BILL ANALYSIS

Senate Research Center

C.S.S.B. 7
By: Nelson; Patrick
Health & Human Services
3/1/2013
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

C.S.S.B. 7 improves the coordination of Medicaid long-term care services and supports with acute care services, redesigns the long-term care services and supports system to more efficiently serve individuals with intellectual and developmental disabilities, and expands on quality-based payment initiatives to promote high-quality, efficient care throughout Medicaid.

C.S.S.B. 7 amends current law relating to improving the delivery and quality of certain health and human services, including the delivery and quality of Medicaid acute care services and long-term services and supports.

RULEMAKING AUTHORITY

Rulemaking authority previously granted to the executive commissioner of the Health and Human Services Commission (executive commissioner) is rescinded in SECTION 2.04 (Subchapter D, Chapter 533, Government Code) of this bill.

Rulemaking authority is expressly granted to the executive commissioner in SECTION 3.02 (Section 533.03551, Health and Safety Code) and SECTION 4.15 (Section 536.253, Government Code) of this bill.

Rulemaking authority previously granted to the executive commissioner is modified in SECTION 4.14 (Section 536.151, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

ARTICLE 1. DELIVERY SYSTEM REDESIGN FOR THE PROVISION OF ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

SECTION 1.01. Amends Subtitle I, Title 4, Government Code, by adding Chapter 534, as follows:

CHAPTER 534. SYSTEM REDESIGN FOR DELIVERY OF MEDICAID ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 534.001. DEFINITIONS. Defines "advisory committee," "basic attendant services," "department," "habilitation services," "ICF-IID," "ICF-IID program," "local intellectual and developmental disability authority," "managed care organization," "managed care plan," "potentially preventable event," "Medicaid program," "Medicaid waiver program," and "state supported living center."

Sec. 534.002. CONFLICT WITH OTHER LAW. Provides that the provision of this chapter, to the extent of a conflict between a provision of this chapter and another state law, controls.

SUBCHAPTER B. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM

Sec. 534.051. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES. Requires the Texas Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS), in accordance with this chapter, to jointly design and implement an acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities 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;

(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;

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

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

Sec. 534.052. IMPLEMENTATION OF SYSTEM REDESIGN. Requires HHSC and DADS, in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee (redesign advisory committee), to jointly implement the acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities in the manner and in the stages described in this chapter.

Sec. 534.053. INTELLECTUAL AND DEVELOPMENTAL DISABILITY SYSTEM REDESIGN ADVISORY COMMITTEE. (a) Establishes the redesign advisory committee to advise HHSC and DADS on the implementation of the acute care services and long-term services and supports system redesign under this chapter. Requires the executive commissioner of HHSC (executive commissioner) and the commissioner of DADS, subject to Subsection (b), to jointly appoint members of the redesign advisory committee who are stakeholders from the intellectual and developmental disabilities community, including:

(1) individuals with intellectual and developmental disabilities who are recipients of Medicaid waiver program services or individuals who are advocates of those recipients;

(2) representatives of health care providers participating in a Medicaid managed care program, including physicians who are primary care providers and physicians who are specialty care providers; nonphysician mental health professionals; and 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 program service delivery, including independent living centers, area agencies on aging, 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, community mental health and intellectual disability centers, and the NorthSTAR Behavioral Health Program provided under Chapter 534 (Community Services), Health and Safety Code; and

(4) representatives of managed care organizations contracting with the state to provide services to individuals with intellectual and developmental disabilities.

(b) Requires the executive commissioner and the commissioner of DADS, to the greatest extent possible, to appoint members of the redesign advisory committee who reflect the geographic diversity of the state and include members who represent rural Medicaid program recipients.

(c) Requires the executive commissioner to appoint the presiding officer of the redesign advisory committee.

(d) Requires the redesign advisory committee to meet at least quarterly or more frequently if the presiding officer determines that it is necessary to address planning and development needs related to implementation of the acute care services and long-term services and supports system.

(e) Provides that a member of the redesign advisory committee serves without compensation. Provides that a member of the redesign advisory committee who is a Medicaid program recipient or the relative of a Medicaid program recipient is entitled to a per diem allowance and reimbursement at rates established in the General Appropriations Act.

(f) Provides that the redesign advisory committee is subject to the requirements of Chapter 551 (Open Meetings).

(g) Provides that, on January 1, 2024, the redesign advisory committee is abolished, and this section expires.

Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION. (a) Requires HHSC, not later than December 1 of each year, to submit a report to the legislature regarding the implementation of the system required by this chapter, including appropriate information regarding the provision of acute care services and long-term services and supports to individuals with intellectual and developmental disabilities under the Medicaid program; and recommendations, including recommendations regarding appropriate statutory changes to facilitate the implementation.

(b) Provides that this section expires January 1, 2024.

SUBCHAPTER C. STAGE ONE: PROGRAMS TO IMPROVE SERVICE DELIVERY MODELS

Sec. 534.101. DEFINITIONS. Defines "capitation" and "provider" in this subchapter.

Sec. 534.102. PILOT PROGRAMS TO TEST MANAGED CARE STRATEGIES BASED ON CAPITATION. Authorizes HHSC and DADS to develop and implement pilot programs in accordance with this subchapter to test one or more service delivery models involving a managed care strategy based on capitation to deliver long-term services and supports under the Medicaid program to individuals with intellectual and developmental disabilities.

Sec. 534.103. STAKEHOLDER INPUT. Requires DADS, as part of developing and implementing a pilot program under this subchapter, to develop a process to receive and evaluate input from statewide stakeholders and stakeholders from the region of the state in which the pilot program will be implemented.

Sec. 534.104. MANAGED CARE STRATEGY PROPOSALS; PILOT PROGRAM SERVICE PROVIDERS. (a) Requires DADS to identify private services providers 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 the Medicaid program to individuals with intellectual and developmental disabilities through a pilot program established under this subchapter.

