FsecBILL ANALYSIS

Senate Research Center

H.B. 4533
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Health & Human Services
5/13/2019
Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 7 (83R) directed the carve in of long-term care Medicaid services into a managed care model. S.B. 7 authorized the Health and Human Services Commission (HHSC) to implement a pilot program to best determine the method and approach for carving these services into managed care. HHSC choose not to implement this pilot.

Considering HHSC's decision to not implement the S.B. 7 pilot, H.B. 3523 (84R) delayed the roll out for this population from 2017 to 2018. HB 3295 (85R) further delayed the roll out again from 2018 to 2020.

H.B. 4533 seeks to implement the pilot envisioned by S.B. 7 to determine the best method and approach for carving these services into managed care.

H.B. 4533 amends current law relating to the system redesign for delivery of Medicaid acute care services and long-term services and supports to persons with an intellectual or developmental disability or with similar functional needs.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 24 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 534.001, Government Code, by amending Subdivision (3) and adding Subdivisions (3-a) and (11-a), as follows:

> (3) Defines "comprehensive long-term services and supports provider," rather than defining "department."
>
> (3-a) Defines "consumer direction model."
>
> (11-a) Defines "residential services."

SECTION 2. Amends Sections 534.051 and 534.052, Government Code, as follows:

> Sec. 534.051. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. Requires the Health and Human Services Commission (HHSC) to, in accordance with this chapter (System Redesign For Delivery of Medicaid Acute Care Services and Long-Term Services and Support to Persons With an Intellectual or Developmental Disability), rather than requiring 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 an intellectual or developmental disability that supports the following goals:

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

(2)–(12) makes no changes to these subdivisions.

Sec. 534.052. IMPLEMENTATION OF SYSTEM REDESIGN. Makes a conforming change.

SECTION 3. Amends Sections 534.053(a) and (b), Government Code, as follows:

(a) Makes a conforming change. Requires the executive commissioner of HHSC (executive commissioner), subject to Subsection (b) (relating to the executive commissioner appointing members to the Intellectual and Developmental Disability System Redesign Advisory Committee (advisory committee) who represent rural Medicaid recipients) to appoint members of the advisory committee who are stakeholders from the intellectual and developmental disabilities community, including certain persons, rather than requiring the executive commissioner and the commissioner of aging and disability services to jointly appoint members of the advisory committee who are stakeholders from the intellectual and developmental disabilities community, including certain persons.

(b) Makes a conforming change to this subsection.

SECTION 4. Reenacts Section 534.053(g), Government Code, as amended by Chapters 837 (S.B. 200), 946 (S.B. 277), and 1117 (H.B. 3523), Acts of the 84th Legislature, Regular Session, 2015, and amends it, as follows:

(g) Provides that on the second anniversary, rather than the one-year anniversary, of the date HHSC completes implementation of the transition required under Section 534.202 the advisory committee is abolished and this section (Intellectual and Developmental Disability System Redesign Advisory Committee) expires.

SECTION 5. Amends Section 534.054(b), Government Code, as follows:

(b) Provides that this section (Annual Report on Implementation) expires on the second anniversary of the date HHSC completes implementation of the transition required under Section 534.202, rather than expiring January 1, 2026.

SECTION 6. Amends the heading to Subchapter C, Chapter 534, Government Code, to read as follows:

SUBCHAPTER C. STAGE ONE: PILOT PROGRAM FOR IMPROVING SERVICE DELIVERY MODELS

SECTION 7. Amends Section 534.101, Government Code, by amending Subdivision (2) and adding Subdivision (3), as follows:

(2) Defines "pilot program," rather than defining "provider."

(3) Defines "pilot program workgroup."

SECTION 8. Amends Subchapter C, Chapter 534, Government Code, by adding Section 534.1015, as follows:

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

(b) Provides that the pilot program workgroup is composed of certain persons.

SECTION 9. Amends Sections 534.102 and 534.103, Government Code, as follows:

Sec. 534.102. New heading: PILOT PROGRAM TO TEST PERSON-CENTERED MANAGED CARE STRATEGIES AND IMPROVEMENTS BASED ON CAPITATION. Requires HHSC, in consultation and collaboration with the advisory committee and pilot program workgroup, to develop and implement a pilot program in accordance with this subchapter to test, through the STAR+PLUS Medicaid managed care program, the delivery of long-term services and supports to individuals participating in the pilot program, rather than authorizing 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 Medicaid to individuals with an intellectual or developmental disability.

