

1-1 By: Klick, Raymond (Senate Sponsor - Kolkhorst) H.B. No. 4533
1-2 (In the Senate - Received from the House May 13, 2019;
1-3 May 13, 2019, read first time and referred to Committee on Health &
1-4 Human Services; May 17, 2019, reported favorably by the following
1-5 vote: Yeas 9, Nays 0; May 17, 2019, sent to printer.)

1-6 COMMITTEE VOTE

| | Yea | Nay | Absent | PNV |
|------|-----|-----|--------|-----|
| 1-7 | | | | |
| 1-8 | X | | | |
| 1-9 | X | | | |
| 1-10 | X | | | |
| 1-11 | X | | | |
| 1-12 | X | | | |
| 1-13 | X | | | |
| 1-14 | X | | | |
| 1-15 | X | | | |
| 1-16 | X | | | |

1-17 A BILL TO BE ENTITLED
1-18 AN ACT

1-19 relating to the system redesign for delivery of Medicaid acute care
1-20 services and long-term services and supports to persons with an
1-21 intellectual or developmental disability or with similar
1-22 functional needs.

1-23 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

1-24 SECTION 1. Section 534.001, Government Code, is amended by
1-25 amending Subdivision (3) and adding Subdivisions (3-a) and (11-a)
1-26 to read as follows:

1-27 (3) "Comprehensive long-term services and supports
1-28 provider" means a provider of long-term services and supports under
1-29 this chapter that ensures the coordinated, seamless delivery of the
1-30 full range of services in a recipient's program plan. The term
1-31 includes:

1-32 (A) a provider under the ICF-IID program; and

1-33 (B) a provider under a Medicaid waiver program
1-34 [~~"Department" means the Department of Aging and Disability~~
1-35 ~~Services~~].

1-36 (3-a) "Consumer direction model" has the meaning
1-37 assigned by Section 531.051.

1-38 (11-a) "Residential services" means services provided
1-39 to an individual with an intellectual or developmental disability
1-40 through a community-based ICF-IID, three- or four-person home or
1-41 host home setting under the home and community-based services (HCS)
1-42 waiver program, or a group home under the deaf-blind with multiple
1-43 disabilities (DBMD) waiver program.

1-44 SECTION 2. Sections 534.051 and 534.052, Government Code,
1-45 are amended to read as follows:

1-46 Sec. 534.051. ACUTE CARE SERVICES AND LONG-TERM SERVICES
1-47 AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH AN INTELLECTUAL OR
1-48 DEVELOPMENTAL DISABILITY. In accordance with this chapter, the
1-49 commission [~~and the department~~] shall [~~jointly~~] design and
1-50 implement an acute care services and long-term services and
1-51 supports system for individuals with an intellectual or
1-52 developmental disability that supports the following goals:

1-53 (1) provide Medicaid services to more individuals in a
1-54 cost-efficient manner by providing the type and amount of services
1-55 most appropriate to the individuals' needs and preferences in the
1-56 most integrated and least restrictive setting;

1-57 (2) improve individuals' access to services and
1-58 supports by ensuring that the individuals receive information about
1-59 all available programs and services, including employment and least
1-60 restrictive housing assistance, and how to apply for the programs
1-61 and services;

- 2-1 (3) improve the assessment of individuals' needs and
 2-2 available supports, including the assessment of individuals'
 2-3 functional needs;
- 2-4 (4) promote person-centered planning, self-direction,
 2-5 self-determination, community inclusion, and customized,
 2-6 integrated, competitive employment;
- 2-7 (5) promote individualized budgeting based on an
 2-8 assessment of an individual's needs and person-centered planning;
- 2-9 (6) promote integrated service coordination of acute
 2-10 care services and long-term services and supports;
- 2-11 (7) improve acute care and long-term services and
 2-12 supports outcomes, including reducing unnecessary
 2-13 institutionalization and potentially preventable events;
- 2-14 (8) promote high-quality care;
- 2-15 (9) provide fair hearing and appeals processes in
 2-16 accordance with applicable federal law;
- 2-17 (10) ensure the availability of a local safety net
 2-18 provider and local safety net services;
- 2-19 (11) promote independent service coordination and
 2-20 independent ombudsmen services; and
- 2-21 (12) ensure that individuals with the most significant
 2-22 needs are appropriately served in the community and that processes
 2-23 are in place to prevent inappropriate institutionalization of
 2-24 individuals.

2-25 Sec. 534.052. IMPLEMENTATION OF SYSTEM REDESIGN. The
 2-26 commission [~~and department~~] shall, in consultation and
 2-27 collaboration with the advisory committee, [~~jointly~~] implement the
 2-28 acute care services and long-term services and supports system for
 2-29 individuals with an intellectual or developmental disability in the
 2-30 manner and in the stages described in this chapter.

2-31 SECTION 3. Sections 534.053(a) and (b), Government Code,
 2-32 are amended to read as follows:

2-33 (a) The Intellectual and Developmental Disability System
 2-34 Redesign Advisory Committee shall advise the commission [~~and the~~
 2-35 ~~department~~] on the implementation of the acute care services and
 2-36 long-term services and supports system redesign under this
 2-37 chapter. Subject to Subsection (b), the executive commissioner
 2-38 [~~and the commissioner of aging and disability services~~] shall
 2-39 [~~jointly~~] appoint members of the advisory committee who are
 2-40 stakeholders from the intellectual and developmental disabilities
 2-41 community, including:

2-42 (1) individuals with an intellectual or developmental
 2-43 disability who are recipients of services under the Medicaid waiver
 2-44 programs, individuals with an intellectual or developmental
 2-45 disability who are recipients of services under the ICF-IID
 2-46 program, and individuals who are advocates of those recipients,
 2-47 including at least three representatives from intellectual and
 2-48 developmental disability advocacy organizations;

2-49 (2) representatives of Medicaid managed care and
 2-50 nonmanaged care health care providers, including:

2-51 (A) physicians who are primary care providers and
 2-52 physicians who are specialty care providers;

2-53 (B) nonphysician mental health professionals;
 2-54 and

2-55 (C) providers of long-term services and
 2-56 supports, including direct service workers;

2-57 (3) representatives of entities with responsibilities
 2-58 for the delivery of Medicaid long-term services and supports or
 2-59 other Medicaid service delivery, including:

2-60 (A) representatives of aging and disability
 2-61 resource centers established under the Aging and Disability
 2-62 Resource Center initiative funded in part by the federal
 2-63 Administration on Aging and the Centers for Medicare and Medicaid
 2-64 Services;

2-65 (B) representatives of community mental health
 2-66 and intellectual disability centers;

2-67 (C) representatives of and service coordinators
 2-68 or case managers from private and public home and community-based
 2-69 services providers that serve individuals with an intellectual or

3-1 developmental disability; and

3-2 (D) representatives of private and public
3-3 ICF-IID providers; and

3-4 (4) representatives of managed care organizations
3-5 contracting with the state to provide services to individuals with
3-6 an intellectual or developmental disability.

3-7 (b) To the greatest extent possible, the executive
3-8 commissioner [~~and the commissioner of aging and disability~~
3-9 ~~services~~] shall appoint members of the advisory committee who
3-10 reflect the geographic diversity of the state and include members
3-11 who represent rural Medicaid recipients.