(b) Requires DADS to solicit managed care strategy proposals from the private services providers identified under Subsection (a).

(c) Requires that a managed care strategy based on capitation developed for implementation through a pilot program under this subchapter 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 meaningful outcomes by using person-centered planning, individualized budgeting, and self-determination, and promote community inclusion and customized gainful employment;

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

(5) promote efficiency and the best use of funding;

(6) promote the placement of an individual in housing that is the least restrictive setting appropriate to the individual's needs;

(7) promote employment assistance and supported employment;

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

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

(d) Requires DADS, in consultation with the redesign advisory committee, to evaluate each submitted managed care strategy proposal and determine whether the proposed strategy satisfies the requirements of this section, and the private services provider 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) Authorizes DADS, based on the evaluation performed under Subsection (d), to select as pilot program service providers one or more private services providers.

(f) Requires DADS, for each pilot program service provider, to develop and implement a pilot program. Requires the pilot program service provider, under a pilot program, to provide long-term services and supports under the Medicaid program to persons with intellectual and developmental disabilities to test its managed care strategy based on capitation.

(g) Requires DADS to analyze information provided by the pilot program service providers and any information collected by DADS during the operation of the pilot programs for purposes of making a recommendation about a system of programs and services for implementation through future state legislation or rules.

Sec. 534.105. PILOT PROGRAM: MEASURABLE GOALS. (a) Requires DADS, in consultation with the redesign advisory committee, to identify measurable goals to be achieved by each pilot program implemented under this subchapter. Requires that the identified goals align with information that will be collected under Section 534.108(a), and be designed to improve the quality of outcomes for individuals receiving services through the pilot program.

(b) Requires DADS, in consultation with the redesign advisory committee, to propose specific strategies for achieving the identified goals. Authorizes a proposed strategy to be evidence-based if there is an evidence-based strategy available for meeting the pilot program's goals.

Sec. 534.106. IMPLEMENTATION, LOCATION, AND DURATION. (a) Requires HHSC and DADS to implement any pilot programs established under this subchapter not later than September 1, 2016.

(b) Requires that a pilot program established under this subchapter operate for not less than 24 months, except that a pilot program may cease operation before the expiration of 24 months if the pilot program service provider terminates the contract with HHSC before the agreed-to termination date.

(c) Requires that a pilot program established under this subchapter be conducted in one or more regions selected by DADS.

Sec. 534.107. COORDINATING SERVICES. Requires a pilot program service provider, in providing long-term services and supports under the Medicaid program to an individual with intellectual or developmental disabilities, to:

(1) coordinate through the pilot program institutional and community-based services available to the individual, including services provided through a facility licensed under Chapter 252 (Intermediate Care Facilities for the Mentally Retarded), Health and Safety Code, a Medicaid waiver program, or a community-based intermediate care facility serving individuals with intellectual and developmental disabilities (ICF-IID) operated by local authorities;

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

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

(4) accept the risk of inappropriate institutionalizations of individuals previously residing in community settings.

Sec. 534.108. PILOT PROGRAM INFORMATION. (a) Requires HHSC and DADS to 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 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) Requires the pilot program service provider to collect any information described by Subsection (a) that is available to the provider and provide the information to DADS and HHSC not later than the 30th day before the date the program's operation concludes.

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

(d) Requires HHSC and DADS, on or before December 1, 2016, and December 1, 2017, in consultation with the redesign advisory committee, to review and evaluate the progress and outcomes of each pilot program implemented under this subchapter and submit a report to the legislature during the operation of the pilot programs. Requires that each report include recommendations for program improvement and continued implementation.

Sec. 534.109. PERSON-CENTERED PLANNING. Requires HHSC, in cooperation with DADS, to ensure that each individual with intellectual or developmental disabilities who receives services and supports under the Medicaid program through a pilot program established under this subchapter or the individual's legally authorized representative has access to a facilitated, person-centered plan that identifies outcomes for the individual and drives the development of the individualized budget. Provides that the consumer direction model, as defined by Section 531.051 (Consumer Direction of Certain Services for Person with Disabilities and Elderly Persons), may be an outcome of the plan.

Sec. 534.110. TRANSITION BETWEEN PROGRAMS. Requires HHSC to ensure that there is a comprehensive plan for transitioning the provision of Medicaid program benefits between a Medicaid waiver program and a pilot program under this subchapter to protect continuity of care.

Sec. 534.111. CONCLUSION OF PILOT PROGRAMS; EXPIRATION. Provides that on September 1, 2018, each pilot program established under this subchapter that is still in operation is required to conclude and this subchapter expires.

SUBCHAPTER D. STAGE ONE: PROVISION OF ACUTE CARE AND CERTAIN OTHER SERVICES

Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES. Requires HHSC to provide acute care Medicaid program benefits to individuals with intellectual and developmental disabilities through the STAR + PLUS Medicaid managed care program or the most appropriate integrated capitated managed care program delivery model.

Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR + PLUS AND STAR KIDS MEDICAID MANAGED CARE PROGRAMS. Requires HHSC to implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with intellectual and developmental disabilities under the STAR + PLUS and STAR Kids Medicaid managed care programs that maximizes federal funding for the delivery of services across those and other similar programs.

SUBCHAPTER E. STAGE TWO: TRANSITION OF LONG-TERM CARE MEDICAID WAIVER PROGRAM RECIPIENTS TO INTEGRATED MANAGED CARE SYSTEM

Sec. 534.201. TRANSITION OF RECIPIENTS UNDER TEXAS HOME LIVING (TxHmL) WAIVER PROGRAM TO MANAGED CARE PROGRAM. (a) Provides that this section applies to individuals with intellectual and developmental disabilities who are receiving long-term services and supports under the Texas home living (TxHmL) waiver program on the date HHSC implements the transition described by Subsection (b).

(b) Requires HHSC, not later than September 1, 2017, to transition the provision of Medicaid program 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 HHSC based on cost-effectiveness and the experience of the STAR + PLUS Medicaid managed care program in providing basic attendant and

habilitation services and of the pilot programs established under Subchapter C, subject to Subsection (c)(1).

