING. The commission, in consultation and collaboration [~~cooperation~~] with the advisory committee and pilot program workgroup [~~department~~], shall ensure that each individual [~~with an intellectual or developmental disability~~] who receives services and supports under Medicaid through the [~~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 direction model must be an available option for individuals to achieve self-determination, choice, and control[~~, as defined by Section 531.051, may be an outcome of the plan~~].

SECTION 19. Section 534.110, Government Code, is amended to read as follows:

Sec. 534.110. TRANSITION BETWEEN PROGRAMS; CONTINUITY OF SERVICES. (a) During the evaluation of the pilot program required under Section 534.112, the [~~The~~] commission may continue the pilot program to ensure continuity of care for pilot program participants. If the commission does not continue the pilot

program following the evaluation, the commission shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits for pilot program participants to the benefits provided before participating in the pilot program [~~between a Medicaid waiver program or an ICF-IID program and a pilot program under this subchapter to protect continuity of care~~].

(b) A [~~The~~] transition plan under Subsection (a) shall be developed in consultation and collaboration with the advisory committee and pilot program workgroup and with stakeholder input as described by Section 534.103.

SECTION 20. Section 534.111, Government Code, is amended to read as follows:

Sec. 534.111. CONCLUSION OF PILOT PROGRAM [~~PROGRAMS; EXPIRATION~~]. (a) On September 1, 2025, the pilot program is concluded unless the commission continues the pilot program under Section 534.110 [~~2019:~~

[~~(1) each pilot program established under this subchapter that is still in operation must conclude; and~~

[~~(2) this subchapter expires~~].

(b) If the commission continues the pilot program under Section 534.110, the commission shall publish notice of the pilot program's continuance in the Texas Register not later than September 1, 2025.

SECTION 21. Subchapter C, Chapter 534, Government Code, is amended by adding Section 534.112 to read as follows:

Sec. 534.112. PILOT PROGRAM EVALUATIONS AND REPORTS. (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 and submit, as part of the annual report required under Section 534.054, a report on the pilot program's status that includes recommendations for improving the program.

(b) Not later than September 1, 2026, the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall prepare and submit to the legislature a written report that evaluates the pilot program based on a comprehensive analysis. The analysis must:

(1) assess the effect of the pilot program on:

(A) access to and 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 pilot program participant'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 hearings and appeals in accordance with applicable federal and state law;

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

(G) increasing the use of alternatives to

guardianship, including supported decision-making agreements as defined by Section 1357.002, Estates Code;

(H) achieving the best and most cost-effective use of funding based on a pilot program participant's needs and preferences; and

(I) attendant recruitment and retention;

(2) analyze the experiences and outcomes of the following systems changes:

(A) the comprehensive assessment instrument described by Section 533A.0335, Health and Safety Code;

(B) the 21st Century Cures Act (Pub. L. No. 114-255);

(C) implementation of the federal rule adopted by the Centers for Medicare and Medicaid Services and published at 79 Fed. Reg. 2948 (January 16, 2014) related to the provision of long-term services and supports through a home and community-based services (HCS) waiver program under Section 1915(c), 1915(i), or 1915(k) of the federal Social Security Act (42 U.S.C. Section 1396n(c), (i), or (k));

(D) the provision of basic attendant and habilitation services under Section 534.152; and

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

(3) include feedback on the pilot program based on the personal experiences of:

(A) individuals with an intellectual or developmental disability and individuals with similar functional

needs who participated in the pilot program;

(B) families of and other persons actively involved in the lives of individuals described by Paragraph (A); and

(C) comprehensive long-term services and supports providers who delivered services under the pilot program;

(4) be incorporated in the annual report required under Section 534.054; and

(5) include recommendations on:

(A) a system of programs and services for consideration by the legislature;

(B) necessary statutory changes; and

(C) whether to implement the pilot program statewide under the STAR+PLUS Medicaid managed care program for eligible individuals.

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. The heading to Section 534.202, 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.

SECTION 24. Sections 534.202(a), (b), (c), (e), and (i), Government Code, are amended to read as follows:

(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 [~~other than the Texas home living (TxHmL) waiver program~~]; or

(2) an ICF-IID program.

(b) Subject to Subsection (g), after [~~After~~] implementing the pilot program under Subchapter C and completing the evaluation under Section 534.112 [~~transition required by Section 534.201, 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 an ICF-IID program or a Medicaid waiver program to a Medicaid managed care model. The plan must include:

(1) a process for transitioning the services in phases as follows:

(A) beginning September 1, 2027, the Texas home living (TxHmL) waiver program services;

(B) beginning September 1, 2029, the community living assistance and support services (CLASS) waiver program services;

(C) beginning September 1, 2031, nonresidential services provided under the home and community-based services (HCS) waiver program and the deaf-blind with multiple disabilities (DBMD) waiver program; and

(D) subject to Subdivision (2), the residential

services provided under an ICF-IID program, the home and community-based services (HCS) waiver program, and the deaf-blind with multiple disabilities (DBMD) waiver program; and

(2) a process for evaluating and determining the feasibility and cost efficiency of transitioning residential services described by Subdivision (1)(D) to a Medicaid managed care model that is based on an evaluation of a separate pilot program conducted by the commission, in consultation and collaboration with the advisory committee, that operates after the transition process described by Subdivision (1) [~~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) Before implementing the [~~At the time of the~~] transition described by Subsection (b), the commission shall, subject to Subsection (g), determine whether to:

(1) continue operation of the Medicaid waiver programs or ICF-IID program 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 [~~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 or ICF-IID program through the managed care program delivery model selected by the commission.