3-12 SECTION 4. Section 534.053(g), Government Code, as amended
3-13 by Chapters 837 (S.B. 200), 946 (S.B. 277), and 1117 (H.B. 3523),
3-14 Acts of the 84th Legislature, Regular Session, 2015, is reenacted
3-15 and amended to read as follows:

3-16 (g) On the second [~~one-year~~] anniversary of the date the
3-17 commission completes implementation of the transition required
3-18 under Section 534.202:

3-19 (1) the advisory committee is abolished; and

3-20 (2) this section expires.

3-21 SECTION 5. Section 534.054(b), Government Code, is amended
3-22 to read as follows:

3-23 (b) This section expires on the second anniversary of the
3-24 date the commission completes implementation of the transition
3-25 required under Section 534.202 [January 1, 2026].

3-26 SECTION 6. The heading to Subchapter C, Chapter 534,
3-27 Government Code, is amended to read as follows:

3-28 SUBCHAPTER C. STAGE ONE: PILOT PROGRAM FOR IMPROVING [~~PROGRAMS TO~~
3-29 ~~IMPROVE~~] SERVICE DELIVERY MODELS

3-30 SECTION 7. Section 534.101, Government Code, is amended by
3-31 amending Subdivision (2) and adding Subdivision (3) to read as
3-32 follows:

3-33 (2) "Pilot program" means the pilot program
3-34 established under this subchapter [~~"Provider" means a person with~~
3-35 ~~whom the commission contracts for the provision of long-term~~
3-36 ~~services and supports under Medicaid to a specific population based~~
3-37 ~~on capitation].~~

3-38 (3) "Pilot program workgroup" means the pilot program
3-39 workgroup established under Section 534.1015.

3-40 SECTION 8. Subchapter C, Chapter 534, Government Code, is
3-41 amended by adding Section 534.1015 to read as follows:

3-42 Sec. 534.1015. PILOT PROGRAM WORKGROUP. (a) The executive
3-43 commissioner, in consultation with the advisory committee, shall
3-44 establish a pilot program workgroup to provide assistance in
3-45 developing and advice concerning the operation of the pilot
3-46 program.

3-47 (b) The pilot program workgroup is composed of:

3-48 (1) representatives of the advisory committee;

3-49 (2) stakeholders representing individuals with an
3-50 intellectual or developmental disability;

3-51 (3) stakeholders representing individuals with
3-52 similar functional needs as those individuals described by
3-53 Subdivision (2); and

3-54 (4) representatives of managed care organizations
3-55 that contract with the commission to provide services under the
3-56 STAR+PLUS Medicaid managed care program.

3-57 (c) Chapter 2110 applies to the pilot program workgroup.

3-58 SECTION 9. Sections 534.102 and 534.103, Government Code,
3-59 are amended to read as follows:

3-60 Sec. 534.102. PILOT PROGRAM [~~PROGRAMS~~] TO TEST
3-61 PERSON-CENTERED MANAGED CARE STRATEGIES AND IMPROVEMENTS BASED ON
3-62 CAPITATION. The commission, in consultation and collaboration with
3-63 the advisory committee and pilot program workgroup, shall [~~and the~~
3-64 ~~department may~~] develop and implement a pilot program [~~programs~~] in
3-65 accordance with this subchapter to test, through the STAR+PLUS
3-66 Medicaid managed care program, the delivery of [~~one or more service~~
3-67 ~~delivery models involving a managed care strategy based on~~
3-68 ~~capitation to deliver~~] long-term services and supports [~~under~~
3-69 ~~Medicaid~~] to individuals participating in the pilot program [~~with~~

4-1 ~~an intellectual or developmental disability].~~

4-2 Sec. 534.103. STAKEHOLDER INPUT. As part of developing and
4-3 implementing ~~the [a] pilot program [under this subchapter],~~ the
4-4 commission, in consultation and collaboration with the advisory
4-5 committee and pilot program workgroup, [department] shall develop a
4-6 process to receive and evaluate:

4-7 (1) input from statewide stakeholders and
4-8 stakeholders from a STAR+PLUS Medicaid managed care service area
4-9 ~~[the region of the state]~~ in which the pilot program will be
4-10 implemented; and

4-11 (2) other evaluations and data.

4-12 SECTION 10. Subchapter C, Chapter 534, Government Code, is
4-13 amended by adding Section 534.1035 to read as follows:

4-14 Sec. 534.1035. MANAGED CARE ORGANIZATION SELECTION. (a)
4-15 The commission, in consultation and collaboration with the advisory
4-16 committee and pilot program workgroup, shall develop criteria
4-17 regarding the selection of a managed care organization to
4-18 participate in the pilot program.

4-19 (b) The commission shall select and contract with not more
4-20 than two managed care organizations that contract with the
4-21 commission to provide services under the STAR+PLUS Medicaid managed
4-22 care program to participate in the pilot program.

4-23 SECTION 11. Section 534.104, Government Code, is amended to
4-24 read as follows:

4-25 Sec. 534.104. ~~[MANAGED CARE STRATEGY PROPOSALS;]~~ PILOT
4-26 PROGRAM DESIGN ~~[SERVICE PROVIDERS].~~ (a) ~~The [department, in~~
4-27 ~~consultation and collaboration with the advisory committee, shall~~
4-28 ~~identify private services providers or managed care organizations~~
4-29 ~~that are good candidates to develop a service delivery model~~
4-30 ~~involving a managed care strategy based on capitation and to test~~
4-31 ~~the model in the provision of long-term services and supports under~~
4-32 ~~Medicaid to individuals with an intellectual or developmental~~
4-33 ~~disability through a pilot program established under this~~
4-34 ~~subchapter.~~

4-35 ~~[(b) The department shall solicit managed care strategy~~
4-36 ~~proposals from the private services providers and managed care~~
4-37 ~~organizations identified under Subsection (a). In addition, the~~
4-38 ~~department may accept and approve a managed care strategy proposal~~
4-39 ~~from any qualified entity that is a private services provider or~~
4-40 ~~managed care organization if the proposal provides for a~~
4-41 ~~comprehensive array of long-term services and supports, including~~
4-42 ~~case management and service coordination.~~

4-43 ~~[(c) A managed care strategy based on capitation developed~~
4-44 ~~for implementation through a] pilot program [under this subchapter]~~
4-45 must be designed to:

4-46 (1) increase access to long-term services and
4-47 supports;

4-48 (2) improve quality of acute care services and
4-49 long-term services and supports;

4-50 (3) promote:
4-51 (A) informed choice and meaningful outcomes by
4-52 using person-centered planning, flexible consumer-directed
4-53 services, individualized budgeting, and self-determination; [7] and
4-54 (B) [promote] community inclusion and
4-55 engagement;

4-56 (4) promote integrated service coordination of acute
4-57 care services and long-term services and supports;

4-58 (5) promote efficiency and the best use of funding
4-59 based on an individual's needs and preferences;

4-60 (6) promote through housing supports and navigation
4-61 services stability [the placement of an individual] in housing that
4-62 is the most integrated and least restrictive based on [setting
4-63 appropriate to] the individual's needs and preferences;

4-64 (7) promote employment assistance and customized,
4-65 integrated, and competitive employment;

4-66 (8) provide fair hearing and appeals processes in
4-67 accordance with applicable federal and state law; ~~[and]~~

4-68 (9) promote sufficient flexibility to achieve the
4-69 goals listed in this section through the pilot program;