(c) Requires HHSC, at the time of the transition described by Subsection (b), to determine whether to:

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

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

(d) Requires HHSC, in implementing the transition described by Subsection (b), to develop a process to receive and evaluate input from interested statewide stakeholders that is in addition to the input provided by the redesign advisory committee.

(e) Requires HHSC to ensure that there is a comprehensive plan for transitioning the provision of Medicaid program benefits under this section that protects the continuity of care provided to individuals to whom this section applies.

Sec. 534.202. TRANSITION OF ICF-IID PROGRAM RECIPIENTS AND CERTAIN OTHER MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM. (a) Provides that this section applies to individuals with intellectual and developmental disabilities who, on the date HHSC implements the transition described by Subsection (b), are receiving long-term services and supports under a Medicaid waiver program other than the TxHmL waiver program or an ICF-IID program.

(b) Requires HHSC, after implementing the transition required by Section 534.201 but not later than September 1, 2020, to transition the provision of Medicaid program 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 HHSC based on cost-effectiveness and the experience of the transition of TxHmL waiver program recipients to a managed care program delivery model under Section 534.201, subject to Subsection (c)(1).

(c) Requires HHSC, at the time of the transition described by Subsection (b), to determine whether to:

(1) continue operation of the Medicaid waiver programs or Medicaid ICF-IID program for purposes of providing supplemental long-term services and supports not available under the managed care program delivery model selected by HHSC; or

(2) provide all or a portion of the long-term services and supports previously available under the Medicaid waiver programs or Medicaid ICF-IID program through the managed care program delivery model selected by HHSC.

(d) Requires HHSC, in implementing the transition described by Subsection (b), to develop a process to receive and evaluate input from interested statewide stakeholders that is in addition to the input provided by the redesign advisory committee.

(e) Requires HHSC to ensure that there is a comprehensive plan for transitioning the provision of Medicaid program benefits under this section that protects the continuity of care provided to individuals to whom this section applies.

(f) Requires a managed care organization providing services under the managed care program delivery model selected by HHSC, before transitioning the provision of Medicaid program benefits for children under this section, to demonstrate to the satisfaction of HHSC that the organization's network of providers has experience and expertise in the provision of services to children with intellectual and developmental disabilities.

SECTION 1.02. Requires the executive commissioner and the commissioner of DADS, not later than October 1, 2013, to appoint the members of the redesign advisory committee as required by Section 534.053, Government Code, as added by this article.

SECTION 1.03. Requires HHSC to submit the initial report on the implementation of the acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities as required by Section 534.054, Government Code, as added by this article, not later than December 1, 2014, and the final report under that section not later than December 1, 2023.

SECTION 1.04. Requires HHSC, not later than June 1, 2016, to submit a report to the legislature regarding HHSC's experience in, including the cost-effectiveness of, delivering basic attendant and habilitation services for individuals with intellectual and developmental disabilities under the STAR + PLUS and STAR Kids Medicaid managed care programs under Section 534.152, Government Code, as added by this article.

SECTION 1.05. Requires HHSC and DADS to implement any pilot program to be established under Subchapter C, Chapter 534, Government Code, as added by this article, as soon as practicable after the effective date of this Act.

SECTION 1.06. (a) Requires HHSC and DADS to:

(1) in consultation with the redesign advisory committee established under Section 534.053, Government Code, as added by this article, review and evaluate the outcomes of:

(A) the transition of the provision of benefits to individuals under the TxHmL waiver program to a managed care program delivery model under Section 534.201, Government Code, as added by this article; and

(B) the transition of the provision of benefits to individuals under the Medicaid waiver programs, other than the TxHmL waiver program, and the ICF-IID program to a managed care program delivery model under Section 534.202, Government Code, as added by this article; and

(2) submit as part of an annual report required by Section 534.054, Government Code, as added by this article, due on or before December 1 of 2018, 2019, and 2020, a report on the review and evaluation conducted under Subdivisions (1)(A) and (B) of this subsection that includes recommendations for continued implementation of and improvements to the acute care and long-term services and supports system under Chapter 534, Government Code, as added by this article.

(b) Provides that this section expires September 1, 2024.

ARTICLE 2. MEDICAID MANAGED CARE EXPANSION

SECTION 2.01. Amends Section 533.0025, Government Code, by amending Subsections (a) and (b) and adding Subsections (f), (g), and (h), as follows:

(a) Defines "medical assistance" in this section and Sections 533.00251, 533.00252, and 533.00253.

(b) Requires the Health and Human Services Commission (HHSC) or an agency operating part of the state Medicaid managed care program, as appropriate, notwithstanding any other law, rather than requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, except as otherwise provided by this section and notwithstanding any other law, to provide medical assistance for acute care services through the most cost-effective model of Medicaid capitated managed care as determined by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate. Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to require mandatory participation in a Medicaid capitated managed care program for all persons eligible for acute care medical assistance benefits. Deletes existing text authorizing HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, if HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, determines that it is more cost-effective, to provide medical assistance for acute care in a certain part of this state or to a certain population of recipients using a health maintenance organization model, including the acute care portion of Medicaid STAR + PLUS pilot programs, a primary care case management model, a prepaid health plan model, an exclusive provider organization model, or another Medicaid managed care model or arrangement.

(f) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to conduct a study to evaluate the feasibility of automatically enrolling applicants determined eligible for benefits under the medical assistance program in a Medicaid managed care plan, and report the results of the study to the legislature not later than December 1, 2014.

(g) Provides that Subsection (f) and this subsection expire September 1, 2015.

(h) Authorizes HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, if HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, determines that it is feasible, to, notwithstanding any other law, implement an automatic enrollment process under which applicants determined eligible for medical assistance benefits are automatically enrolled in a Medicaid managed care plan. Authorizes HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to elect to implement the automatic enrollment process as to certain populations of recipients under the medical assistance program.

