By: Nelson S.B. No. 7

A BILL TO BE ENTITLED

AN ACT

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.

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

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. Subtitle I, Title 4, Government Code, is amended by adding Chapter 534 to read 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. In this chapter:

(1) "Capitation" means a method of compensating a provider on a monthly basis for providing or coordinating the provision of a defined set of services and supports that is based on a predetermined payment per services recipient.

(2) "Department" means the Department of Aging and Disability Services.

(3) "ICF-IID" means the Medicaid program serving individuals with intellectual and developmental disabilities who receive care in intermediate care facilities, but does not include

a state supported living center, as defined by Section 531.002, Health and Safety Code.

(4) "Local intellectual and developmental disability authority" means a local mental retardation authority described by Section 533.035, Health and Safety Code.

(5) "Managed care organization," "managed care plan," and "potentially preventable event" have the meanings assigned under Section 536.001.

(6) "Medicaid program" means the medical assistance program established under Chapter 32, Human Resources Code.

(7) "Medicaid waiver program" means only the following programs that are authorized under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) for the provision of services to persons with intellectual and developmental disabilities:

(A) the community living assistance and support services (CLASS) waiver program;

(B) the home and community-based services (HCS) waiver program;

(C) the deaf, blind, and multiple disabilities (DBMD) waiver program; and

(D) the Texas home living (TxHmL) waiver program.

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

[Sections 534.003-534.050 reserved 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. In accordance with this chapter, the commission and the department shall 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. The commission and

department shall 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) Not later than September 1 of each year, the commission shall submit a report to the legislature regarding:

(1) 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

(2) recommendations, including recommendations regarding appropriate statutory changes to facilitate the implementation.

(b) This section expires January 1, 2019.

[Sections 534.054-534.100 reserved 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. The commission and the department may 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. In developing and

implementing pilot programs under this subchapter, the department shall develop a process for statewide stakeholder input to be received and evaluated.

Sec. 534.103. PILOT PROGRAM PROVIDERS. (a) The department shall 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) The department shall solicit managed care strategy proposals from the local intellectual and developmental disability authorities and private care providers identified under Subsection (a).

(c) A managed care strategy based on capitation developed for implementation through a pilot program under this subchapter must be designed to:

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

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

(3) promote person-centered planning and self-direction; and

(4) promote efficiency and the best use of funding.

(d) The department shall evaluate each submitted managed

care strategy proposal and determine whether:

(1) the proposed strategy satisfies the requirements of this section; and

(2) 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) Based on the evaluation performed by the department under Subsection (d), the department may select as pilot program service providers one intellectual and developmental disability authority and one private care provider.

(f) For each pilot program service provider, the department shall develop and implement a pilot program. Under a pilot program, the pilot program service provider shall 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) The department shall identify measurable goals to be achieved by each pilot program implemented under this subchapter.

(b) The department shall propose specific strategies for achieving the identified goals. A proposed strategy may be evidence-based if there is an evidence-based strategy available for meeting the pilot program's goals.

Sec. 534.105. IMPLEMENTATION, LOCATION, AND DURATION. (a) The commission and department shall implement any pilot

programs established under this subchapter not later than September 1, 2014.

(b) A pilot program established under this subchapter must operate for not less than 24 months.

(c) A pilot program established under this subchapter shall be conducted in one or more regions selected by the department.

Sec. 534.106. COORDINATING SERVICES. In providing long-term care services and supports under the Medicaid program to an individual with intellectual or developmental disabilities, a pilot program service provider shall:

(1) coordinate through the pilot program institutional and community-based services available to the individual, including services provided through:

(A) a facility licensed under Chapter 252, Health and Safety Code;

(B) a Medicaid waiver program; or

(C) a community-based ICF-IID operated by local authorities; 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) The commission and the department shall 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) The pilot program service provider shall collect any information described by Subsection (a) that is available to the provider and provide the information to the department and the commission not later than the 30th day before the date the program's operation concludes.

Sec. 534.108. PERSON-CENTERED PLANNING. The commission, in cooperation with the department, shall 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.

Sec. 534.109. TRANSITION BETWEEN PROGRAMS. The commission shall 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. On September 1, 2018:

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

(2) this subchapter expires.

[Sections 534.111-534.150 reserved 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. The commission shall 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. The commission shall 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. In implementing the most cost-effective option under this subchapter, the commission shall develop a process for statewide stakeholder input to be received and evaluated.