5-1 (10) promote the use of innovative technologies and
5-2 benefits, including telemedicine, telemonitoring, the testing of
5-3 remote monitoring, transportation services, and other innovations
5-4 that support community integration;
5-5 (11) ensure an adequate provider network that includes
5-6 comprehensive long-term services and supports providers and ensure
5-7 that pilot program participants have a choice among those
5-8 providers;
5-9 (12) ensure the timely initiation and consistent
5-10 provision of long-term services and supports in accordance with an
5-11 individual's person-centered plan;
5-12 (13) ensure that individuals with complex behavioral,
5-13 medical, and physical needs are assessed and receive appropriate
5-14 services in the most integrated and least restrictive setting based
5-15 on the individuals' needs and preferences;
5-16 (14) increase access to, expand flexibility of, and
5-17 promote the use of the consumer direction model; and
5-18 (15) promote independence, self-determination, the
5-19 use of the consumer direction model, and decision making by
5-20 individuals participating in the pilot program by using
5-21 alternatives to guardianship, including a supported
5-22 decision-making agreement as defined by Section 1357.002, Estates
5-23 Code.
5-24 (b) An individual is not required to use an innovative
5-25 technology described by Subsection (a)(10). If an individual
5-26 chooses to use an innovative technology described by that
5-27 subdivision, the commission shall ensure that services associated
5-28 with the technology are delivered in a manner that:
5-29 (1) ensures the individual's privacy, health, and
5-30 well-being;
5-31 (2) provides access to housing in the most integrated
5-32 and least restrictive environment;
5-33 (3) assesses individual needs and preferences to
5-34 promote autonomy, self-determination, the use of the consumer
5-35 direction model, and privacy;
5-36 (4) increases personal independence;
5-37 (5) specifies the extent to which the innovative
5-38 technology will be used, including:
5-39 (A) the times of day during which the technology
5-40 will be used;
5-41 (B) the place in which the technology may be
5-42 used;
5-43 (C) the types of telemonitoring or remote
5-44 monitoring that will be used; and
5-45 (D) for what purposes the technology will be
5-46 used;
5-47 (6) is consistent with and agreed on during the
5-48 person-centered planning process;
5-49 (7) ensures that staff overseeing the use of an
5-50 innovative technology:
5-51 (A) review the person-centered and
5-52 implementation plans for each individual before overseeing the use
5-53 of the innovative technology; and
5-54 (B) demonstrate competency regarding the support
5-55 needs of each individual using the innovative technology;
5-56 (8) ensures that an individual using an innovative
5-57 technology is able to request the removal of equipment relating to
5-58 the technology and, on receipt of a request for the removal, the
5-59 equipment is immediately removed; and
5-60 (9) ensures that an individual is not required to use
5-61 telemedicine at any point during the pilot program and, in the event
5-62 the individual refuses to use telemedicine, the managed care
5-63 organization providing health care services to the individual under
5-64 the pilot program arranges for services that do not include
5-65 telemedicine.
5-66 (c) The pilot program must be designed to test innovative
5-67 payment rates and methodologies for the provision of long-term
5-68 services and supports to achieve the goals of the pilot program by
5-69 using payment methodologies that include:

6-1 (1) the payment of a bundled amount without downside
 6-2 risk to a comprehensive long-term services and supports provider
 6-3 for some or all services delivered as part of a comprehensive array
 6-4 of long-term services and supports;

6-5 (2) enhanced incentive payments to comprehensive
 6-6 long-term services and supports providers based on the completion
 6-7 of predetermined outcomes or quality metrics; and

6-8 (3) any other payment models approved by the
 6-9 commission.

6-10 (d) An alternative payment rate or methodology described by
 6-11 Subsection (c) may be used for a managed care organization and
 6-12 comprehensive long-term services and supports provider only if the
 6-13 organization and provider agree in advance and in writing to use the
 6-14 rate or methodology [The department, in consultation and
 6-15 collaboration with the advisory committee, shall evaluate each
 6-16 submitted managed care strategy proposal and determine whether:

6-17 [(1) the proposed strategy satisfies the requirements
 6-18 of this section; and

6-19 [(2) the private services provider or managed care
 6-20 organization that submitted the proposal has a demonstrated ability
 6-21 to provide the long-term services and supports appropriate to the
 6-22 individuals who will receive services through the pilot program
 6-23 based on the proposed strategy, if implemented].

6-24 (e) In developing an alternative payment rate or
 6-25 methodology described by Subsection (c), the commission, managed
 6-26 care organizations, and comprehensive long-term services and
 6-27 supports providers shall consider:

6-28 (1) the historical costs of long-term services and
 6-29 supports, including Medicaid fee-for-service rates;

6-30 (2) reasonable cost estimates for new services under
 6-31 the pilot program; and

6-32 (3) whether an alternative payment rate or methodology
 6-33 is sufficient to promote quality outcomes and ensure a provider's
 6-34 continued participation in the pilot program [Based on the
 6-35 evaluation performed under Subsection (d), the department may
 6-36 select as pilot program service providers one or more private
 6-37 services providers or managed care organizations with whom the
 6-38 commission will contract].

6-39 (f) An alternative payment rate or methodology described by
 6-40 Subsection (c) may not reduce the minimum payment received by a
 6-41 provider for the delivery of long-term services and supports under
 6-42 the pilot program below the fee-for-service reimbursement rate
 6-43 received by the provider for the delivery of those services before
 6-44 participating in the pilot program.

6-45 (g) The pilot program must allow a comprehensive long-term
 6-46 services and supports provider for individuals with an intellectual
 6-47 or developmental disability or similar functional needs that
 6-48 contracts with the commission to provide services under Medicaid
 6-49 before the implementation date of the pilot program to voluntarily
 6-50 participate in the pilot program. A provider's choice not to
 6-51 participate in the pilot program does not affect the provider's
 6-52 status as a significant traditional provider.

6-53 (h) [(f) For each pilot program service provider, the
 6-54 department shall develop and implement a pilot program.] Under the
 6-55 [a] pilot program, a participating managed care organization [the
 6-56 pilot program service provider] shall provide long-term services
 6-57 and supports under Medicaid to persons with an intellectual or
 6-58 developmental disability and persons with similar functional needs
 6-59 to test its managed care strategy based on capitation.

6-60 (i) [(g)] The commission [department], in consultation and
 6-61 collaboration with the advisory committee and pilot program
 6-62 workgroup, shall analyze information provided by the managed care
 6-63 organizations participating in the pilot program [service
 6-64 providers] and any information collected by the commission
 6-65 [department] during the operation of the pilot program [programs]
 6-66 for purposes of making a recommendation about a system of programs
 6-67 and services for implementation through future state legislation or
 6-68 rules.

