

1-1 By: Raymond, Klick (Senate Sponsor - Perry) H.B. No. 3523  
1-2 (In the Senate - Received from the House May 5, 2015;  
1-3 May 6, 2015, read first time and referred to Committee on Health  
1-4 and Human Services; May 22, 2015, reported adversely, with  
1-5 favorable Committee Substitute by the following vote: Yeas 9,  
1-6 Nays 0; May 22, 2015, sent to printer.)

1-7 COMMITTEE VOTE

	Yea	Nay	Absent	PNV
1-8				
1-9	X			
1-10	X			
1-11	X			
1-12	X			
1-13	X			
1-14	X			
1-15	X			
1-16	X			
1-17	X			

1-18 COMMITTEE SUBSTITUTE FOR H.B. No. 3523 By: Uresti

1-19 A BILL TO BE ENTITLED  
1-20 AN ACT

1-21 relating to improving the delivery and quality of Medicaid acute  
1-22 care services and long-term care services and supports.

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

1-24 SECTION 1. Section 533.00251, Government Code, is amended  
1-25 by amending Subsection (c), as amended by S.B. No. 219, Acts of the  
1-26 84th Legislature, Regular Session, 2015, and amending Subsection  
1-27 (g) to read as follows:

1-28 (c) Subject to Section 533.0025 and notwithstanding any  
1-29 other law, the commission, in consultation with the advisory  
1-30 committee, shall provide benefits under Medicaid to recipients who  
1-31 reside in nursing facilities through the STAR + PLUS Medicaid  
1-32 managed care program. In implementing this subsection, the  
1-33 commission shall ensure:

1-34 (1) that the commission is responsible for setting the  
1-35 minimum reimbursement rate paid to a nursing facility under the  
1-36 managed care program~~[, including the staff rate enhancement paid to~~  
1-37 ~~a nursing facility that qualifies for the enhancement];~~

1-38 (2) that a nursing facility is paid not later than the  
1-39 10th day after the date the facility submits a clean claim;

1-40 (3) the appropriate utilization of services  
1-41 consistent with criteria established by the commission;

1-42 (4) a reduction in the incidence of potentially  
1-43 preventable events and unnecessary institutionalizations;

1-44 (5) that a managed care organization providing  
1-45 services under the managed care program provides discharge  
1-46 planning, transitional care, and other education programs to  
1-47 physicians and hospitals regarding all available long-term care  
1-48 settings;

1-49 (6) that a managed care organization providing  
1-50 services under the managed care program:

1-51 (A) assists in collecting applied income from  
1-52 recipients; and

1-53 (B) provides payment incentives to nursing  
1-54 facility providers that reward reductions in preventable acute care  
1-55 costs and encourage transformative efforts in the delivery of  
1-56 nursing facility services, including efforts to promote a  
1-57 resident-centered care culture through facility design and  
1-58 services provided;

1-59 (7) the establishment of a portal that is in  
1-60 compliance with state and federal regulations, including standard

2-1 coding requirements, through which nursing facility providers  
2-2 participating in the STAR + PLUS Medicaid managed care program may  
2-3 submit claims to any participating managed care organization;

2-4 (8) that rules and procedures relating to the  
2-5 certification and decertification of nursing facility beds under  
2-6 Medicaid are not affected; ~~and~~

2-7 (9) that a managed care organization providing  
2-8 services under the managed care program, to the greatest extent  
2-9 possible, offers nursing facility providers access to:

2-10 (A) acute care professionals; and

2-11 (B) telemedicine, when feasible and in  
2-12 accordance with state law, including rules adopted by the Texas  
2-13 Medical Board; and

2-14 (10) that the commission approves the staff rate  
2-15 enhancement methodology for the staff rate enhancement paid to a  
2-16 nursing facility that qualifies for the enhancement under the  
2-17 managed care program.

2-18 (g) Subsection [~~Subsections (c),~~] (d) [~~, (e), and (f)~~] and  
2-19 this subsection expire September 1, 2021 [~~2019~~].

2-20 SECTION 2. Effective September 1, 2021, Section  
2-21 [533.00251](#)(c), Government Code, as amended by S.B. No. 219, Acts of  
2-22 the 84th Legislature, Regular Session, 2015, is amended to read as  
2-23 follows:

2-24 (c) Subject to Section [533.0025](#) and notwithstanding any  
2-25 other law, the commission, in consultation with the advisory  
2-26 committee, shall provide benefits under Medicaid to recipients who  
2-27 reside in nursing facilities through the STAR + PLUS Medicaid  
2-28 managed care program. In implementing this subsection, the  
2-29 commission shall ensure:

2-30 (1) [~~that the commission is responsible for setting~~  
2-31 ~~the minimum reimbursement rate paid to a nursing facility under the~~  
2-32 ~~managed care program, including the staff rate enhancement paid to~~  
2-33 ~~a nursing facility that qualifies for the enhancement;~~