[Sections 534.154-534.200 reserved 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) 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 the commission implements the transition described by Subsection (b).

(b) Not later than September 1, 2016, the commission shall 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 the commission 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) At the time of the transition described by Subsection (b), the commission shall determine whether to:

(1) continue operation of the Texas home living (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 the commission; or

(2) cease operation of the Texas home living (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 the commission.

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

(e) The commission shall ensure that there is a comprehensive plan for transitioning services from the Texas home living (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) This section applies to individuals with intellectual and developmental disabilities who are receiving long-term services and supports and who, on the date the commission implements the transition described by Subsection (b):

(1) meet the eligibility criteria required to receive long-term care services and supports under a Medicaid waiver program other than the Texas home living (TxHmL) waiver program; or

(2) reside in a facility licensed under Chapter 252, Health and Safety Code, or in a community-based ICF-IID operated by

local authorities.

(b) After implementing the transition required by Section 534.201 but not later than September 1, 2018, the commission shall 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 the commission based on cost-effectiveness and an evaluation of 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 Subsection (c)(1).

(c) At the time of the transition described by Subsection (b), the commission shall 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 the commission; 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 the commission.

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

(e) The commission shall 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. The Health and Human Services Commission shall submit:

(1) 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

(2) the final report under that section not later than September 1, 2018.

SECTION 1.03. The Health and Human Services Commission and the Department of Aging and Disability Services shall 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. Subsection (b), Section 533.0025, Government Code, is amended to read as follows:

(b) Notwithstanding [~~Except as otherwise provided by this section and notwithstanding~~] any other law, the commission shall provide medical assistance for acute care services through the most cost-effective model of Medicaid capitated managed care as determined by the commission. The [~~If the~~] commission shall require mandatory participation in a Medicaid capitated managed care program for all persons eligible for acute care [~~determines that it is more cost-effective, the commission may provide~~] medical assistance benefits [~~for acute care in a certain part of this state or to a certain population of recipients using:~~

[~~(1) a health maintenance organization model, including the acute care portion of Medicaid Star + Plus pilot programs;~~

[~~(2) a primary care case management model;~~

[~~(3) a prepaid health plan model;~~

[~~(4) an exclusive provider organization model; or~~

[~~(5) another Medicaid managed care model or arrangement~~].

SECTION 2.02. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00251 and 533.00252 to read as follows:

Sec. 533.00251. DELIVERY OF SERVICES THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) In this section:

(1) "Nursing facility" has the meaning assigned by Section 531.912.

(2) "Potentially preventable event" has the meaning assigned by Section 536.001.

(b) The commission shall 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) Notwithstanding any other law, the commission shall provide benefits under the medical assistance program to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. In implementing this subsection, the commission shall ensure:

(1) that the commission is responsible for setting the

reimbursement rate paid to a nursing facility under the managed care program;

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

(3) the appropriate utilization of services;

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

(5) 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) In this section:

(1) "Health home" means a primary care provider practice or, if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under the medical assistance program.

(2) "Medical assistance" has the meaning assigned by Section 32.003, Human Resources Code.

(3) "Potentially preventable event" has the meaning assigned by Section 536.001.

(b) The commission shall establish a mandatory STAR Kids capitated managed care program tailored to provide medical

assistance benefits to children with disabilities who are not otherwise enrolled in the STAR + PLUS Medicaid managed care program. The managed care program developed under this section must:

(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) The commission shall 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. The commission

shall 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. Section 32.0212, Human Resources Code, is amended to read as follows:

Sec. 32.0212. DELIVERY OF MEDICAL ASSISTANCE. Notwithstanding any other law [~~and subject to Section 533.0025, Government Code~~], the department shall provide medical assistance for acute care services through the Medicaid managed care system implemented under Chapter 533, Government Code, or another Medicaid capitated managed care program.

SECTION 2.04. Subsections (c) and (d), Section 533.0025, Government Code, and Subchapter D, Chapter 533, Government Code, are repealed.

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

SECTION 3.01. Subchapter B, Chapter 533, Health and Safety Code, is amended by adding Section 533.0335 to read as follows:

Sec. 533.0335. COMPREHENSIVE ASSESSMENT AND RESOURCE ALLOCATION PROCESS. (a) In this section:

(1) "Department" means the Department of Aging and Disability Services.

(2) "Medicaid waiver program" has the meaning assigned by Section 534.001, Government Code.

(b) Subject to the availability of federal funding, the department shall develop and implement a comprehensive assessment

instrument and a resource allocation process. The assessment instrument and resource allocation process must 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) The department may 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. This subsection expires on the date Subchapter C, Chapter 534, Government Code, expires.

(d) The department shall establish a prior authorization process for requests for placement of an individual with intellectual and developmental disabilities in a group home. The process must 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. Subchapter B, Chapter 533, Health and Safety Code, is amended by adding Sections 533.03551 and 533.03552 to read as follows:

Sec. 533.03551. FLEXIBLE, LOW-COST RESIDENTIAL OPTIONS. (a) To the extent permitted under federal law and regulations, the executive commissioner shall 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:

(1) congregate living arrangements, such as houses, condominiums, or rental properties that may be in close proximity to each other;

(2) non-provider-owned residential settings;

(3) assistance with living more independently; and

(4) rental properties with on-site supports.

(b) The Department of Aging and Disability Services, in cooperation with the Texas Department of Housing and Community Affairs, shall 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) The Department of Aging and Disability Services shall 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) In this section, "department" means the Department of Aging and Disability Services.

(b) Subject to the availability of federal funding, the department shall 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) Subject to the availability of federal funding, the department shall establish one or more behavioral health intervention teams to provide services and supports to individuals with intellectual and developmental disabilities and behavioral health needs. An intervention team may include one or more professionals such as a:

(1) psychiatrist or psychologist;

(2) physician;

(3) registered nurse;

(4) behavior analyst;

(5) social worker; or

(6) crisis coordinator.

(d) In providing services and supports, a behavioral health intervention team established by the department shall:

(1) use the team's best efforts to ensure an individual remains in the community and avoids institutionalization;

(2) focus on stabilizing the individual and assessing the individual for medical, psychiatric, psychological, and other needs;

(3) provide support to the individual's family members and other caregivers;

(4) provide intensive behavioral assessment and training to assist the individual in establishing positive behaviors and continuing to live in the community; and

(5) provide clinical and other referrals.

ARTICLE 4. QUALITY-BASED OUTCOMES AND PAYMENTS PROVISIONS

SECTION 4.01. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00511 to read as follows:

Sec. 533.00511. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM FOR MANAGED CARE ORGANIZATIONS. (a) In this section, "potentially preventable admission," "potentially preventable ancillary service," "potentially preventable complication," "potentially preventable emergency room visit," "potentially preventable readmission," and "potentially preventable event" have the meanings assigned by Section 536.001.

(b) The commission shall 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:

(1) the quality of care provided through the managed care organization offering that managed care plan;

(2) the organization's ability to efficiently and effectively provide services, taking into consideration the acuity of populations primarily served by the organization; and

(3) the organization's performance with respect to exceeding, or failing to achieve, appropriate outcome and process measures developed by the commission, including measures based on all potentially preventable events.

SECTION 4.02. Section 533.013, Government Code, is amended by adding Subsection (e) to read as follows:

(e) The commission shall pursue premium rate-setting strategies that encourage payment reform to providers and more

efficient service delivery and provider practices. In this effort, the commission shall review strategies employed or being considered by other states and, if necessary, shall submit a waiver to the federal Centers for Medicare and Medicaid Services.

SECTION 4.03. Section 533.014, Government Code, is amended by amending Subsection (b) and adding Subsection (c) to read as follows:

(b) Except as provided by Subsection (c), any [~~Any~~] amount received by the state under this section shall be deposited in the general revenue fund for the purpose of funding the state Medicaid program.

(c) If cost-effective, the commission may 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. Section 536.003, Government Code, is amended by amending Subsections (a) and (b) and adding Subsection (a-1) to read as follows:

(a) The commission, in consultation with the advisory committee, shall 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 and long-term care services across all delivery models and payment systems, including fee-for-service and managed care payment

systems. Subject to Subsection (a-1), the [~~The~~] commission, in developing outcome and process measures under this section, must include measures based on all [~~consider measures addressing~~] potentially preventable events.