6-69 (j) [(h)] The analysis under Subsection (i) [(g)] must

7-1 include an assessment of the effect of the managed care strategies
 7-2 implemented in the pilot program [~~programs~~] on the goals described
 7-3 by this section [~~+~~
 7-4 [~~(1) access to long-term services and supports;~~
 7-5 [~~(2) the quality of acute care services and long-term~~
 7-6 ~~services and supports;~~
 7-7 [~~(3) meaningful outcomes using person-centered~~
 7-8 ~~planning, individualized budgeting, and self-determination,~~
 7-9 ~~including a person's inclusion in the community;~~
 7-10 [~~(4) the integration of service coordination of acute~~
 7-11 ~~care services and long-term services and supports;~~
 7-12 [~~(5) the efficiency and use of funding;~~
 7-13 [~~(6) the placement of individuals in housing that is~~
 7-14 ~~the least restrictive setting appropriate to an individual's needs;~~
 7-15 [~~(7) employment assistance and customized,~~
 7-16 ~~integrated, competitive employment options; and~~
 7-17 [~~(8) the number and types of fair hearing and appeals~~
 7-18 ~~processes in accordance with applicable federal law].~~
 7-19 (k) Before implementing the pilot program, the commission,
 7-20 in consultation and collaboration with the advisory committee and
 7-21 pilot program workgroup, shall develop and implement a process to
 7-22 ensure pilot program participants remain eligible for Medicaid
 7-23 benefits for 12 consecutive months during the pilot program.
 7-24 SECTION 12. Subchapter C, Chapter 534, Government Code, is
 7-25 amended by adding Section 534.1045 to read as follows:
 7-26 Sec. 534.1045. PILOT PROGRAM BENEFITS AND PROVIDER
 7-27 QUALIFICATIONS. (a) Subject to Subsection (b), the commission
 7-28 shall ensure that a managed care organization participating in the
 7-29 pilot program provides:
 7-30 (1) all Medicaid state plan acute care benefits
 7-31 available under the STAR+PLUS Medicaid managed care program;
 7-32 (2) long-term services and supports under the Medicaid
 7-33 state plan, including:
 7-34 (A) Community First Choice services;
 7-35 (B) personal assistance services;
 7-36 (C) day activity health services; and
 7-37 (D) habilitation services;
 7-38 (3) long-term services and supports under the
 7-39 STAR+PLUS home and community-based services (HCBS) waiver program,
 7-40 including:
 7-41 (A) assisted living services;
 7-42 (B) personal assistance services;
 7-43 (C) employment assistance;
 7-44 (D) supported employment;
 7-45 (E) adult foster care;
 7-46 (F) dental care;
 7-47 (G) nursing care;
 7-48 (H) respite care;
 7-49 (I) home-delivered meals;
 7-50 (J) cognitive rehabilitative therapy;
 7-51 (K) physical therapy;
 7-52 (L) occupational therapy;
 7-53 (M) speech-language pathology;
 7-54 (N) medical supplies;
 7-55 (O) minor home modifications; and
 7-56 (P) adaptive aids;
 7-57 (4) the following long-term services and supports
 7-58 under a Medicaid waiver program:
 7-59 (A) enhanced behavioral health services;
 7-60 (B) behavioral supports;
 7-61 (C) day habilitation; and
 7-62 (D) community support transportation;
 7-63 (5) the following additional long-term services and
 7-64 supports:
 7-65 (A) housing supports;
 7-66 (B) behavioral health crisis intervention
 7-67 services; and
 7-68 (C) high medical needs services; and
 7-69 (6) other nonresidential long-term services and

8-1 supports that the commission, in consultation and collaboration
 8-2 with the advisory committee and pilot program workgroup, determines
 8-3 are appropriate and consistent with applicable requirements
 8-4 governing the Medicaid waiver programs, person-centered
 8-5 approaches, home and community-based setting requirements, and
 8-6 achieving the most integrated and least restrictive setting based
 8-7 on an individual's needs and preferences.

8-8 (b) A comprehensive long-term services and supports
 8-9 provider may deliver services listed under the following provisions
 8-10 only if the provider also delivers the services under a Medicaid
 8-11 waver program:

8-12 (1) Subsections (a)(2)(A) and (D);

8-13 (2) Subsections (a)(3)(B), (C), (D), (G), (H), (J),
 8-14 (K), (L), and (M); and

8-15 (3) Subsection (a)(4).

8-16 (c) A comprehensive long-term services and supports
 8-17 provider may deliver services listed under Subsections (a)(5) and
 8-18 (6) only if the managed care organization in the network of which
 8-19 the provider participates agrees to, in a contract with the
 8-20 provider, the provision of those services.

8-21 (d) Day habilitation services listed under Subsection
 8-22 (a)(4)(C) may be delivered by a provider who contracts or
 8-23 subcontracts with the commission to provide day habilitation
 8-24 services under the home and community-based services (HCS) waiver
 8-25 program or the ICF-IID program.

8-26 (e) A comprehensive long-term services and supports
 8-27 provider participating in the pilot program shall work in
 8-28 coordination with the care coordinators of a managed care
 8-29 organization participating in the pilot program to ensure the
 8-30 seamless delivery of acute care and long-term services and supports
 8-31 on a daily basis in accordance with an individual's plan of care. A
 8-32 comprehensive long-term services and supports provider may be
 8-33 reimbursed by a managed care organization for coordinating with
 8-34 care coordinators under this subsection.

8-35 (f) Before implementing the pilot program, the commission,
 8-36 in consultation and collaboration with the advisory committee and
 8-37 pilot program workgroup, shall:

8-38 (1) for purposes of the pilot program only, develop
 8-39 recommendations to modify adult foster care and supported
 8-40 employment and employment assistance benefits to increase access to
 8-41 and availability of those services; and

8-42 (2) as necessary, define services listed under
 8-43 Subsections (a)(4) and (5) and any other services determined to be
 8-44 appropriate under Subsection (a)(6).

8-45 SECTION 13. Sections 534.105, 534.106, 534.1065, 534.107,
 8-46 534.108, and 534.109, Government Code, are amended to read as
 8-47 follows:

8-48 Sec. 534.105. PILOT PROGRAM: MEASURABLE GOALS. (a) The
 8-49 commission [~~department~~], in consultation and collaboration with
 8-50 the advisory committee and pilot program workgroup and using
 8-51 national core indicators, the National Quality Forum long-term
 8-52 services and supports measures, and other appropriate Consumer
 8-53 Assessment of Healthcare Providers and Systems measures, shall
 8-54 identify measurable goals to be achieved by the [~~each~~] pilot
 8-55 program [~~implemented under this subchapter~~. The identified goals
 8-56 must:

8-57 ~~[(1) align with information that will be collected~~
 8-58 ~~under Section 534.108(a), and~~

8-59 ~~[(2) be designed to improve the quality of outcomes~~
 8-60 ~~for individuals receiving services through the pilot program].~~

8-61 (b) The commission [~~department~~], in consultation and
 8-62 collaboration with the advisory committee and pilot program
 8-63 workgroup, shall develop [~~propose~~] specific strategies and
 8-64 performance measures for achieving the identified goals. A
 8-65 proposed strategy may be evidence-based if there is an
 8-66 evidence-based strategy available for meeting the pilot program's
 8-67 goals.

8-68 (c) The commission, in consultation and collaboration with
 8-69 the advisory committee and pilot program workgroup, shall ensure

9-1 that mechanisms to report, track, and assess specific strategies
 9-2 and performance measures for achieving the identified goals are
 9-3 established before implementing the pilot program.

9-4 Sec. 534.106. IMPLEMENTATION, LOCATION, AND DURATION. (a)
 9-5 The commission [~~and the department~~] shall implement the [~~any~~] pilot
 9-6 program on [~~programs established under this subchapter not later~~
 9-7 ~~than~~] September 1, 2023 [~~2017~~].

9-8 (b) The [A] pilot program [~~established under this~~
 9-9 ~~subchapter~~] shall [~~may~~] operate for at least [~~up to~~] 24 months. [A
 9-10 pilot program may cease operation if the pilot program service
 9-11 provider terminates the contract with the commission before the
 9-12 agreed-to termination date.]

9-13 (c) The [A] pilot program [~~established under this~~
 9-14 ~~subchapter~~] shall be conducted in a STAR+PLUS Medicaid managed care
 9-15 service area [~~one or more regions~~] selected by the commission
 9-16 [~~department~~].

9-17 Sec. 534.1065. RECIPIENT ENROLLMENT, PARTICIPATION, AND
 9-18 ELIGIBILITY [~~IN PROGRAM VOLUNTARY~~]. (a) An individual who is
 9-19 eligible for the pilot program will be enrolled automatically
 9-20 [~~Participation in a pilot program established under this subchapter~~
 9-21 ~~by an individual with an intellectual or developmental disability~~
 9-22 ~~is voluntary~~], and the decision whether to opt out of participation
 9-23 [~~participate~~] in the pilot [~~a~~] program and not receive long-term
 9-24 services and supports under the pilot [~~from a provider through~~
 9-25 ~~that~~] program may be made only by the individual or the individual's
 9-26 legally authorized representative.

9-27 (b) To ensure prospective pilot program participants are
 9-28 able to make an informed decision on whether to participate in the
 9-29 pilot program, the commission, in consultation and collaboration
 9-30 with the advisory committee and pilot program workgroup, shall
 9-31 develop and distribute informational materials on the pilot program
 9-32 that describe the pilot program's benefits, the pilot program's
 9-33 impact on current services, and other related information. The
 9-34 commission shall establish a timeline and process for the
 9-35 development and distribution of the materials and shall ensure:

9-36 (1) the materials are developed and distributed to
 9-37 individuals eligible to participate in the pilot program with
 9-38 sufficient time to educate the individuals, their families, and
 9-39 other persons actively involved in their lives regarding the pilot
 9-40 program;

9-41 (2) individuals eligible to participate in the pilot
 9-42 program, including individuals enrolled in the STAR+PLUS Medicaid
 9-43 managed care program, their families, and other persons actively
 9-44 involved in their lives, receive the materials and oral information
 9-45 on the pilot program;

9-46 (3) the materials contain clear, simple language
 9-47 presented in a manner that is easy to understand; and

9-48 (4) the materials explain, at a minimum, that:

9-49 (A) on conclusion of the pilot program, pilot
 9-50 program participants will be asked to provide feedback on their
 9-51 experience, including feedback on whether the pilot program was
 9-52 able to meet their unique support needs;

9-53 (B) participation in the pilot program does not
 9-54 remove individuals from any Medicaid waiver program interest list;

9-55 (C) individuals who choose to participate in the
 9-56 pilot program and who, during the pilot program's operation, are
 9-57 offered enrollment in a Medicaid waiver program may accept the
 9-58 enrollment, transition, or diversion offer; and

9-59 (D) pilot program participants have a choice
 9-60 among acute care and comprehensive long-term services and supports
 9-61 providers and service delivery options, including the consumer
 9-62 direction model and comprehensive services model.

9-63 (c) The commission, in consultation and collaboration with
 9-64 the advisory committee and pilot program workgroup, shall develop
 9-65 pilot program participant eligibility criteria. The criteria must
 9-66 ensure pilot program participants:

9-67 (1) include individuals with an intellectual or
 9-68 developmental disability or a cognitive disability, including:

9-69 (A) individuals with autism;

10-1 (B) individuals with significant complex
 10-2 behavioral, medical, and physical needs who are receiving home and
 10-3 community-based services through the STAR+PLUS Medicaid managed
 10-4 care program;

10-5 (C) individuals enrolled in the STAR+PLUS
 10-6 Medicaid managed care program who:

10-7 (i) are on a Medicaid waiver program
 10-8 interest list;

10-9 (ii) meet the criteria for an intellectual
 10-10 or developmental disability; or

10-11 (iii) have a traumatic brain injury that
 10-12 occurred after the age of 21; and

10-13 (D) other individuals with disabilities who have
 10-14 similar functional needs without regard to the age of onset or
 10-15 diagnosis; and

10-16 (2) do not include individuals who are receiving only
 10-17 acute care services under the STAR+PLUS Medicaid managed care
 10-18 program and are enrolled in the community-based ICF-IID program or
 10-19 another Medicaid waiver program.

10-20 Sec. 534.107. COMMISSION RESPONSIBILITIES [COORDINATING
 10-21 SERVICES]. (a) The commission [In providing long-term services
 10-22 and supports under Medicaid to individuals with an intellectual or
 10-23 developmental disability, a pilot program service provider] shall
 10-24 require that a managed care organization participating in the pilot
 10-25 program:

10-26 (1) ensures that individuals participating in the
 10-27 pilot program have a choice among acute care and comprehensive
 10-28 long-term services and supports providers and service delivery
 10-29 options, including the consumer direction model [coordinate
 10-30 through the pilot program institutional and community-based
 10-31 services available to the individuals, including services provided
 10-32 through:

10-33 [(A) a facility licensed under Chapter 252,
 10-34 Health and Safety Code;

10-35 [(B) a Medicaid waiver program; or

10-36 [(C) a community-based ICF-IID operated by local
 10-37 authorities];

10-38 (2) demonstrates to the commission's satisfaction that
 10-39 the organization's network of acute care, long-term services and
 10-40 supports, and comprehensive long-term services and supports
 10-41 providers have experience and expertise in providing services for
 10-42 individuals with an intellectual or developmental disability and
 10-43 individuals with similar functional needs [collaborate with
 10-44 managed care organizations to provide integrated coordination of
 10-45 acute care services and long-term services and supports, including
 10-46 discharge planning from acute care services to community-based
 10-47 long-term services and supports];

10-48 (3) has [have] a process for preventing inappropriate
 10-49 institutionalizations of individuals; and

10-50 (4) ensures the timely initiation and consistent
 10-51 provision of services in accordance with an individual's
 10-52 person-centered plan [accept the risk of inappropriate
 10-53 institutionalizations of individuals previously residing in
 10-54 community settings].

10-55 (b) For the duration of the pilot program, the commission
 10-56 shall ensure that comprehensive long-term services and supports
 10-57 providers are considered significant traditional providers and
 10-58 included in the provider network of a managed care organization
 10-59 participating in the pilot program.