2-34 [~~(2)~~] that a nursing facility is paid not later than  
2-35 the 10th day after the date the facility submits a clean claim;

2-36 (2) [~~(3)~~] the appropriate utilization of services  
2-37 consistent with criteria established by the commission;

2-38 (3) [~~(4)~~] a reduction in the incidence of potentially  
2-39 preventable events and unnecessary institutionalizations;

2-40 (4) [~~(5)~~] that a managed care organization providing  
2-41 services under the managed care program provides discharge  
2-42 planning, transitional care, and other education programs to  
2-43 physicians and hospitals regarding all available long-term care  
2-44 settings;

2-45 (5) [~~(6)~~] that a managed care organization providing  
2-46 services under the managed care program:

2-47 (A) assists in collecting applied income from  
2-48 recipients; and

2-49 (B) provides payment incentives to nursing  
2-50 facility providers that reward reductions in preventable acute care  
2-51 costs and encourage transformative efforts in the delivery of  
2-52 nursing facility services, including efforts to promote a  
2-53 resident-centered care culture through facility design and  
2-54 services provided;

2-55 (6) [~~(7)~~] the establishment of a portal that is in  
2-56 compliance with state and federal regulations, including standard  
2-57 coding requirements, through which nursing facility providers  
2-58 participating in the STAR + PLUS Medicaid managed care program may  
2-59 submit claims to any participating managed care organization;

2-60 (7) [~~(8)~~] that rules and procedures relating to the  
2-61 certification and decertification of nursing facility beds under  
2-62 Medicaid are not affected; ~~and~~

2-63 (8) [~~(9)~~] that a managed care organization providing  
2-64 services under the managed care program, to the greatest extent  
2-65 possible, offers nursing facility providers access to:

2-66 (A) acute care professionals; and

2-67 (B) telemedicine, when feasible and in  
2-68 accordance with state law, including rules adopted by the Texas  
2-69 Medical Board; and

3-1 (9) that the commission approves the staff rate  
3-2 enhancement methodology for the staff rate enhancement paid to a  
3-3 nursing facility that qualifies for the enhancement under the  
3-4 managed care program.

3-5 SECTION 3. Section 534.053, Government Code, is amended by  
3-6 adding Subsection (e-1) and amending Subsection (g) to read as  
3-7 follows:

3-8 (e-1) The advisory committee may establish work groups that  
3-9 meet at other times for purposes of studying and making  
3-10 recommendations on issues the committee considers appropriate.

3-11 (g) On January 1, 2026 [2024]:

3-12 (1) the advisory committee is abolished; and

3-13 (2) this section expires.

3-14 SECTION 4. Section 534.054, Government Code, as amended by  
3-15 S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015,  
3-16 is amended to read as follows:

3-17 Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not  
3-18 later than September 30 of each year, the commission, in  
3-19 consultation and collaboration with the advisory committee, shall  
3-20 prepare and submit a report to the legislature that must include  
3-21 [regarding]:

3-22 (1) an assessment of the implementation of the system  
3-23 required by this chapter, including appropriate information  
3-24 regarding the provision of acute care services and long-term  
3-25 services and supports to individuals with an intellectual or  
3-26 developmental disability under Medicaid as described by this  
3-27 chapter; [and]

3-28 (2) recommendations regarding implementation of and  
3-29 improvements to the system redesign, including recommendations  
3-30 regarding appropriate statutory changes to facilitate the  
3-31 implementation; and

3-32 (3) an assessment of the effect of the system on the  
3-33 following:

3-34 (A) access to long-term services and supports;

3-35 (B) the quality of acute care services and  
3-36 long-term services and supports;

3-37 (C) meaningful outcomes for Medicaid recipients  
3-38 using person-centered planning, individualized budgeting, and  
3-39 self-determination, including a person's inclusion in the  
3-40 community;

3-41 (D) the integration of service coordination of  
3-42 acute care services and long-term services and supports;

3-43 (E) the efficiency and use of funding;

3-44 (F) the placement of individuals in housing that  
3-45 is the least restrictive setting appropriate to an individual's  
3-46 needs;

3-47 (G) employment assistance and customized,  
3-48 integrated, competitive employment options; and

3-49 (H) the number and types of fair hearing and  
3-50 appeals processes in accordance with applicable federal law.

3-51 (b) This section expires January 1, 2026 [2024].

3-52 SECTION 5. Section 534.104, Government Code, is amended by  
3-53 amending Subsection (a), as amended by S.B. No. 219, Acts of the  
3-54 84th Legislature, Regular Session, 2015, amending Subsections (b),  
3-55 (c), (d), (e), and (g), and adding Subsection (h) to read as  
3-56 follows:

3-57 (a) The department, in consultation and collaboration with  
3-58 the advisory committee, shall identify private services providers  
3-59 or managed care organizations that are good candidates to develop a  
3-60 service delivery model involving a managed care strategy based on  
3-61 capitation and to test the model in the provision of long-term  
3-62 services and supports under Medicaid to individuals with an  
3-63 intellectual or developmental disability through a pilot program  
3-64 established under this subchapter.