Sec. 534.103. STAKEHOLDER INPUT. Requires HHSC, as part of developing and implementing the pilot program, in consultation and collaboration with the advisory committee and pilot program workgroup, to develop a process to receive and evaluate input from statewide stakeholders and stakeholders from a STAR+PLUS Medicaid managed care service area in which the pilot program will be implemented and other evaluations and data, rather than requiring 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.

SECTION 10. Amends Subchapter C, Chapter 534, Government Code, by adding Section 534.1035, as follows:

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

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

SECTION 11. Amends Section 534.104, Government Code, as follows:

Sec. 534.104. PILOT PROGRAM DESIGN. (a) Requires the pilot program to be designed to:

(1) and (2) creates these subdivisions from existing text and makes no further changes;

(3) promote:

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

(B) community inclusion and engagement;

(4) creates this subdivision from existing text and makes no further changes;

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

(6) promote through housing supports and navigation services stability in housing that is the most integrated and least restrictive based on the individual's needs and preferences, rather than promoting the placement of an individual in housing that is the least restrictive setting appropriate to the individual's needs;

(7) creates this subdivision from existing text and makes no further changes;

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

(9) creates this subdivision from existing text and makes no further changes;

(10) promote the use of innovative technologies and benefits, including telemedicine, telemonitoring, the testing of remote monitoring, transportation services, and other innovations that support community integration;

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

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

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

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

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

Redesignates existing Subdivisions (c)(1)–(9) as Subdivisions (a)(1)–(9)

(b) Provides that an individual is not required to use an innovative technology described by Subsection (a)(10). Requires HHSC, if an individual chooses to use an innovative technology described by that subdivision, to ensure that services associated with the technology are delivered in a certain manner.

(c) Requires the pilot program to be designed to test innovative payment rates and methodologies for the provision of long-term services and supports to achieve the goals of the pilot program by using certain payment methodologies.

(d) Authorizes an alternative payment rate or methodology described by Subsection (c) to be used for a managed care organization and comprehensive long-term services and supports provider only if the organization and provider agree in advance and in writing to use the rate or methodology. Deletes existing text requiring DADS, in consultation and collaboration with the 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 or managed care organization that submitted the proposal has a demonstrated ability to provide the long-term services and supports appropriate to the individuals who will receive services through the pilot program based on the proposed strategy, if implemented.

(e) Requires HHSC, managed care organizations, and comprehensive long-term services and supports providers, in developing an alternative payment rate or methodology described by Subsection (c), to consider:

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

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

(3) whether an alternative payment rate or methodology is sufficient to promote quality outcomes and ensure a provider's continued participation in the pilot program.

Deletes existing text authorizing DADS, based on the evaluation performed under Subsection (d), the department to select as pilot program service providers one or more private services providers or managed care organizations with whom HHSC will contract

(f) Prohibits an alternative payment rate or methodology described by Subsection (c) from reducing the minimum payment received by a provider for the delivery of long-term services and supports under the pilot program below the fee-for-service reimbursement rate received by the provider for the delivery of those services before participating in the pilot program.

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

(h) Redesignates existing Subsection (g) as Subsection (h). Delete existing text requiring DADS, for each pilot program service provider, to develop and implement a pilot program. Requires a participating managed care organization, under the pilot program, to provide long-term services and supports under Medicaid to persons with an intellectual or developmental disability and persons with similar functional needs to test its managed care strategy based on capitation. Requires the pilot program service provider, under a pilot program, to provide long-term services and supports under Medicaid to persons with an intellectual or developmental disability to test its managed care strategy based on capitation, rather than requiring the pilot program service provider, under a pilot program, to provide long-term services and supports under Medicaid to persons with an intellectual or developmental disability to test its managed care strategy based on capitation.

(i) Redesignates existing Subsection (g) as Subsection (i). Requires HHSC, in consultation and collaboration with the advisory committee and pilot program workgroup, to analyze information provided by the managed care organizations participating in the pilot program and any information collected by HHSC during the operation of the pilot program for purposes of making a recommendation about a system of programs and services for implementation through future state legislation or rules, rather than requiring DADS, in consultation and collaboration with the advisory committee, 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.

(j) Redesignates existing Subsection (h) as Subsection (j). Requires the analysis under Subsection (i) to include an assessment of the effect of the managed care strategies implemented in the pilot program on the goals described by this section, rather than requiring the analysis under Subsection (g) to include an assessment of the effect of the managed care strategies implemented in the pilot programs on certain measurements.

(k) Requires HHSC, before implementing the pilot program, in consultation and collaboration with the advisory committee and pilot program workgroup, to develop and implement a process to ensure pilot program participants remain eligible for Medicaid benefits for 12 consecutive months during the pilot program.