SECTION 2.02. Amends Subchapter A, Chapter 533, Government Code, by adding Sections 533.00251, 533.00252, and 533.00253, as follows:

Sec. 533.00251. DELIVERY OF NURSING FACILITY BENEFITS THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) Defines "advisory committee," "nursing facility," and "potentially preventable event" in this section and Section 533.00252.

(b) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to expand the STAR + PLUS Medicaid managed care program to all areas of this state to serve individuals eligible for acute care services and long-term services and supports under the medical assistance program.

(c) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, notwithstanding any other law, in consultation with the STAR + PLUS Nursing Facility Advisory Committee (SPNF advisory committee), to provide benefits under the medical assistance program to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, in implementing this subsection, to ensure:

(1) that HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, is responsible for setting the minimum reimbursement rate paid to a nursing facility under the managed care program, including the staff rate enhancement paid to a nursing facility that qualifies for the enhancement;

(2) that a nursing facility is paid not later than the 10th day after the date the facility submits a clean claim;

(3) the appropriate utilization of services;

(4) a reduction in the incidence of potentially preventable events and unnecessary institutionalizations;

(5) that a managed care organization providing services under the managed care program provides discharge planning, transitional care, and other education programs to physicians and hospitals regarding all available long-term care settings;

(6) that a managed care organization providing services under the managed care program provides payment incentives to nursing facility providers that reward reductions in preventable acute care costs and encourage transformative efforts in the delivery of nursing facility services, including efforts to promote a resident-centered care culture through facility design and services provided; and

(7) the establishment of a single portal through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims to any participating managed care organization.

(d) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, subject to Subsection (e), to ensure that a nursing facility provider authorized to provide services under the medical assistance program on September 1, 2013, is allowed to participate in the STAR + PLUS Medicaid managed care program through August 31, 2016. Provides that this subsection expires September 1, 2017.

(e) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to establish credentialing and minimum performance standards for nursing facility providers seeking to participate in the STAR + PLUS Medicaid managed care program. Authorizes a managed care organization to refuse to contract with a nursing facility provider if the nursing facility does not meet the minimum performance standards established by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, under this section.

Sec. 533.00252. STAR + PLUS NURSING FACILITY ADVISORY COMMITTEE. (a) Establishes the SPNF advisory committee to advise HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, on the implementation of and other activities related to the provision of medical assistance benefits to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program under Section 533.00251, including advising HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, regarding its duties with respect to developing quality-based outcomes and process measures for long-term services and supports provided in nursing facilities; developing quality-based long-term care payment systems and quality initiatives for nursing facilities; transparency of information received from managed care organizations; the reporting of outcome and process measures; the

sharing of data among health and human services agencies; and patient care coordination, quality of care improvement, and cost savings.

(b) Requires the executive commissioner to appoint the members of the SPNF advisory committee. Requires the committee to consist of nursing facility providers, representatives of managed care organizations, and other stakeholders interested in nursing facility services provided in this state, including at least one member who is a nursing facility provider with experience providing the long-term continuum of care, including home care and hospice; at least one member who is a nonprofit nursing facility provider; at least one member who is a for-profit nursing facility provider; at least one member who is a consumer representative; and at least one member who is a managed care organization providing services as provided by Section 533.00251.

(c) Requires the executive commissioner to appoint the presiding officer of the advisory committee.

(d) Provides that a member of the SPNF advisory committee serves without compensation.

(e) Provides that the SPNF advisory committee is subject to the requirements of Chapter 551.

(f) Provides that, on September 1, 2016, the SPNF advisory committee is abolished and this section expires.

Sec. 533.00253. STAR KIDS MEDICAID MANAGED CARE PROGRAM. (a) Defines "health home" and "potentially preventable event" in this section.

(b) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to establish a mandatory STAR Kids capitated managed care program tailored to provide medical assistance benefits to children with disabilities. Requires that the managed care program developed under this section:

(1) provide medical assistance benefits that are customized to meet the health care needs of recipients under the program through a defined system of care, including benefits described under Section 534.152;

(2) better coordinate care of recipients under the program;

(3) improve the health outcomes of recipients;

(4) improve recipients' access to health care services;

(5) achieve cost containment and cost efficiency;

(6) reduce the administrative complexity of delivering medical assistance benefits;

(7) reduce the incidence of unnecessary institutionalizations and potentially preventable events by ensuring the availability of appropriate services and care management;

(8) require a health home;

(9) coordinate and collaborate with long-term care service providers and long-term management providers, if recipients are receiving long-term services and supports outside of the managed care organization; and

(10) coordinate services provided to children also receiving services under Section 534.152.

(c) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to provide medical assistance benefits through the STAR Kids managed care program established under this section to children who are receiving benefits under the medically dependent children waiver program (MDCP). Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to ensure that the STAR Kids managed care program provides all or a portion of the benefits provided under MDCP to the extent necessary to implement this subsection.

(d) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to ensure there is a plan for transitioning the provision of Medicaid program benefits to recipients 21 years of age or older from under the STAR Kids program to under the STAR + PLUS Medicaid managed care program that protects continuity of care. Requires that the plan ensure that coordination between the programs begins when a recipient reaches 18 years of age.

SECTION 2.03. Amends Section 32.0212, Human Resources Code, to require HHSC or an agency operating part of the medical assistance program, as appropriate, notwithstanding any other law, rather than notwithstanding any other law and subject to Section 533.0025 (Delivery of Services), Government Code, to provide medical assistance for acute care services through the Medicaid managed care system implemented under Chapter 533 (Implementation of Medicaid Managed Care Program), Government Code, or another Medicaid capitated managed care program.

SECTION 2.04. Repealers: Sections 533.0025(c) (relating to certain considerations required to be made by the commissioner of health and human services in determining whether certain models or arrangements for delivery of services are more cost-effective) and (d) (relating to providing medical assistance for acute care through a traditional fee-for-service arrangement if using a Medicaid managed care model to provide certain types of medical assistance for acute care in a certain area or to certain medical assistance recipients is determined not to be more cost-effective by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate), Government Code.