(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 direction model.

(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 direction 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, Government Code, is amended to read as follows:

Sec. 534.203. RESPONSIBILITIES OF COMMISSION UNDER SUBCHAPTER. In administering this subchapter, the commission shall ensure, on making a determination to transition services under Section 534.202:

(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 commission [~~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 [~~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 the consumer direction model is an available option for each individual with an intellectual or developmental disability who receives Medicaid benefits in accordance with this subchapter to achieve self-determination, choice, and control, and that the individual or the individual's legally authorized representative has access to a comprehensive, facilitated, person-centered plan that identifies outcomes for the individual.

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

SUBCHAPTER F. OTHER IMPLEMENTATION REQUIREMENTS AND RESPONSIBILITIES

Sec. 534.251. DELAYED IMPLEMENTATION AUTHORIZED. Notwithstanding any other law, the commission may delay implementation of a provision of this chapter without further investigation, adjustments, or legislative action if the commission determines the provision adversely affects the system of services and supports to persons and programs to which this chapter applies.

Sec. 534.252. REQUIREMENTS REGARDING TRANSITION OF SERVICES. (a) For purposes of implementing the pilot program under Subchapter C and transitioning the provision of services provided to recipients under certain Medicaid waiver programs to a Medicaid managed care delivery model following completion of the pilot program, the commission shall:

(1) implement and maintain a certification process for and maintain regulatory oversight over providers under the Texas

home living (TxHmL) and home and community-based services (HCS) waiver programs; and

(2) require managed care organizations to include in the organizations' provider networks providers who are certified in accordance with the certification process described by Subdivision (1).

(b) For purposes of implementing the pilot program under Subchapter C and transitioning the provision of services described by Section 534.202 to the STAR+PLUS Medicaid managed care program, a comprehensive long-term services and supports provider:

(1) must report to the managed care organization in the network of which the provider participates each encounter of any directly contracted service;

(2) must provide to the managed care organization quarterly reports on:

(A) coordinated services and time frames for the delivery of those services; and

(B) the goals and objectives outlined in an individual's person-centered plan and progress made toward meeting those goals and objectives; and

(3) may not be held accountable for the provision of services specified in an individual's service plan that are not authorized or subsequently denied by the managed care organization.

(c) On transitioning services under a Medicaid waiver program to a Medicaid managed care delivery model, the commission shall ensure that individuals do not lose benefits they receive under the Medicaid waiver program.

SECTION 27. Section 534.201, Government Code, is repealed.

SECTION 28. The Health and Human Services Commission shall issue a request for information to seek information and comments regarding contracting with a managed care organization to arrange for or provide a managed care plan under the STAR Kids managed care program established under Section 533.00253, Government Code, as amended by this Act, throughout the state instead of on a regional basis.

SECTION 29. (a) Using available resources, the Health and Human Services Commission shall report available data on the 30-day limitation on reimbursement for inpatient hospital care provided to Medicaid recipients enrolled in the STAR+PLUS Medicaid managed care program under 1 T.A.C. Section 354.1072(a)(1) and other applicable law. To the extent data is available on the subject, the commission shall also report on:

(1) the number of Medicaid recipients affected by the limitation and their clinical outcomes; and

(2) the impact of the limitation on reducing unnecessary Medicaid inpatient hospital days and any cost savings achieved by the limitation under Medicaid.

(b) Not later than December 1, 2020, the Health and Human Services Commission shall submit the report containing the data described by Subsection (a) of this section to the governor, the legislature, and the Legislative Budget Board. The report required under this subsection may be combined with any other report required by this Act or other law.

SECTION 30. The Health and Human Services Commission shall

implement:

(1) the Medicaid provider management and enrollment system required by Section 531.021182(c), Government Code, as added by this Act, not later than September 1, 2020; and

(2) the modernized claims processing system required by Section 531.021182(d), Government Code, as added by this Act, not later than September 1, 2023.

SECTION 31. The Health and Human Services Commission shall require that a managed care plan offered by a managed care organization with which the commission enters into or renews a contract under Chapter 533, Government Code, on or after the effective date of this Act comply with Section 533.0031, Government Code, as added by this Act, not later than September 1, 2022.

SECTION 32. Not later than September 1, 2020, and only if the Health and Human Services Commission determines it would be cost effective, the executive commissioner of the Health and Human Services Commission shall seek a waiver or authorization from the appropriate federal agency to provide Medicaid benefits to medically fragile individuals:

(1) who are 21 years of age or older; and

(2) whose health care costs exceed cost limits under appropriate Medicaid waiver programs, as defined by Section 534.001, Government Code.

SECTION 33. As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall adopt rules as necessary to implement the changes in law made by this Act.

SECTION 34. 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 35. The Health and Human Services Commission is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the commission may, but is not required to, implement a provision of this Act using other appropriations available for that purpose.

SECTION 36. This Act takes effect September 1, 2019.

President of the Senate

Speaker of the House

I certify that H.B. No. 4533 was passed by the House on May 10, 2019, by the following vote: Yeas 134, Nays 5, 2 present, not voting; and that the House concurred in Senate amendments to H.B. No. 4533 on May 24, 2019, by the following vote: Yeas 142, Nays 0, 2 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 4533 was passed by the Senate, with amendments, on May 20, 2019, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor