BILL ANALYSIS

Senate Research Center

S.B. 7
By: Nelson; Patrick
Health & Human Services
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

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.

As proposed, 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 care 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granted to the executive commissioner of the Health and Human Services Commission (executive commissioner) is rescinded in SECTION 2.04 (Subchapter D, Chapter 533, Government Code) of this bill.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 4.12 (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 CARE 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 CARE SERVICES AND SUPPORTS TO PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 534.001. DEFINITIONS. Defines "capitation," "department," "ICF-IID," "local intellectual and developmental disability authority," "managed care organization," "managed care plan," "potentially preventable event," "Medicaid program," and "Medicaid waiver program."

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.

[Reserves Sections 534.003-534.050 for expansion.]

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

Sec. 534.051. ACUTE CARE SERVICES AND LONG-TERM CARE 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 care 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 by ensuring that the individuals receive information about all available programs and services and how to apply for the programs and services;

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

(4) promote integrated coordinated case management of acute care services and long-term care services and supports;

(5) improve the coordination of acute care services and long-term care services and supports;

(6) improve acute care and long-term care outcomes, including reducing potentially preventable events;

(7) promote high-quality care; and

(8) promote person-centered planning and self-direction.

Sec. 534.052. IMPLEMENTATION OF SYSTEM. Requires HHSC and DADS to jointly implement the acute care services and long-term care 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. ANNUAL REPORT ON IMPLEMENTATION. (a) Requires HHSC, not later than September 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 care 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, 2019.

[Reserves Sections 534.054-534.100 for expansion.]

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

Sec. 534.101. 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 care

services and supports under the Medicaid program to individuals with intellectual and developmental disabilities.

Sec. 534.102. STAKEHOLDER INPUT. Requires DADS, in developing and implementing pilot programs under this subchapter, to develop a process for statewide stakeholder input to be received and evaluated.

Sec. 534.103. PILOT PROGRAM PROVIDERS. (a) Requires DADS to identify local intellectual and developmental disability authorities and private care 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 care 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 local intellectual and developmental disability authorities and private care 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 increase access to long-term care services and supports; improve quality and promote integrated coordinated case management of acute care services and long-term services and supports; promote person-centered planning and self-direction; and promote efficiency and the best use of funding.

(d) Requires DADS to evaluate each submitted managed care strategy proposal and determine whether the proposed strategy satisfies the requirements of this section, and the local intellectual and developmental disability authority or private care provider that submitted the proposal is likely able to provide the long-term care services and supports appropriate to the individuals who will receive care through the program.

(e) Authorizes DADS, based on the evaluation performed by DADS under Subsection (d), to select as pilot program service providers one intellectual and developmental disability authority and one private care provider.

(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 care services and supports under the Medicaid program to persons with intellectual and developmental disabilities to test its managed care strategy based on capitation.

Sec. 534.104. PILOT PROGRAM GOALS. (a) Requires DADS to identify measurable goals to be achieved by each pilot program implemented under this subchapter.

(b) Requires DADS 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. 534.105. IMPLEMENTATION, LOCATION, AND DURATION. (a) Requires HHSC and DADS to implement any pilot programs established under this subchapter not later than September 1, 2014.

(b) Requires that a pilot program established under this subchapter operate for not less than 24 months.

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

Sec. 534.106. COORDINATING SERVICES. Requires a pilot program service provider, in providing long-term care 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; and

(2) coordinate with managed care organizations to promote integrated coordinated case management of acute care services and long-term care services and supports.

Sec. 534.107. PILOT PROGRAM INFORMATION. (a) Requires HHSC and DADS to collect and compute the following information with respect to each pilot program established under this subchapter to the extent it is available:

(1) the difference between the average monthly cost per person for all services 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 534.106, 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 non-residential 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 care 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 care 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; and

(6) the difference between the percentage of individuals receiving services through the pilot program whose behavioral outcomes have improved since the beginning of the program and the percentage of individuals receiving services through the program whose behavioral outcomes improved before the operation of the program, as measured over a comparable period.