Repealer: Subchapter D (Integrated Care Management Model), Chapter 533, Government Code.

SECTION 2.05. (a) Requires HHSC and DADS to:

(1) review and evaluate the outcomes of the transition of the provision of benefits to recipients under MDCP to the STAR Kids managed care program delivery model established under Section 533.00253, Government Code, as added by this article;

(2) not later than December 1, 2016, submit an initial report to the legislature on the review and evaluation conducted under Subdivision (1) of this subsection, including recommendations for continued implementation and improvement of the program; and

(3) not later than December 1 of each year after 2016 and until December 1, 2020, submit additional reports that include the information described by Subdivision (1) of this subsection.

(b) Provides that this section expires September 1, 2021.

SECTION 2.06. Requires HHSC, as soon as practicable after the effective date of this Act, to provide a single portal through which nursing facility providers participating in the STAR +

PLUS Medicaid managed care program may submit claims in accordance with Section 533.00251(c)(7), Government Code, as added by this article.

SECTION 2.07. Provides that the changes in law made by this article are not intended to negatively affect Medicaid recipients' access to quality health care. Requires HHSC, as the state agency designated to supervise the administration and operation of the Medicaid program and to plan and direct the Medicaid program in each state agency that operates a portion of the Medicaid program, including directing the Medicaid managed care system, to continue to timely enforce all laws applicable to the Medicaid program and the Medicaid managed care system, including laws relating to provider network adequacy, the prompt payment of claims, and the resolution of patient and provider complaints.

ARTICLE 3. OTHER PROVISIONS RELATING TO INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

SECTION 3.01. Amends Subchapter B, Chapter 533, Health and Safety Code, by adding Section 533.0335, as follows:

Sec. 533.0335. COMPREHENSIVE ASSESSMENT AND RESOURCE ALLOCATION PROCESS. (a) Defines "advisory committee," "department," "functional need," and "Medicaid waiver program" in this section.

(b) Requires DADS, subject to the availability of federal funding, to develop and implement a comprehensive assessment instrument and a resource allocation process. Requires that the assessment instrument and resource allocation process be designed to recommend for each individual with intellectual and developmental disabilities enrolled in a Medicaid waiver program the type, intensity, and range of services that are both appropriate and available, based on the functional needs of that individual.

(c) Requires DADS, in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee (redesign advisory committee), to establish a prior authorization process for requests for supervised living or residential support services available in the home and community-based services (HCS) Medicaid waiver program. Requires that the process ensure that supervised living or residential support services available in the home and community-based services (HCS) Medicaid waiver program are available only to individuals for whom a more independent setting is not appropriate or available.

(d) Requires DADS to cooperate with the redesign advisory committee to establish the prior authorization process required by Subsection (c). Provides that this subsection expires January 1, 2024.

SECTION 3.02. Amends Subchapter B, Chapter 533, Health and Safety Code, by adding Sections 533.03551 and 533.03552, as follows:

Sec. 533.03551. FLEXIBLE, LOW-COST HOUSING OPTIONS. (a) Requires the executive commissioner of the Health and Human Services Commission (executive commissioner), to the extent permitted under federal law and regulations, to adopt or amend rules as necessary to allow for the development of additional housing supports for individuals with intellectual and developmental disabilities in urban and rural areas, including a selection of community-based housing options that comprise a continuum of integration, varying from most to least restrictive, that permits individuals to select the most integrated and least restrictive setting appropriate to the individual's needs and preferences, non-provider-owned residential settings, assistance with living more independently, and rental properties with on-site supports.

(b) Requires DADS, in cooperation with the Texas Department of Housing and Community Affairs, the Department of Agriculture, the Texas State Affordable Housing Corporation, and the redesign advisory committee, to coordinate with

federal, state, and local public housing entities as necessary to expand opportunities for accessible, affordable, and integrated housing to meet the complex needs of individuals with intellectual and developmental disabilities.

(c) Requires DADS to develop a process to receive input from statewide stakeholders to ensure the most comprehensive review of opportunities and options for housing services described by this section.

Sec. 533.03552. BEHAVIORAL SUPPORTS FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES AT RISK OF INSTITUTIONALIZATION; INTERVENTION TEAMS. (a) Defines "department" in this section.

(b) Requires DADS, subject to the availability of federal funding, to develop and implement specialized training for providers, family members, caregivers, and first responders providing direct services and supports to individuals with intellectual and developmental disabilities and behavioral health needs who are at risk of institutionalization.

(c) Requires DADS, subject to the availability of federal funding, to establish one or more behavioral health intervention teams to provide services and supports to individuals with intellectual and developmental disabilities and behavioral health needs who are at risk of institutionalization. Authorizes an intervention team to include a psychiatrist or psychologist, physician, registered nurse, pharmacist or representative of a pharmacy, behavior analyst, social worker, crisis coordinator, peer specialist, and family partner.

(d) Requires a behavioral health intervention team established by DADS, in providing services and supports, to use the team's best efforts to ensure an individual remains in the community and avoids institutionalization; focus on stabilizing the individual and assessing the individual for intellectual, medical, psychiatric, psychological, and other needs; provide support to the individual's family members and other caregivers; provide intensive behavioral assessment and training to assist the individual in establishing positive behaviors and continuing to live in the community; and provide clinical and other referrals.

(e) Requires DADS to ensure that members of a behavioral health intervention team established under this section receive training on trauma-informed care, which is an approach to providing care to individuals with behavioral health needs based on awareness that a history of trauma or the presence of trauma symptoms may create the behavioral health needs of the individual.

SECTION 3.03. (a) Requires HHSC and DADS to conduct a study to identify crisis intervention programs currently available to, evaluate the need for appropriate housing for, and develop strategies for serving the needs of persons in this state with Prader-Willi Syndrome.