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

(b) To the extent feasible, the commission shall develop outcome and process measures:

(1) consistently across all child health plan and Medicaid program delivery models and payment systems;

(2) in a manner that takes into account appropriate patient risk factors, including the burden of chronic illness on a patient and the severity of a patient's illness;

(3) that will have the greatest effect on improving quality of care and the efficient use of services, including acute and long-term care services; [~~and~~]

(4) that are similar to outcome and process measures used in the private sector, as appropriate;

(5) that reflect effective coordination of acute and long-term care services;

(6) that can be tied to expenditures; and

(7) that reduce preventable health care utilization and costs.

SECTION 4.05. Subchapter A, Chapter 536, Government Code, is amended by adding Sections 536.0031 and 536.0032 to read as follows:

Sec. 536.0031. SHARING OF DATA AMONG HEALTH AND HUMAN SERVICES AGENCIES. To the extent permitted under state and federal requirements, the commission and other health and human services agencies shall share data to facilitate patient care coordination, quality improvement, and cost savings in the Medicaid program, CHIP program, and other programs supported by general revenue.

Sec. 536.0032. MANAGED CARE COLLABORATIVE PROGRAM IMPROVEMENT PLANS. In consultation with the Medicaid and CHIP Quality-Based Payment Advisory Committee, the commission shall establish a clinical improvement program to establish goals, and the commission shall require managed care organizations to develop and implement collaborative program improvement strategies to address these goals. Clinical goals established under the program may be targeted by region and program type.

SECTION 4.06. Subsection (a), Section 536.004, Government Code, is amended to read as follows:

(a) Using quality-based outcome and process measures developed under Section 536.003 and subject to this section, the commission, after consulting with the advisory committee, shall develop quality-based payment systems, and require managed care organizations to develop quality-based payment systems, for compensating a physician or other health care provider participating in the child health plan or Medicaid program that:

(1) align payment incentives with high-quality, cost-effective health care;

(2) reward the use of evidence-based best practices;

(3) promote the coordination of health care;

(4) encourage appropriate physician and other health care provider collaboration;

(5) promote effective health care delivery models; and

(6) take into account the specific needs of the child health plan program enrollee and Medicaid recipient populations.

SECTION 4.07. Section 536.005, Government Code, is amended by adding Subsection (c) to read as follows:

(c) Notwithstanding Subsection (a) and to the extent possible, the commission shall convert outpatient hospital reimbursement systems under the child health plan and Medicaid programs to an appropriate prospective payment system that will allow the commission to:

(1) more accurately classify the full range of outpatient service episodes;

(2) more accurately account for the intensity of services provided; and

(3) motivate outpatient service providers to increase efficiency and effectiveness.

SECTION 4.08. Section 536.006, Government Code, is amended to read as follows:

Sec. 536.006. TRANSPARENCY. The commission and the advisory committee shall:

(1) ensure transparency in the development and establishment of:

(A) quality-based payment and reimbursement systems under Section 536.004 and Subchapters B, C, and D, including the development of outcome and process measures under

Section 536.003; and

(B) quality-based payment initiatives under Subchapter E, including the development of quality of care and cost-efficiency benchmarks under Section 536.204(a) and efficiency performance standards under Section 536.204(b);

(2) develop guidelines establishing procedures for providing notice and information to, and receiving input from, managed care organizations, health care providers, including physicians and experts in the various medical specialty fields, and other stakeholders, as appropriate, for purposes of developing and establishing the quality-based payment and reimbursement systems and initiatives described under Subdivision (1); [~~and~~]

(3) in developing and establishing the quality-based payment and reimbursement systems and initiatives described under Subdivision (1), consider that as the performance of a managed care organization or physician or other health care provider improves with respect to an outcome or process measure, quality of care and cost-efficiency benchmark, or efficiency performance standard, as applicable, there will be a diminishing rate of improved performance over time; and

(4) 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; this capability must support the requirements of the electronic health information exchange system described in Sections 531.907-531.909.

SECTION 4.09. Section 536.008, Government Code, is amended

to read as follows:

Sec. 536.008. ANNUAL REPORT. (a) The commission shall submit to the legislature and make available to the public an annual report [~~to the legislature~~] regarding:

(1) the quality-based outcome and process measures developed under Section 536.003, including measures based on each potentially preventable event; and

(2) the progress of the implementation of quality-based payment systems and other payment initiatives implemented under this chapter.