(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.

Sec. 534.108. 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 has choice, direction, and control over Medicaid benefits should the individual choose the consumer direction model, as defined by Section 531.051 (Consumer Direction of Certain Services for Person with Disabilities and Elderly Persons).

Sec. 534.109. TRANSITION BETWEEN PROGRAMS. Requires HHSC to ensure that there is a comprehensive plan for transitioning services from the Medicaid waiver program to another program to protect continuity of care.

Sec. 534.110. 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.

[Reserves Sections 534.111-534.150 for expansion.]

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 Medicaid program benefits for acute care services to individuals with intellectual and developmental disabilities through:

(1) the STAR Medicaid managed care program, or the most appropriate capitated managed care program delivery model, if the individual receives long-term care Medicaid waiver program services or ICF-IID services not integrated into the STAR + PLUS Medicaid managed care delivery model or other managed care delivery model under Section 534.201 or 534.202; and

(2) the STAR + PLUS Medicaid managed care program or the most appropriate integrated capitated managed care program delivery model, if the individual is eligible to receive medical assistance for acute care services and is not receiving medical assistance under a Medicaid waiver program.

Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR + PLUS MEDICAID MANAGED CARE PROGRAM. 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 Medicaid managed care program that maximizes federal funding for the delivery of services across that and other similar programs.

Sec. 534.153. STAKEHOLDER INPUT. Requires HHSC, in implementing the most cost-effective option under this subchapter, to develop a process for statewide stakeholder input to be received and evaluated.

[Reserves Sections 534.154-534.200 for expansion.]

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 care 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, 2016, 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 the cost effectiveness and the experience of the STAR + PLUS Medicaid managed care program in providing basic attendant and habilitation services and 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 care services and supports not available under the managed care program delivery model selected by HHSC; or

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

(d) Requires HHSC, in implementing the transition described by Subsection (b), to develop a process for statewide stakeholder input to be received and evaluated.

(e) Requires HHSC to ensure that there is a comprehensive plan for transitioning services from the TxHmL waiver program to another program to protect continuity of care.

Sec. 534.202. TRANSITION OF ICF-IID RECIPIENTS AND CERTAIN OTHER MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM. (a) Provides that this section applies to individuals with intellectual and developmental abilities who are receiving long-term services and supports and who, on the date HHSC implements the transition described by Subsection (b), meet the eligibility criteria required to receive long-term care services and supports under a Medicaid waiver program other than the TxHmL waiver program, or reside in a facility licensed under Chapter 252, Health and Safety Code, or in a community-based ICF-IID operated by local authorities.

(b) Requires HHSC, after implementing the transition required by Section 534.201 but not later than September 1, 2018, 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 an evaluation of 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 for purposes of providing supplemental long-term care services and supports not available under the managed care program delivery model selected by HHSC; or

(2) cease operation of the Medicaid waiver programs and expand all or a portion of the long-term care services and supports previously available

under the waiver programs to the managed care program delivery model selected by HHSC.

(d) Requires HHSC, in implementing the transition described by Subsection (b), to develop a process for statewide stakeholder input to be received and evaluated.

(e) Requires HHSC to ensure that there is a comprehensive plan for transitioning services from the Medicaid waiver program to another program to protect continuity of care.

SECTION 1.02. Requires HHSC to submit the initial report on the implementation of the acute care services and long-term care services and supports system for individuals with intellectual and developmental disabilities as required by Section 534.053, Government Code, as added by this Act, not later than September 1, 2014, and the final report under that section not later than September 1, 2018.

SECTION 1.03. Requires HHSC and DADS to implement any pilot program to be established under Subchapter C, Chapter 534, Government Code, as added by this Act, as soon as practicable after the effective date of this Act.

ARTICLE 2. MEDICAID MANAGED CARE EXPANSION

SECTION 2.01. Amends Section 533.0025(b), Government Code, as follows:

(b) Requires HHSC, notwithstanding any other law, rather than requires HHSC, 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. Requires HHSC 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, if HHSC 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.