10-60 Sec. 534.108. PILOT PROGRAM INFORMATION. (a) The
 10-61 commission, in consultation and collaboration with the advisory
 10-62 committee and pilot program workgroup, [and the department] shall
 10-63 determine which information will be collected from a managed care
 10-64 organization participating in the pilot program to use in
 10-65 conducting the evaluation and preparing the report under Section
 10-66 534.112 [collect and compute the following information with respect
 10-67 to each pilot program implemented under this subchapter to the
 10-68 extent it is available:

10-69 [(1) the difference between the average monthly cost

11-1 ~~per person for all acute care services and long-term services and~~
 11-2 ~~supports received by individuals participating in the pilot program~~
 11-3 ~~while the program is operating, including services provided through~~
 11-4 ~~the pilot program and other services with which pilot program~~
 11-5 ~~services are coordinated as described by Section 534.107, and the~~
 11-6 ~~average monthly cost per person for all services received by the~~
 11-7 ~~individuals before the operation of the pilot program;~~

11-8 ~~[(2) the percentage of individuals receiving services~~
 11-9 ~~through the pilot program who begin receiving services in a~~
 11-10 ~~nonresidential setting instead of from a facility licensed under~~
 11-11 ~~Chapter 252, Health and Safety Code, or any other residential~~
 11-12 ~~setting;~~

11-13 ~~[(3) the difference between the percentage of~~
 11-14 ~~individuals receiving services through the pilot program who live~~
 11-15 ~~in non-provider-owned housing during the operation of the pilot~~
 11-16 ~~program and the percentage of individuals receiving services~~
 11-17 ~~through the pilot program who lived in non-provider-owned housing~~
 11-18 ~~before the operation of the pilot program;~~

11-19 ~~[(4) the difference between the average total Medicaid~~
 11-20 ~~cost, by level of need, for individuals in various residential~~
 11-21 ~~settings receiving services through the pilot program during the~~
 11-22 ~~operation of the program and the average total Medicaid cost, by~~
 11-23 ~~level of need, for those individuals before the operation of the~~
 11-24 ~~program;~~

11-25 ~~[(5) the difference between the percentage of~~
 11-26 ~~individuals receiving services through the pilot program who obtain~~
 11-27 ~~and maintain employment in meaningful, integrated settings during~~
 11-28 ~~the operation of the program and the percentage of individuals~~
 11-29 ~~receiving services through the program who obtained and maintained~~
 11-30 ~~employment in meaningful, integrated settings before the operation~~
 11-31 ~~of the program;~~

11-32 ~~[(6) the difference between the percentage of~~
 11-33 ~~individuals receiving services through the pilot program whose~~
 11-34 ~~behavioral, medical, life-activity, and other personal outcomes~~
 11-35 ~~have improved since the beginning of the program and the percentage~~
 11-36 ~~of individuals receiving services through the program whose~~
 11-37 ~~behavioral, medical, life-activity, and other personal outcomes~~
 11-38 ~~improved before the operation of the program, as measured over a~~
 11-39 ~~comparable period; and~~

11-40 ~~[(7) a comparison of the overall client satisfaction~~
 11-41 ~~with services received through the pilot program, including for~~
 11-42 ~~individuals who leave the program after a determination is made in~~
 11-43 ~~the individuals' cases at hearings or on appeal, and the overall~~
 11-44 ~~client satisfaction with services received before the individuals~~
 11-45 ~~entered the pilot program].~~

11-46 (b) For the duration of the pilot program, a managed care
 11-47 organization participating in the pilot program shall submit to the
 11-48 commission and the advisory committee quarterly reports on the
 11-49 services provided to each pilot program participant that include
 11-50 information on:

11-51 (1) the level of each requested service and the
 11-52 authorization and utilization rates for those services;

11-53 (2) timelines of:

11-54 (A) the delivery of each requested service;

11-55 (B) authorization of each requested service;

11-56 (C) the initiation of each requested service; and

11-57 (D) each unplanned break in the delivery of
 11-58 requested services and the duration of the break;

11-59 (3) the number of pilot program participants using
 11-60 employment assistance and supported employment services;

11-61 (4) the number of service denials and fair hearings
 11-62 and the dispositions of fair hearings;

11-63 (5) the number of complaints and inquiries received by
 11-64 the managed care organization and the outcome of each complaint;
 11-65 and

11-66 (6) the number of pilot program participants who
 11-67 choose the consumer direction model and the reasons why other
 11-68 participants did not choose the consumer direction model [The pilot
 11-69 program service provider shall collect any information described by

12-1 ~~Subsection (a) that is available to the provider and provide the~~
 12-2 ~~information to the department and the commission not later than the~~
 12-3 ~~30th day before the date the program's operation concludes].~~

12-4 (c) The commission shall ensure that the mechanisms to
 12-5 report and track the information and data required by this section
 12-6 are established before implementing the pilot program [In addition
 12-7 to the information described by Subsection (a), the pilot program
 12-8 service provider shall collect any information specified by the
 12-9 department for use by the department in making an evaluation under
 12-10 Section 534.104(g).

12-11 ~~[(d) The commission and the department, in consultation and~~
 12-12 ~~collaboration with the advisory committee, shall review and~~
 12-13 ~~evaluate the progress and outcomes of each pilot program~~
 12-14 ~~implemented under this subchapter and submit, as part of the annual~~
 12-15 ~~report to the legislature required by Section 534.054, a report to~~
 12-16 ~~the legislature during the operation of the pilot programs. Each~~
 12-17 ~~report must include recommendations for program improvement and~~
 12-18 ~~continued implementation].~~

12-19 Sec. 534.109. PERSON-CENTERED PLANNING. The commission, in
 12-20 consultation and collaboration ~~[cooperation]~~ with the advisory
 12-21 committee and pilot program workgroup ~~[department]~~, shall ensure
 12-22 that each individual ~~[with an intellectual or developmental~~
 12-23 ~~disability]~~ who receives services and supports under Medicaid
 12-24 through the ~~[a]~~ pilot program ~~[established under this subchapter]~~,
 12-25 or the individual's legally authorized representative, has access
 12-26 to a comprehensive, facilitated, person-centered plan that
 12-27 identifies outcomes for the individual and drives the development
 12-28 of the individualized budget. The consumer direction model must be
 12-29 an available option for individuals to achieve self-determination,
 12-30 choice, and control~~[, as defined by Section 531.051, may be an~~
 12-31 ~~outcome of the plan].~~

12-32 SECTION 14. Section 534.110, Government Code, is amended to
 12-33 read as follows:

12-34 Sec. 534.110. TRANSITION BETWEEN PROGRAMS; CONTINUITY OF
 12-35 SERVICES. (a) During the evaluation of the pilot program required
 12-36 under Section 534.112, the [The] commission may continue the pilot
 12-37 program to ensure continuity of care for pilot program
 12-38 participants. If the commission does not continue the pilot
 12-39 program following the evaluation, the commission shall ensure that
 12-40 there is a comprehensive plan for transitioning the provision of
 12-41 Medicaid benefits for pilot program participants to the benefits
 12-42 provided before participating in the pilot program [between a
 12-43 Medicaid waiver program or an ICF-IID program and a pilot program
 12-44 under this subchapter to protect continuity of care].

12-45 (b) A [The] transition plan under Subsection (a) shall be
 12-46 developed in consultation and collaboration with the advisory
 12-47 committee and pilot program workgroup and with stakeholder input as
 12-48 described by Section 534.103.

12-49 SECTION 15. Section 534.111, Government Code, is amended to
 12-50 read as follows:

12-51 Sec. 534.111. CONCLUSION OF PILOT PROGRAM ~~[PROGRAMS,~~
 12-52 ~~EXPIRATION]~~. (a) On September 1, 2025, the pilot program is
 12-53 concluded unless the commission continues the pilot program under
 12-54 Section 534.110 [2019].

12-55 ~~[(1) each pilot program established under this~~
 12-56 ~~subchapter that is still in operation must conclude, and~~

12-57 ~~[(2) this subchapter expires].~~

12-58 (b) If the commission continues the pilot program under
 12-59 Section 534.110, the commission shall publish notice of the pilot
 12-60 program's continuance in the Texas Register not later than
 12-61 September 1, 2025.