(b) As appropriate, the [~~The~~] commission shall report outcome and process measures under Subsection (a)(1) by:

(1) geographic location, which may require reporting by county, health care service region, or other appropriately defined geographic area;

(2) recipient population or eligibility group served;

(3) type of health care provider, such as acute care or long-term care provider;

(4) quality-based payment system; and

(5) service delivery model.

(c) The annual report may not identify specific health care providers.

SECTION 4.10. Subsection (a), Section 536.051, Government Code, is amended to read as follows:

(a) Subject to Section 1903(m)(2)(A), Social Security Act (42 U.S.C. Section 1396b(m)(2)(A)), and other applicable federal law, the commission shall 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[~~, including outcome measures addressing~~] potentially preventable events and that advance quality improvement and innovation. The measures utilized should change over time in order to promote continuous system reform, improved quality, and reduced costs. The commission may adjust measures to account for managed care organizations new to a service area.

SECTION 4.11. Subsection (a), Section 536.052, Government Code, is amended to read as follows:

(a) The commission may 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:

(1) achieve high-quality, cost-effective health care;

(2) increase the use of high-quality, cost-effective delivery models; [~~and~~]

(3) reduce potentially preventable events; and

(4) increase the use of alternative payment systems.

SECTION 4.12. Section 536.151, Government Code, is amended by amending Subsections (a) and (b) and adding Subsection (a-1) to read as follows:

(a) The executive commissioner shall 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) The commission shall collect data from hospitals on present-on-admission indicators for purposes of this section.

(b) The commission shall 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) [~~readmissions and potentially preventable complications~~]. To the extent possible, a report provided under this section should include all potentially preventable events [~~readmissions and potentially preventable complications information~~] across all child health plan and Medicaid program payment systems. A hospital shall distribute the information contained in the report to physicians and other health care providers providing services at the hospital.

SECTION 4.13. Subsection (a), Section 536.152, Government Code, is amended to read as follows:

(a) Subject to Subsection (b), using the data collected

under Section 536.151 and the diagnosis-related groups (DRG) methodology implemented under Section 536.005, if applicable, the commission, after consulting with the advisory committee, shall 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, [~~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. Subsection (a), Section 536.202, Government Code, is amended to read as follows:

(a) The commission shall, after consulting with the advisory committee, 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) improve the quality of health care provided to the enrollees or recipients;

(2) reduce potentially preventable events;

(3) promote prevention and wellness;

(4) increase the use of evidence-based best practices;

(5) increase appropriate physician and other health care provider collaboration; [~~and~~]

(6) contain costs; and

(7) improve integration of acute care services and long-term care services and supports.

SECTION 4.15. Chapter 536, Government Code, is amended by adding Subchapter F to read as follows:

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

Sec. 536.251. QUALITY-BASED LONG-TERM CARE PAYMENTS. (a) Subject to this subchapter, the commission, after consulting with the advisory committee, may 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. A quality-based payment system developed under this section must 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) The commission may 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. To ensure that the commission is using the best data to inform the development and implementation of quality-based payment systems under Section

536.251, the commission shall evaluate the reliability, validity, and functionality of post-acute and long-term care services and supports data sets. The commission's evaluation under this section should assess:

(1) to what degree data sets relied on by the commission meet a standard:

(A) for integrating care;

(B) for developing coordinated care plans; and

(C) 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) The executive commissioner shall 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) The commission shall 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. To the extent possible, a report provided under this section should include applicable potentially preventable events information across all Medicaid program payment systems.

(c) A report provided to a provider under this section is confidential and is not subject to Chapter 552.

SECTION 4.16. Not later than September 1, 2013, the Health and Human Services Commission shall convert outpatient hospital reimbursement systems as required by Subsection (c), Section 536.005, Government Code, as added by this Act.

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

SECTION 5.01. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0133 to read as follows:

Sec. 533.0133. INCLUSION OF RETROACTIVE FEE-FOR-SERVICE PAYMENTS IN PREMIUMS PAID. If the commission determines that it is cost-effective, the commission shall 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. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0642 to read as follows:

Sec. 32.0642. PREMIUM REQUIREMENT FOR RECEIPT OF CERTAIN SERVICES. 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, the executive commissioner of the Health and Human Services Commission shall 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. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 6.02. The Health and Human Services Commission may use any available revenue, including legislative appropriations and available federal funds, for purposes of implementing any provision of this Act.

SECTION 6.03. This Act takes effect September 1, 2013.