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

Sec. 533.00251. DELIVERY OF SERVICES THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) Defines "nursing facility" and "potentially preventable event" in this section.

(b) Requires HHSC 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 care services and supports under the medical assistance program.

(c) Requires HHSC, notwithstanding any other law, 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, in implementing this subsection, to ensure that HHSC is responsible for setting the reimbursement rate paid to a nursing facility under the managed care program; that a nursing facility is paid not later than the 10th day after the date the facility submits a proper claim; the appropriate utilization of services; a reduction in the incidence of potentially preventable events; and 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.

Sec. 533.00252. STAR KIDS MEDICAID MANAGED CARE PROGRAM. (a) Defines "health home," "medical assistance," and "potentially preventable event" in this section.

(b) Requires HHSC to establish a mandatory STAR kids capitated managed care program tailored to provide medical benefits to children with disabilities who are not otherwise enrolled in the STAR + PLUS Medicaid managed care program. 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;

(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 potentially preventable events by ensuring the availability of appropriate services and care management;

(8) require a health home; and

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

(c) Requires HHSC 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 (MDCP) waiver program. Requires HHSC to ensure that the STAR Kids managed care program provides all or a portion of the benefits provided under the medically dependent children (MDCP) waiver program to the extent necessary to implement this subsection.

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), Government Code.

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

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 "department" 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) Authorizes DADS to satisfy the requirement to implement the comprehensive assessment instrument and the resource allocation process developed under Subsection (b) by implementing the instrument and process only for purposes of pilot programs established under Subchapter C, Chapter 534, Government Code. Provides that this subsection expires on the date Subchapter C, Chapter 534, Government Code, expires.

(d) Requires DADS to establish a prior authorization process for requests for placement of an individual with intellectual and developmental disabilities in a group home. Requires that the process ensure that placement in a group home is available only to individuals for whom a more independent setting is not appropriate or available.

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 RESIDENTIAL 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 congregate living arrangements, such as houses, condominiums, or rental properties that may be in close proximity to each other, 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, 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 for statewide stakeholder input to ensure the most comprehensive review of opportunities and options for residential services.

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.

(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. Authorizes an intervention team to include one or more professionals such as a psychiatrist or psychologist, physician, registered nurse, behavior analyst, social worker, or crisis coordinator.

(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 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.

ARTICLE 4. QUALITY-BASED OUTCOMES AND PAYMENTS PROVISIONS

SECTION 4.01. 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 admission," "potentially preventable ancillary service," "potentially preventable complication," "potentially preventable emergency room visit," "potentially preventable readmission," and "potentially preventable event" in this section.

(b) Requires the Health and Human Services Commission (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, to 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 4.02. 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 premium rate-setting strategies that encourage payment reform to providers 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 this effort, to review strategies employed or being considered by other states and, if necessary, to submit a waiver to the federal Centers for Medicare and Medicaid Services.

SECTION 4.03. 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 allocate shared profits earned by managed care organizations to provide incentives to specific managed care organizations in order to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce inappropriate or preventable service utilization.

SECTION 4.04. Amends Section 536.003, Government Code, by amending Subsections (a) and (b) and adding Subsection (a-1), as follows:

(a) Requires HHSC, subject to Subsection (a-1), in developing outcome and process measures under this section (Development of Quality-Based Outcome and Process Measures), to include measures based on all potentially preventable events, rather than requires HHSC, in developing outcome measures under this section, to consider measures addressing potentially preventable events.

(a-1) Requires that the outcome measures based on potentially preventable events be risk-adjusted and allow for rate-based performance among health care providers.

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

SECTION 4.05. Amends Subchapter A, Chapter 536, Government Code, by adding Sections 536.0031 and 536.0032, as follows:

Sec. 536.0031. SHARING OF DATA AMONG HEALTH AND HUMAN SERVICE AGENCIES. Requires HHSC and other health and human services agencies, to the extent permitted under state and federal requirements, to share data to facilitate patient care coordination, quality improvement, and cost savings in the Medicaid program, Children's Health Insurance Program (CHIP), and other programs supported by general revenue.