(b) Requires HHSC and DADS, in conducting the study, to seek stakeholder input.

(c) Requires HHSC, not later than December 1, 2014, to submit a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the presiding officers of the standing committees of the senate and house of representatives having jurisdiction over the Medicaid program regarding the study required by this section.

(d) Provides that this section expires September 1, 2015.

ARTICLE 4. QUALITY-BASED OUTCOMES AND PAYMENT PROVISIONS

SECTION 4.01. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.00254, as follows:

Sec. 533.00254. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM. (a) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, in consultation with the Medicaid and CHIP Quality-Based Payment Advisory Committee (QBP advisory committee) established under Section 536.002 and other appropriate stakeholders with an interest in the provision of acute care services and long-term services and supports under the Medicaid managed care program, to establish a clinical improvement program to identify goals designed to improve quality of care and care management and to reduce potentially preventable events, as defined by Section 536.001, and require managed care organizations to develop and implement collaborative program improvement strategies to address the goals.

(b) Provides that goals established under this section may be set by geographical region and program type.

SECTION 4.02. Amends Sections 533.0051(a) and (g), Government Code, as follows:

(a) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to establish outcome-based performance measures and incentives to include in each contract between a health maintenance organization and HHSC for the provision of health care services to recipients that is procured and managed under a value-based purchasing model. Requires that the performance measures and incentives be designed to facilitate and increase recipients' access to appropriate health care services, and to the extent possible, align with other state and regional quality care improvement initiatives.

(g) Authorizes HHSC, or an agency operating part of the state Medicaid managed care program, as appropriate, in performing HHSC's duties under Subsection (d) (relating to requiring HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to assess the feasibility and cost-effectiveness of including certain provision) with respect to assessing feasibility and cost-effectiveness, to consult with participating Medicaid providers, including those with expertise in quality improvement and performance measurement, rather than to consult with physicians, including those with expertise in quality improvement and performance measurement, and hospitals.

SECTION 4.03. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.00511, as follows:

Sec. 533.00511. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM FOR MANAGED CARE ORGANIZATIONS. (a) Defines "potentially preventable event" in this section.

(b) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to create an incentive program that automatically enrolls a greater percentage of recipients who did not actively choose their managed care plan in a managed care plan, based on the quality of care provided through the managed care organization offering that managed care plan; the organization's ability to efficiently and effectively provide services, taking into consideration the acuity of populations primarily served by the organization; and the organization's performance with respect to exceeding, or failing to achieve, appropriate outcome and process measures developed by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, including measures based on all potentially preventable events.

SECTION 4.04. Amends Section 533.0071, Government Code, as follows:

Sec. 533.0071. ADMINISTRATION OF CONTRACTS. Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to make every effort to improve the administration of contracts with managed care organizations.

Requires HHSC, or an agency operating part of the state Medicaid managed care program, as appropriate, to improve the administration of these contracts, to:

(1)-(3) Makes no changes to these subdivisions;

(4) decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks to the extent that those changes are compatible with state law and existing Medicaid managed care contracts, including decreasing those burdens by:

(A) where possible, decreasing the duplication of administrative reporting and process requirements for the managed care organizations and providers, such as requirements for the submission of encounter data, quality reports, historically underutilized business reports, and claims payment summary reports;

(B)-(D) Makes no changes to these paragraphs; and

(E) providing a single portal through which providers in any managed care organization's provider network may submit acute care services and long-term services and supports claims; and

(5) Makes no changes to this subdivision.

SECTION 4.05. Amends Section 533.014, Government Code, by amending Subsection (b) and adding Subsection (c), as follows:

(b) Requires that any amount received by the state under this section (Profit Sharing), except as provided by Subsection (c), be deposited in the general revenue fund for the purpose of funding the state Medicaid program.

(c) Authorizes HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, if cost-effective, to use amounts received by the state under this section to provide incentives to specific managed care organizations to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce inappropriate or preventable service utilization.

SECTION 4.06. Amends Section 536.002(b), Government Code, as follows:

(b) Requires the executive commissioner to appoint the members of the QBP advisory committee. Requires the QBP advisory committee to consist of certain physicians and other health care providers, representatives of health care facilities, representatives of managed care organizations, and other stakeholders interested in health care services provided in this state, including certain members of whom at least three members who are or who represent a health care provider that primarily provides long-term services and supports, rather than at least one member who is or who represents a health care provider that primarily provides long-term care services.

SECTION 4.07. Amends Section 536.003, Government Code, by amending Subsections (a) and (b) and adding Subsection (a-1), as follows:

(a) Requires HHSC, in consultation with the QBP advisory committee, to develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used in the child health plan and Medicaid programs to implement quality-based payments for acute care services and long-term services and supports, rather than for acute and long-term care services, across all delivery models and payment systems, including managed care payment systems, rather than including fee-for-service and managed care payment systems. Requires HHSC, subject to Subsection (a-1), in developing outcome and process measures under this section, to include measures that are based on all potentially preventable events and that advance quality

improvement and innovation, rather than to consider measures addressing potentially preventable events. Authorizes HHSC to change measures developed to promote continuous system reform, improved quality, and reduced costs, and to account for managed care organizations added to a service area.

(a-1) Requires that the outcome measures based on potentially preventable events allow for rate-based determination of health care provider performance compared to statewide norms, and be risk-adjusted to account for the severity of the illnesses of patients served by the provider.

(b) Requires HHSC, to the extent feasible, to develop outcome and process measures that meet certain criteria, including outcome and process measures that will have the greatest effect on improving quality of care and the efficient use of services, including acute care services and long-term services and supports, that reflect effective coordination of acute care services and long-term services and supports, that can be tied to expenditures, and that reduce preventable health care utilization and costs.