Deletes existing Subsection (a) requiring DADS, in consultation and collaboration with the advisory committee, to identify private services providers or managed care organizations that are good candidates to develop a service delivery model involving a managed care strategy based on capitation and to test the model in the provision of long-term services and supports under Medicaid to individuals with an intellectual or developmental disability through a pilot program established under this subchapter.

Deletes existing Subsection (b) requiring DADS to solicit managed care strategy proposals from the private services providers and managed care organizations identified under Subsection (a) and authorizing DADS to accept and approve a managed care strategy proposal from any qualified entity that is a private services provider or managed care organization if the proposal provides for a comprehensive array of long-term services and supports, including case management and service coordination.

Deletes existing Subsection (c) requiring managed care strategy based on capitation developed for implementation through a pilot program under this subchapter to be designed to accomplish certain goals.

SECTION 12. Amends Subchapter C, Chapter 534, Government Code, by adding Section 534.1045, as follows:

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

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

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

(A) Community First Choice services;

(B) personal assistance services;

(C) day activity health services; and

(D) habilitation services;

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

(A) assisted living services;

(B) personal assistance services;

(C) employment assistance;

(D) supported employment;

(E) adult foster care;

(F) dental care;

(G) nursing care;

(H) respite care;

(I) home-delivered meals;

(J) cognitive rehabilitative therapy;

(K) physical therapy;

(L) occupational therapy;

(M) speech-language pathology;

(N) medical supplies;

(O) minor home modifications; and

(P) adaptive aids;

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

(A) enhanced behavioral health services;

(B) behavioral supports;

(C) day habilitation; and

(D) community support transportation;

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

(A) housing supports;

(B) behavioral health crisis intervention services; and

(C) high medical needs services; and

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

and achieving the most integrated and least restrictive setting based on an individual's needs and preferences.

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

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

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

(3) Subsection (a)(4).

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

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

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

(f) Requires HHSC, before implementing the pilot program, in consultation and collaboration with the advisory committee and pilot program workgroup, to:

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

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

SECTION 13. Amends Sections 534.105, 534.106, 534.1065, 534.107, 534.108, and 534.109, Government Code, as follows:

Sec. 534.105. PILOT PROGRAM: MEASURABLE GOALS. (a) Requires HHSC, in consultation and collaboration with the advisory committee and pilot program workgroup and using national core indicators, the National Quality Forum long-term services and supports measures, and other appropriate Consumer Assessment of Healthcare Providers and Systems measures, to identify measurable goals to be achieved by the pilot program, rather than requiring DADS, in consultation with the advisory committee, to identify measurable goals to be achieved by each pilot program implemented under this subchapter. Deletes existing text requiring the identified goals to meet certain criteria.

(b) Requires HHSC, in in consultation and collaboration with the advisory committee and pilot program workgroup, to develop specific strategies and performance measures for achieving the identified goals, rather than requiring

DADS, in consultation with the advisory committee, to propose specific strategies for achieving the identified goals.

(c) Requires HHSC, in consultation and collaboration with the advisory committee and pilot program workgroup, to ensure that mechanisms to report, track, and assess specific strategies and performance measures for achieving the identified goals are established before implementing the pilot program.

Sec. 534.106. IMPLEMENTATION, LOCATION, AND DURATION. (a) Requires HHSC to implement the pilot program on September 1, 2023, rather than requiring HHSC and DADS to implement any pilot programs established under this subchapter not later than September 1, 2017.

(b) Requires the pilot program to operate for at least 24 months, rather than authorizing a pilot program established under this subchapter to operate for up to 24 months. Deletes existing text authorizing a pilot program to cease operation if the pilot program service provider terminates the contract with HHSC before the agreed-to termination date.

(c) Requires the pilot program to be conducted in a STAR+PLUS Medicaid managed care service area selected by HHSC, rather than requiring a pilot program established under this subchapter to be conducted in one or more regions selected by DADS.

Sec. 534.1065. New heading: RECIPIENT ENROLLMENT, PARTICIPATION, AND ELIGIBILITY. (a) Creates this subsection from existing text. Provides that an individual who is eligible for the pilot program will be enrolled automatically and the decision whether to opt out of participation in the pilot program and not receive long-term services and supports under the pilot program may be made only by the individual or the individual's legally authorized representative, rather than providing that participation in a pilot program established under this subchapter by an individual with an intellectual or developmental disability is voluntary, and the decision whether to participate in a program and receive long-term services and supports from a provider through that program may be made only by the individual or the individual's legally authorized representative.