12-62 SECTION 16. Subchapter C, Chapter 534, Government Code, is
 12-63 amended by adding Section 534.112 to read as follows:

12-64 Sec. 534.112. PILOT PROGRAM EVALUATIONS AND REPORTS. (a)
 12-65 The commission, in consultation and collaboration with the advisory
 12-66 committee and pilot program workgroup, shall review and evaluate
 12-67 the progress and outcomes of the pilot program and submit, as part
 12-68 of the annual report required under Section 534.054, a report on the
 12-69 pilot program's status that includes recommendations for improving

13-1 the program.

13-2 (b) Not later than September 1, 2026, the commission, in
 13-3 consultation and collaboration with the advisory committee and
 13-4 pilot program workgroup, shall prepare and submit to the
 13-5 legislature a written report that evaluates the pilot program based
 13-6 on a comprehensive analysis. The analysis must:

13-7 (1) assess the effect of the pilot program on:

13-8 (A) access to and quality of long-term services
 13-9 and supports;

13-10 (B) informed choice and meaningful outcomes
 13-11 using person-centered planning, flexible consumer-directed
 13-12 services, individualized budgeting, and self-determination,
 13-13 including a pilot program participant's inclusion in the community;

13-14 (C) the integration of service coordination of
 13-15 acute care services and long-term services and supports;

13-16 (D) employment assistance and customized,
 13-17 integrated, competitive employment options;

13-18 (E) the number, types, and dispositions of fair
 13-19 hearings and appeals in accordance with applicable federal and
 13-20 state law;

13-21 (F) increasing the use and flexibility of the
 13-22 consumer direction model;

13-23 (G) increasing the use of alternatives to
 13-24 guardianship, including supported decision-making agreements as
 13-25 defined by Section 1357.002, Estates Code;

13-26 (H) achieving the best and most cost-effective
 13-27 use of funding based on a pilot program participant's needs and
 13-28 preferences; and

13-29 (I) attendant recruitment and retention;

13-30 (2) analyze the experiences and outcomes of the
 13-31 following systems changes:

13-32 (A) the comprehensive assessment instrument
 13-33 described by Section 533A.0335, Health and Safety Code;

13-34 (B) the 21st Century Cures Act (Pub. L. No.
 13-35 114-255);

13-36 (C) implementation of the federal rule adopted by
 13-37 the Centers for Medicare and Medicaid Services and published at 79
 13-38 Fed. Reg. 2948 (January 16, 2014) related to the provision of
 13-39 long-term services and supports through a home and community-based
 13-40 services (HCS) waiver program under Section 1915(c), 1915(i), or
 13-41 1915(k) of the federal Social Security Act (42 U.S.C. Section
 13-42 1396n(c), (i), or (k));

13-43 (D) the provision of basic attendant and
 13-44 habilitation services under Section 534.152; and

13-45 (E) the benefits of providing STAR+PLUS Medicaid
 13-46 managed care services to persons based on functional needs;

13-47 (3) include feedback on the pilot program based on the
 13-48 personal experiences of:

13-49 (A) individuals with an intellectual or
 13-50 developmental disability and individuals with similar functional
 13-51 needs who participated in the pilot program;

13-52 (B) families of and other persons actively
 13-53 involved in the lives of individuals described by Paragraph (A);
 13-54 and

13-55 (C) comprehensive long-term services and
 13-56 supports providers who delivered services under the pilot program;

13-57 (4) be incorporated in the annual report required
 13-58 under Section 534.054; and

13-59 (5) include recommendations on:

13-60 (A) a system of programs and services for
 13-61 consideration by the legislature;

13-62 (B) necessary statutory changes; and

13-63 (C) whether to implement the pilot program
 13-64 statewide under the STAR+PLUS Medicaid managed care program for
 13-65 eligible individuals.

13-66 SECTION 17. The heading to Subchapter E, Chapter 534,
 13-67 Government Code, is amended to read as follows:

13-68 SUBCHAPTER E. STAGE TWO: TRANSITION OF ICF-IID PROGRAM RECIPIENTS
 13-69 AND LONG-TERM CARE MEDICAID WAIVER PROGRAM RECIPIENTS TO INTEGRATED

MANAGED CARE SYSTEM

14-2 SECTION 18. The heading to Section 534.202, Government
14-3 Code, is amended to read as follows:

14-4 Sec. 534.202. DETERMINATION TO TRANSITION [OF] ICF-IID
14-5 PROGRAM RECIPIENTS AND CERTAIN OTHER MEDICAID WAIVER PROGRAM
14-6 RECIPIENTS TO MANAGED CARE PROGRAM.

14-7 SECTION 19. Sections 534.202(a), (b), (c), (e), and (i),
14-8 Government Code, are amended to read as follows:

14-9 (a) This section applies to individuals with an
14-10 intellectual or developmental disability who [~~on the date the~~
14-11 ~~commission implements the transition described by Subsection (b),~~]
14-12 are receiving long-term services and supports under:

14-13 (1) a Medicaid waiver program [~~other than the Texas~~
14-14 ~~home living (TxHmL) waiver program~~]; or

14-15 (2) an ICF-IID program.

14-16 (b) Subject to Subsection (g), after [After] implementing
14-17 the pilot program under Subchapter C and completing the evaluation
14-18 under Section 534.112 [transition required by Section 534.201, on
14-19 September 1, 2021], the commission, in consultation and
14-20 collaboration with the advisory committee, shall develop a plan for
14-21 the transition of all or a portion of the services provided through
14-22 an ICF-IID program or a Medicaid waiver program to a Medicaid
14-23 managed care model. The plan must include:

14-24 (1) a process for transitioning the services in phases
14-25 as follows:

14-26 (A) beginning September 1, 2027, the Texas home
14-27 living (TxHmL) waiver program services;

14-28 (B) beginning September 1, 2029, the community
14-29 living assistance and support services (CLASS) waiver program
14-30 services;

14-31 (C) beginning September 1, 2031, nonresidential
14-32 services provided under the home and community-based services (HCS)
14-33 waiver program and the deaf-blind with multiple disabilities (DBMD)
14-34 waiver program; and

14-35 (D) subject to Subdivision (2), the residential
14-36 services provided under an ICF-IID program, the home and
14-37 community-based services (HCS) waiver program, and the deaf-blind
14-38 with multiple disabilities (DBMD) waiver program; and

14-39 (2) a process for evaluating and determining the
14-40 feasibility and cost efficiency of transitioning residential
14-41 services described by Subdivision (1)(D) to a Medicaid managed care
14-42 model that is based on an evaluation of a separate pilot program
14-43 conducted by the commission, in consultation and collaboration with
14-44 the advisory committee, that operates after the transition process
14-45 described by Subdivision (1) [transition the provision of Medicaid
14-46 benefits to individuals to whom this section applies to the STAR +
14-47 PLUS Medicaid managed care program delivery model or the most
14-48 appropriate integrated capitated managed care program delivery
14-49 model, as determined by the commission based on cost-effectiveness
14-50 and the experience of the transition of Texas home living (TxHmL)
14-51 waiver program recipients to a managed care program delivery model
14-52 under Section 534.201, subject to Subsections (c)(1) and (g)].