SECTION 4.08. Amends Section 536.004(a), Government Code, to require HHSC, after consulting with the QBP advisory committee and other appropriate stakeholders with an interest in the provision of acute care and long-term services and supports under the child health plan and Medicaid programs, to develop quality-based payment systems and require managed care organizations to develop quality-based payment systems using certain quality-based outcome and process measures, for compensating a physician or other health care provider participating in the child health plan or Medicaid program that meet certain criteria.

SECTION 4.09. Amends Section 536.005, Government Code, by adding Subsection (c), to require HHSC, notwithstanding Subsection (a) (relating to the conversion of payment methodology for hospital reimbursement systems under the child health plan and Medicaid programs) and to the extent possible, to convert outpatient hospital reimbursement systems under the child health plan and Medicaid programs to an appropriate prospective payment system that will allow HHSC to more accurately classify the full range of outpatient service episodes, more accurately account for the intensity of services provided, and motivate outpatient service providers to increase efficiency and effectiveness.

SECTION 4.10. Amends Section 536.006, Government Code, as follows:

Sec. 536.006 Transparency. (a) Requires HHSC and the QBP advisory committee to:

(1)-(3) Makes no changes to these subdivisions; and

(4) develop web-based capability to provide managed care organizations and health care providers with data on their clinical and utilization performance, including comparisons to peer organizations and providers in this state and in the provider's respective region.

(b) Requires that the web-based capability required by Subsection (a)(4) support the requirements of the electronic health information exchange system under Sections 531.907 (Electronic Health Information Exchange System Stage Two: Expansion), 531.908 (Electronic Health Information Exchange System Stage Three: Expansion), and 531.909 (Incentives).

SECTION 4.11. Amends Section 536.008, Government Code, as follows:

Sec. 536.008. ANNUAL REPORT. (a) Requires HHSC to submit to the legislature and make available to the public an annual report regarding:

(1) the quality-based outcome and process measures developed under Section 536.003 (Development of Quality-Based Outcome and Process Measures), including measures based on each potentially preventable event; and

(2) Makes no changes to this subdivision.

(b) Requires HHSC, as appropriate, to report outcome and process measures under Subsection (a)(1) by geographic location, which may require reporting by county, health care service region, or other appropriately defined geographic area; recipient population or eligibility group served; type of health care provider, such as acute care or long-term care provider; number of recipients who relocated to a community-based setting from a less integrated setting; quality-based payment system; and service delivery model.

(c) Prohibits the report required under this section from identifying specific health care providers.

SECTION 4.12. Amends Section 536.051(a), Government Code, to require HHSC, subject to Section 1903(m)(2)(A), Social Security Act (42 U.S.C. Section 1396b(m)(2)(A)), and other applicable federal law, to base a percentage of the premiums paid to a managed care organization participating in the child health plan or Medicaid program on the organization's performance with respect to outcome and process measures developed under Section 536.003 that address all potentially preventable events, rather than outcome and process measures developed under Section 536.003, including outcome measures addressing potentially preventable events. Provides that the percentage of the premiums paid may increase each year.

SECTION 4.13. Amends Section 536.052(a), Government Code, to authorize HHSC to allow a managed care organization participating in the child health plan or Medicaid program increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to financial arrangements, in order to achieve certain goals, including to reduce the incidence of unnecessary institutionalization and potentially preventable events; and to increase the use of alternative payment systems, including shared savings models, in collaboration with physicians and other health care providers.

SECTION 4.14. Amends Section 536.151, Government Code, by amending Subsections (a), (b), and (c), and adding Subsections (a-1) and (d), as follows:

(a) Requires the executive commissioner to adopt rules for identifying:

(1) potentially preventable admissions and readmissions of child health plan program enrollees and Medicaid recipients, including preventable admissions to long-term care facilities;

(2) potentially preventable ancillary services provided to or ordered for child health plan program enrollees and Medicaid recipients;

(3) potentially preventable emergency room visits by child health plan program enrollees and Medicaid recipients; and

(4) potentially preventable complications experienced by child health plan program enrollees and Medicaid recipients.

(a-1) Creates this subsection from existing text. Makes no further changes to this subsection.

(b) Requires HHSC to establish a program to provide a confidential report to each hospital in this state that participates in the child health plan or Medicaid program regarding the hospital's performance with respect to each potentially preventable event described under Subsection (a), rather than with respect to potentially preventable readmissions and potentially preventable complications. Requires that a report provided under this section (Collection and Reporting of Certain Information), to the extent possible, include all potentially preventable events, rather than include potentially

preventable readmissions and potentially preventable complications information, across all child health plan and Medicaid program payment systems.

(c) Provides that, except as provided by Subsection (d), a report provided to a hospital under this section is confidential and is not subject to Chapter 552 (Public Information).

(d) Requires HHSC to release the information in the report described by Subsection (b) not earlier than one year after the date the report is submitted to the hospital, and only after receiving and evaluating interested stakeholder input regarding the public release of information under this section generally.

SECTION 4.15. Amends Section 536.152(a), Government Code, to require HHSC, subject to Subsection (b) (relating to a certain report HHSC is required to provide to a hospital at least one year before HHSC adjusts child health plan and Medicaid reimbursements to the hospital under this section (Reimbursement Adjustments)), using the data collected under Section 536.151 and the diagnosis-related groups (DRG) methodology implemented under Section 536.005 (Conversion of Payment Methodology), if applicable, after consulting with the QBP advisory committee, to the extent feasible adjust child health plan and Medicaid reimbursements to hospitals, including payments made under the disproportionate share hospitals and upper payment limit supplemental payment programs, based on the hospital's performance, rather than in a manner that may reward or penalize a hospital based on the hospital's performance, with respect to exceeding, or failing to achieve, outcome and process measures developed under Section 536.003 that address the rates of potentially preventable readmissions and potentially preventable complications.

SECTION 4.16. Amends Section 536.202(a), Government Code, as follows:

(a) Requires HHSC, after consulting with the QBP advisory committee, to establish payment initiatives to test the effectiveness of quality-based payment systems, alternative payment methodologies, and high-quality, cost-effective health care delivery models that provide incentives to physicians and other health care providers to develop health care interventions for child health plan program enrollees or Medicaid recipients, or both, that will:

(1)-(6) Makes no changes to these subdivisions; and

(7) improve integration 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.