(b) Requires HHSC, to ensure prospective pilot program participants are able to make an informed decision on whether to participate in the pilot program, in consultation and collaboration with the advisory committee and pilot program workgroup, to develop and distribute informational materials on the pilot program that describe the pilot program's benefits, the pilot program's impact on current services, and other related information. Requires HHSC to establish a timeline and process for the development and distribution of the materials and to ensure:

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

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

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

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

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

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

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

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

(c) Requires HHSC, in consultation and collaboration with the advisory committee and pilot program workgroup, to develop pilot program participant eligibility criteria. Requires the criteria to ensure pilot program participants meet certain criteria.

Sec. 534.107. New heading: COMMISSION RESPONSIBILITIES. (a) Creates this subsection from existing text. Requires HHSC to require that a managed care organization participating in the pilot program meets certain criteria, rather than requiring a pilot program provider, in providing long-term services and supports under Medicaid to individuals with an intellectual or developmental disability, to perform certain tasks.

(b) Requires HHSC, for the duration of the pilot program, to ensure that comprehensive long-term services and supports providers are considered significant traditional providers and included in the provider network of a managed care organization participating in the pilot program.

Sec. 534.108. PILOT PROGRAM INFORMATION. (a) Requires HHSC, in consultation and collaboration with the advisory committee and pilot program workgroup, to determine which information will be collected from a managed care organization participating in the pilot program to use in conducting the evaluation and preparing the report under Section 534.112. Deletes existing text requiring HHSC and DADS to collect and compute certain information with respect to each pilot program implemented under this subchapter to the extent it is available.

(b) Requires a managed care organization participating in the pilot program, for the duration of the pilot program, a managed care organization participating in the pilot program to submit to HHSC and the advisory committee quarterly reports on the services provided to each pilot program participant that include certain information. Deletes existing text requiring the pilot program service provider to collect any information described by Subsection (a) that is available to the provider and provide the information to DAFS and HHSC not later than the 30th day before the date the program's operation concludes.

(c) Requires HHSC to ensure that the mechanisms to report and track the information and data required by this section are established before implementing the pilot program. Deletes existing text requiring 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).

Deletes existing Subsection (d) requires HHSC and DADS, in consultation and collaboration with the advisory committee, to review and evaluate the progress

and outcomes of each pilot program implemented under this subchapter and submit, as part of the annual report to the legislature required by Section 534.054 (Annual Report on Implementation), a report to the legislature during the operation of the pilot programs, and requiring the report to include certain information.

Sec. 534.109. PERSON-CENTERED PLANNING. Requires HHSC, in consultation and collaboration with the advisory committee and pilot program workgroup, to ensure that each individual who receives services and supports under Medicaid through the pilot program or the individual's legally authorized representative, has access to a comprehensive, facilitated, person-centered plan that identifies outcomes for the individual and drives the development of the individualized budget, rather than requiring HHSC, in cooperation with the department, to ensure that each individual with an intellectual or developmental disability who receives services and supports under Medicaid through a pilot program established under this subchapter, or the individual's legally authorized representative, has access to a facilitated, person-centered plan that identifies outcomes for the individual and drives the development of the individualized budget. Requires the consumer direction model to be an available option for individuals to achieve self-determination, choice, and control, rather than requiring the consumer direction model, as defined by Section 531.051 (Consumer Direction of Certain Service For Person With Disabilities and Elderly Persons), may be an outcome of the plan.

SECTION 14. Amends Section 534.110, Government Code, as follows:

Sec. 534.110. New heading: TRANSITION BETWEEN PROGRAMS; CONTINUITY OF SERVICES. (a) Authorizes HHSC, during the evaluation of the pilot program required under Section 534.112, to continue the pilot program to ensure continuity of care for pilot program participants. Requires HHSC, if HHSC does not continue the pilot program following the evaluation, to ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits for pilot program participants to the benefits provided before participating in the pilot program. Deletes existing text requiring HHSC to ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits between a Medicaid waiver program or an ICF-IID program and a pilot program under this subchapter to protect continuity of care.

(b) Requires the transition plan under Subsection (a) to be developed in consultation and collaboration with the advisory committee and pilot program workgroup and with stakeholder input as described by Section 534.103, rather than requiring the transition plan to be developed in consultation and collaboration with the advisory committee and with stakeholder input as described by Section 534.103.

SECTION 15. Amends Section 534.111, Government Code, as follows:

Sec. 534.111. New heading: CONCLUSION OF PILOT PROGRAM. (a) Creates this subsection from existing text. Provides that on September 1, 2025, the pilot program is concluded unless HHSC continues the pilot program under Section 534.110. Deletes existing text providing that on September 1, 2019, each pilot program established under this subchapter that is still in operation is required to conclude and this subchapter expires.