14-53 (c) Before implementing the [At the time of the] transition
14-54 described by Subsection (b), the commission shall, subject to
14-55 Subsection (g), determine whether to:

14-56 (1) continue operation of the Medicaid waiver programs
14-57 or ICF-IID program only for purposes of providing, if applicable:

14-58 (A) supplemental long-term services and supports
14-59 not available under the managed care program delivery model
14-60 selected by the commission; or

14-61 (B) long-term services and supports to Medicaid
14-62 waiver program recipients who choose to continue receiving benefits
14-63 under the waiver programs [program] as provided by Subsection (g);
14-64 or

14-65 (2) [subject to Subsection (g),] provide all or a
14-66 portion of the long-term services and supports previously available
14-67 under the Medicaid waiver programs or ICF-IID program through the
14-68 managed care program delivery model selected by the commission.

14-69 (e) The commission shall ensure that there is a

15-1 comprehensive plan for transitioning the provision of Medicaid
 15-2 benefits under this section that protects the continuity of care
 15-3 provided to individuals to whom this section applies and ensures
 15-4 individuals have a choice among acute care and comprehensive
 15-5 long-term services and supports providers and service delivery
 15-6 options, including the consumer direction model.

15-7 (i) In addition to the requirements of Section 533.005, a
 15-8 contract between a managed care organization and the commission for
 15-9 the organization to provide Medicaid benefits under this section
 15-10 must contain a requirement that the organization implement a
 15-11 process for individuals with an intellectual or developmental
 15-12 disability that:

15-13 (1) ensures that the individuals have a choice among
 15-14 acute care and comprehensive long-term services and supports
 15-15 providers and service delivery options, including the consumer
 15-16 direction model;

15-17 (2) to the greatest extent possible, protects those
 15-18 individuals' continuity of care with respect to access to primary
 15-19 care providers, including the use of single-case agreements with
 15-20 out-of-network providers; and

15-21 (3) provides access to a member services phone line
 15-22 for individuals or their legally authorized representatives to
 15-23 obtain information on and assistance with accessing services
 15-24 through network providers, including providers of primary,
 15-25 specialty, and other long-term services and supports.

15-26 SECTION 20. Section 534.203, Government Code, is amended to
 15-27 read as follows:

15-28 Sec. 534.203. RESPONSIBILITIES OF COMMISSION UNDER
 15-29 SUBCHAPTER. In administering this subchapter, the commission shall
 15-30 ensure, on making a determination to transition services under
 15-31 Section 534.202:

15-32 (1) that the commission is responsible for setting the
 15-33 minimum reimbursement rate paid to a provider of ICF-IID services
 15-34 or a group home provider under the integrated managed care system,
 15-35 including the staff rate enhancement paid to a provider of ICF-IID
 15-36 services or a group home provider;

15-37 (2) that an ICF-IID service provider or a group home
 15-38 provider is paid not later than the 10th day after the date the
 15-39 provider submits a clean claim in accordance with the criteria used
 15-40 by the commission [~~department~~] for the reimbursement of ICF-IID
 15-41 service providers or a group home provider, as applicable; [~~and~~]

15-42 (3) the establishment of an electronic portal through
 15-43 which a provider of ICF-IID services or a group home provider
 15-44 participating in the STAR+PLUS [~~STAR + PLUS~~] Medicaid managed care
 15-45 program delivery model or the most appropriate integrated capitated
 15-46 managed care program delivery model, as appropriate, may submit
 15-47 long-term services and supports claims to any participating managed
 15-48 care organization; and

15-49 (4) that the consumer direction model is an available
 15-50 option for each individual with an intellectual or developmental
 15-51 disability who receives Medicaid benefits in accordance with this
 15-52 subchapter to achieve self-determination, choice, and control, and
 15-53 that the individual or the individual's legally authorized
 15-54 representative has access to a comprehensive, facilitated,
 15-55 person-centered plan that identifies outcomes for the individual.

15-56 SECTION 21. Chapter 534, Government Code, is amended by
 15-57 adding Subchapter F to read as follows:

15-58 SUBCHAPTER F. OTHER IMPLEMENTATION REQUIREMENTS AND
 15-59 RESPONSIBILITIES

15-60 Sec. 534.251. DELAYED IMPLEMENTATION AUTHORIZED.
 15-61 Notwithstanding any other law, the commission may delay
 15-62 implementation of a provision of this chapter without further
 15-63 investigation, adjustments, or legislative action if the
 15-64 commission determines the provision adversely affects the system of
 15-65 services and supports to persons and programs to which this chapter
 15-66 applies.

15-67 Sec. 534.252. REQUIREMENTS REGARDING TRANSITION OF
 15-68 SERVICES. (a) For purposes of implementing the pilot program under
 15-69 Subchapter C and transitioning the provision of services provided

16-1 to recipients under certain Medicaid waiver programs to a Medicaid
16-2 managed care delivery model following completion of the pilot
16-3 program, the commission shall:

16-4 (1) implement and maintain a certification process for
16-5 and maintain regulatory oversight over providers under the Texas
16-6 home living (TxHmL) and home and community-based services (HCS)
16-7 waiver programs; and

16-8 (2) require managed care organizations to include in
16-9 the organizations' provider networks providers who are certified in
16-10 accordance with the certification process described by Subdivision
16-11 (1).

16-12 (b) For purposes of implementing the pilot program under
16-13 Subchapter C and transitioning the provision of services described
16-14 by Section 534.202 to the STAR+PLUS Medicaid managed care program,
16-15 a comprehensive long-term services and supports provider:

16-16 (1) must report to the managed care organization in
16-17 the network of which the provider participates each encounter of
16-18 any directly contracted service;

16-19 (2) must provide to the managed care organization
16-20 quarterly reports on:

16-21 (A) coordinated services and time frames for the
16-22 delivery of those services; and

16-23 (B) the goals and objectives outlined in an
16-24 individual's person-centered plan and progress made toward meeting
16-25 those goals and objectives; and

16-26 (3) may not be held accountable for the provision of
16-27 services specified in an individual's service plan that are not
16-28 authorized or subsequently denied by the managed care organization.

16-29 (c) On transitioning services under a Medicaid waiver
16-30 program to a Medicaid managed care delivery model, the commission
16-31 shall ensure that individuals do not lose benefits they receive
16-32 under the Medicaid waiver program.

16-33 SECTION 22. Section 534.201, Government Code, is repealed.

16-34 SECTION 23. Not later than September 1, 2020, and only if
16-35 the Health and Human Services Commission determines it would be
16-36 cost effective, the executive commissioner of the Health and Human
16-37 Services Commission shall seek a waiver or authorization from the
16-38 appropriate federal agency to provide Medicaid benefits to
16-39 medically fragile individuals:

16-40 (1) who are 21 years of age or older; and

16-41 (2) whose health care costs exceed cost limits under
16-42 appropriate Medicaid waiver programs, as defined by Section
16-43 534.001, Government Code.

16-44 SECTION 24. As soon as practicable after the effective date
16-45 of this Act, the executive commissioner of the Health and Human
16-46 Services Commission shall adopt rules as necessary to implement the
16-47 changes in law made by this Act.

16-48 SECTION 25. If before implementing any provision of this
16-49 Act a state agency determines that a waiver or authorization from a
16-50 federal agency is necessary for implementation of that provision,
16-51 the agency affected by the provision shall request the waiver or
16-52 authorization and may delay implementing that provision until the
16-53 waiver or authorization is granted.

16-54 SECTION 26. This Act takes effect September 1, 2019.

16-55 * * * * *