Sec. 536.0032. MANAGED CARE COLLABORATIVE PROGRAM IMPROVEMENT PLANS. Requires HHSC, in consultation with the Medicaid and CHIP Quality-Based Payment Advisory Committee (advisory committee), to establish a clinical improvement program to establish goals, and requires HHSC to require managed care organizations to develop and implement collaborative program improvement strategies to address these goals. Authorizes clinical goals established under the program to be targeted by region and program type.

SECTION 4.06. Amends Section 536.004(a), Government Code, to require HHSC, after consulting with the advisory committee, 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 meets certain criteria.

SECTION 4.07. 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 4.08. Amends Section 536.006, Government Code, to require HHSC and the advisory committee to accomplish certain tasks, including to develop a web-based capability to provide managed care organizations and providers with data on their clinical and utilization performance, including comparisons to other peer organizations and providers in Texas and in their region. Requires that this capability support the requirements of the electronic health information exchange system described in 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 4.09. 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; quality-based payment system; and service delivery model.

(c) Prohibits the annual report from identifying specific health care providers.

SECTION 4.10. Amends Section 536.051(a), Government Code, as follows:

(a) Requires 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, which may increase from one year to the next, 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 and that advance quality improvement and innovation, rather than outcome and process measures developed under Section 536.003, including outcome measures addressing potentially preventable events. Provides that the measures utilized should change over time in order to promote continuous system reform, improved quality, and reduced costs. Authorizes HHSC to adjust measures to account for managed care organizations new to a service area.

SECTION 4.11. 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 increase the use of alternative payment systems.

SECTION 4.12. Amends Section 536.151, Government Code, by amending Subsections (a) and (b) and adding Subsection (a-1), 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;

(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. Provides that a report provided under this section (Collection and Reporting of Certain Information), to the extent possible, should include all potentially preventable events, rather than should include potentially preventable readmissions and potentially preventable complications information, across all child health plan and Medicaid program payment systems.

SECTION 4.13. 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 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 4.14. Amends Section 536.202(a), Government Code, as follows:

(a) Requires HHSC, after consulting with the 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 care services and supports.

SECTION 4.15. Amends Chapter 536, Government Code, by adding Subchapter F, as follows:

SUBCHAPTER F. QUALITY-BASED LONG-TERM CARE PAYMENT SYSTEMS

Sec. 536.251. QUALITY-BASED LONG-TERM CARE PAYMENTS. (a) Authorizes HHSC, subject to this subchapter, after consulting with the advisory committee, to develop and implement quality-based payment systems for Medicaid long-term care 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 care 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; and

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

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 care services and supports recipients.

(b) Requires HHSC to establish a program to provide a confidential report to each Medicaid long-term care 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 a report provided to a provider under this section is confidential and is not subject to Chapter 552 (Public Information).

SECTION 4.16. 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 Act.

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

SECTION 5.01. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.0133, as follows:

Sec. 533.0133. INCLUSION OF RETROACTIVE FEE-FOR-SERVICE PAYMENTS IN PREMIUMS PAID. Requires 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 cost-effective, to include all or a portion of any retroactive fee-for-service payments payable under the medical assistance program in the premium paid to a managed care organization under a managed care plan, including retroactive fee-for-service payments owed for services provided to a recipient before the recipient's enrollment in the medical assistance program or the managed care program, as applicable.

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 care services provided to a child under the medical assistance program to be paid by the child's parent or other legal guardian.

ARTICLE 6. FEDERAL AUTHORIZATION, FUNDING, AND EFFECTIVE DATE

SECTION 6.01. 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 6.02. Authorizes HHSC to use any available revenue, including legislative appropriations and available federal funds, for purposes of implementing any provision of this Act.

SECTION 6.03. Effective date: September 1, 2013.