(b) Requires HHSC, if HHSC continues the pilot program under Section 534.110, to publish notice of the pilot program's continuance in the Texas Register not later than September 1, 2025.

SECTION 16. Amends Subchapter C, Chapter 534, Government Code, by adding Section 534.112, as follows:

Sec. 534.112. PILOT PROGRAM EVALUATIONS AND REPORTS. (a) Requires HHSC, in consultation and collaboration with the advisory committee and pilot program

workgroup, to review and evaluate the progress and outcomes of the pilot program and submit, as part of the annual report required under Section 534.054, a report on the pilot program's status that includes recommendations for improving the program.

(b) Requires HHSC, not later than September 1, 2026, in consultation and collaboration with the advisory committee and pilot program workgroup, to prepare and submit to the legislature a written report that evaluates the pilot program based on a comprehensive analysis. Requires the analysis to include certain information.

SECTION 17. Amends the heading to Subchapter E, Chapter 534, Government Code, to read as follows:

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

SECTION 18. Amends the heading to Section 534.202, Government Code, to read as follows:

Sec. 534.202. DETERMINATION TO TRANSITION ICF-IID PROGRAM RECIPIENTS AND CERTAIN OTHER MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM.

SECTION 19. Amends Sections 534.202(a), (b), (c), (e), and (i), Government Code, as follows:

(a) Provides that this section applies to individuals with an intellectual or developmental disability who are receiving long-term services and supports under a Medicaid waiver program or an ICF-IID program, rather than providing that this section applies to individuals with an intellectual or developmental disability 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 Texas home living (TxHmL) waiver program or an ICF-IID program.

(b) Requires HHSC, subject to Subsection (g), after implementing the pilot program under Subchapter C and completing the evaluation under Section 534.112 in consultation and collaboration with the advisory committee, to develop a plan for the transition of all or a portion of the services provided through an ICF-IID program or a Medicaid waiver program to a Medicaid managed care model. Requires the plan to include certain processes. Deletes existing text requiring HHSC, after implementing the transition required by Section 534.201, on September 1, 2021, to transition the provision of Medicaid benefits to individuals to whom this section applies to the STAR + PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as determined by HHSC based on cost-effectiveness and the experience of the transition of Texas home living (TxHmL) waiver program recipients to a managed care program delivery model under Section 534.201, subject to Subsections (c)(1) and (g).

(c) Requires HHSC, before implementing the transition described by Subsection (b), to, subject to Subsection (g), determine whether to:

(1) and (2) makes nonsubstantive changes to these subdivisions.

(e) Requires HHSC to ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits under this section that protects the continuity of care provided to individuals to whom this section applies and ensures individuals have a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model, rather than requiring HHSC to ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits under this section that protects the continuity of care provided to individuals to whom this section applies.

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

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

(2) and (3) makes no changes to these subdivisions.

SECTION 20. Amends Section 534.203, Government Code, as follows:

Sec. 534.203. RESPONSIBILITIES OF COMMISSION UNDER SUBCHAPTER. Requires HHSC, in administering this subchapter, to ensure, on making a determination to transition services under Section 534.202, rather than requiring HHSC, in administering this subchapter, to:

(1) makes no changes to this subdivision;

(2) and (3) makes a conforming and nonsubstantive changes to these subdivisions; and

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

SECTION 21. Amends Chapter 534, Government Code, by adding Subchapter F, as follows:

SUBCHAPTER F. OTHER IMPLEMENTATION REQUIREMENTS AND RESPONSIBILITIES

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

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

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

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

(b) Provides that, for purposes of implementing the pilot program under Subchapter C and transitioning the provision of services described by Section

534.202 to the STAR+PLUS Medicaid managed care program, a comprehensive long-term services and supports provider:

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

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

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

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

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

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

SECTION 22. Repealer: Section 534.201 (Transition of Recipients Under Texas Home Living (TxHmL) Waiver Program to Managed Care Program), Government Code.

SECTION 23. Requires the executive commissioner, not later than September 1, 2020, and only if HHSC determines it would be cost effective, to seek a waiver or authorization from the appropriate federal agency to provide Medicaid benefits to medically fragile individuals:

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

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

SECTION 24. Requires the executive commissioner, as soon as practicable after the effective date of this Act, to adopt rules as necessary to implement the changes in law made by this Act.

SECTION 25. Requires a state agency affected by a provision of this Act to request a waiver or authorization from a federal agency if the state agency determines that such a waiver or authorization is necessary for implementation of a provision of this Act, and authorizes the agency to delay implementation until such a waiver or authorization is granted.

SECTION 26. Effective date: September 1, 2019.