SECTION 4.17. Amends Chapter 536, Government Code, by adding Subchapter F, as follows:

SUBCHAPTER F. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENT SYSTEMS

Sec. 536.251. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENTS. (a) Authorizes HHSC, subject to this subchapter, after consulting with the QBP advisory committee and other appropriate stakeholders representing nursing facility providers with an interest in the provision of long-term services and supports, to develop and implement quality-based payment systems for Medicaid long-term services and supports providers designed to improve quality of care and reduce the provision of unnecessary services. Requires that a quality-based payment system developed under this section base payments to providers on quality and efficiency measures that may include measurable wellness and prevention criteria and use of evidence-based best practices, sharing a portion of any realized cost savings achieved by the provider, and ensuring quality of care outcomes, including a reduction in potentially preventable events.

(b) Authorizes HHSC to develop a quality-based payment system for Medicaid long-term care services and supports providers under this subchapter only if implementing the system would be feasible and cost-effective.

Sec. 536.252. EVALUATION OF DATA SETS. Requires HHSC, to ensure that HHSC is using the best data to inform the development and implementation of quality-based payment systems under Section 536.251, to evaluate the reliability, validity, and functionality of post-acute and long-term services and supports data sets. Requires that HHSC's evaluation under this section assess:

(1) to what degree data sets relied on by HHSC meet a standard for integrating care, for developing coordinated care plans, and that would allow for the meaningful development of risk adjustment techniques;

(2) whether the data sets will provide value for outcome or performance measures and cost containment; and

(3) how classification systems and data sets used for Medicaid long-term services and supports providers can be standardized and, where possible, simplified.

Sec. 536.253. COLLECTION AND REPORTING OF CERTAIN INFORMATION. (a) Requires the executive commissioner to adopt rules for identifying the incidence of potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits by Medicaid long-term services and supports recipients.

(b) Requires HHSC to establish a program to provide a report to each Medicaid long-term services and supports provider in this state regarding the provider's performance with respect to potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits. Provides that, to the extent possible, a report provided under this section should include applicable potentially preventable events information across all Medicaid program payment systems.

(c) Provides that, subject to Subsection (d), a report provided to a provider under this section is confidential and is not subject to Chapter 552.

(d) Requires HHSC to release the information in the report described by Subsection (c) not earlier than one year after the date the report is submitted to the provider, and only after receiving and evaluating interested stakeholder input regarding the public release of information under this section generally.

SECTION 4.18. Requires HHSC, as soon as practicable after the effective date of this Act, to provide a single portal through which providers in any managed care organization's provider network may submit acute care services and long-term services and supports claims as required by Section 533.0071(4)(E), Government Code, as amended by this article.

SECTION 4.19. Requires HHSC, not later than September 1, 2013, to convert outpatient hospital reimbursement systems as required by Section 536.005(c), Government Code, as added by this article.

ARTICLE 5. SPECIFIC PROVISIONS RELATING TO PREMIUMS UNDER THE MEDICAL ASSISTANCE PROGRAM

SECTION 5.01. Amends Section 533.013, Government Code, by adding Subsection (e), as follows:

(e) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to pursue and, if appropriate, implement premium rate-setting strategies that encourage provider payment reform and more efficient service delivery

and provider practices. Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, in pursuing premium rate-setting strategies under this section, to review and consider strategies employed or under consideration by other states. Authorizes HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, if necessary, to request a waiver or other authorization from a federal agency to implement strategies identified under this subsection.

SECTION 5.02. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.0642, as follows:

Sec. 32.0642. PREMIUM REQUIREMENT FOR RECEIPT OF CERTAIN SERVICES. Requires the executive commissioner, to the extent permitted under and in a manner that is consistent with Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), and any other applicable law or regulation or under a federal waiver or other authorization, to adopt and implement in the most cost-effective manner a premium for long-term services and supports provided to a child under the medical assistance program to be paid by the child's parent or other legal guardian.

ARTICLE 6. ADDITIONAL PROVISIONS RELATING TO QUALITY AND DELIVERY OF HEALTH AND HUMAN SERVICES

SECTION 6.01. Amends the heading to Section 531.024, Government Code, to read as follows:

Sec. 531.024. PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES; DATA SHARING.

SECTION 6.02. Amends Section 531.024, Government Code, by adding Subsection (a-1), to require HHSC and other health and human services agencies, to the extent permitted under applicable law, to share data to facilitate patient care coordination, quality improvement, and cost savings in the Medicaid program, child health plan program, and other health and human services programs funded using money appropriated from the general revenue fund.

SECTION 6.03. Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.0981, as follows:

Sec. 531.0981. WELLNESS SCREENING PROGRAM. Authorizes HHSC, if cost-effective, to implement a wellness screening program for Medicaid recipients designed to evaluate a recipient's risk for having certain diseases and medical conditions for purposes of establishing a health baseline for each recipient that may be used to tailor the recipient's treatment plan or for establishing the recipient's health goals.

ARTICLE 7. FEDERAL AUTHORIZATIONS, FUNDING, AND EFFECTIVE DATE

SECTION 7.01. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes a delay of implementation until such a waiver or authorization is granted.

SECTION 7.02. Requires HHSC, as soon as practicable after the effective date of this Act, to apply for and actively seek a waiver or authorization from the appropriate federal agency to waive, with respect to a person who is dually eligible for Medicare and Medicaid, the requirement under 42 C.F.R. Section 409.30 that the person be hospitalized for at least three consecutive calendar days before Medicare covers posthospital skilled nursing facility care for the person.

SECTION 7.03. Authorizes HHSC to use any available revenue, including legislative appropriations and available federal funds, for purposes of implementing any provision of this Act.

SECTION 7.04. Effective date: September 1, 2013.