3-65 (b) The department shall solicit managed care strategy  
3-66 proposals from the private services providers and managed care  
3-67 organizations identified under Subsection (a). In addition, the  
3-68 department may accept and approve a managed care strategy proposal  
3-69 from any qualified entity that is a private services provider or

4-1 managed care organization if the proposal provides for a  
4-2 comprehensive array of long-term services and supports, including  
4-3 case management and service coordination.

4-4 (c) A managed care strategy based on capitation developed  
4-5 for implementation through a pilot program under this subchapter  
4-6 must be designed to:

4-7 (1) increase access to long-term services and  
4-8 supports;

4-9 (2) improve quality of acute care services and  
4-10 long-term services and supports;

4-11 (3) promote meaningful outcomes by using  
4-12 person-centered planning, individualized budgeting, and  
4-13 self-determination, and promote community inclusion [~~and~~  
4-14 ~~customized, integrated, competitive employment~~];

4-15 (4) promote integrated service coordination of acute  
4-16 care services and long-term services and supports;

4-17 (5) promote efficiency and the best use of funding;

4-18 (6) promote the placement of an individual in housing  
4-19 that is the least restrictive setting appropriate to the  
4-20 individual's needs;

4-21 (7) promote employment assistance and customized,  
4-22 integrated, and competitive [~~supported~~] employment;

4-23 (8) provide fair hearing and appeals processes in  
4-24 accordance with applicable federal law; and

4-25 (9) promote sufficient flexibility to achieve the  
4-26 goals listed in this section through the pilot program.

4-27 (d) The department, in consultation and collaboration with  
4-28 the advisory committee, shall evaluate each submitted managed care  
4-29 strategy proposal and determine whether:

4-30 (1) the proposed strategy satisfies the requirements  
4-31 of this section; and

4-32 (2) the private services provider or managed care  
4-33 organization that submitted the proposal has a demonstrated ability  
4-34 to provide the long-term services and supports appropriate to the  
4-35 individuals who will receive services through the pilot program  
4-36 based on the proposed strategy, if implemented.

4-37 (e) Based on the evaluation performed under Subsection (d),  
4-38 the department may select as pilot program service providers one or  
4-39 more private services providers or managed care organizations with  
4-40 whom the commission will contract.

4-41 (g) The department, in consultation and collaboration with  
4-42 the advisory committee, shall analyze information provided by the  
4-43 pilot program service providers and any information collected by  
4-44 the department during the operation of the pilot programs for  
4-45 purposes of making a recommendation about a system of programs and  
4-46 services for implementation through future state legislation or  
4-47 rules.

4-48 (h) The analysis under Subsection (g) must include an  
4-49 assessment of the effect of the managed care strategies implemented  
4-50 in the pilot programs on:

4-51 (1) access to long-term services and supports;

4-52 (2) the quality of acute care services and long-term  
4-53 services and supports;

4-54 (3) meaningful outcomes using person-centered  
4-55 planning, individualized budgeting, and self-determination,  
4-56 including a person's inclusion in the community;

4-57 (4) the integration of service coordination of acute  
4-58 care services and long-term services and supports;

4-59 (5) the efficiency and use of funding;

4-60 (6) the placement of individuals in housing that is  
4-61 the least restrictive setting appropriate to an individual's needs;

4-62 (7) employment assistance and customized, integrated,  
4-63 competitive employment options; and

4-64 (8) the number and types of fair hearing and appeals  
4-65 processes in accordance with applicable federal law.

4-66 SECTION 6. Sections 534.106(a) and (b), Government Code,  
4-67 are amended to read as follows:

4-68 (a) The commission and the department shall implement any  
4-69 pilot programs established under this subchapter not later than

5-1 September 1, ~~2017~~ [2016].

5-2 (b) A pilot program established under this subchapter may  
 5-3 [~~must~~] operate for up to [~~not less than~~] 24 months. A [~~, except that~~  
 5-4 a] pilot program may cease operation [~~before the expiration of 24~~  
 5-5 ~~months~~] if the pilot program service provider terminates the  
 5-6 contract with the commission before the agreed-to termination date.

5-7 SECTION 7. Section 534.108(d), Government Code, is amended  
 5-8 to read as follows:

5-9 (d) The [~~On or before December 1, 2016, and December 1,~~  
 5-10 ~~2017, the~~] commission and the department, in consultation and  
 5-11 collaboration with the advisory committee, shall review and  
 5-12 evaluate the progress and outcomes of each pilot program and  
 5-13 implemented under this subchapter and submit, as part of the annual  
 5-14 report to the legislature required by Section 534.054, a report to  
 5-15 the legislature during the operation of the pilot programs. Each  
 5-16 report must include recommendations for program improvement and  
 5-17 continued implementation.

5-18 SECTION 8. Section 534.110, Government Code, as amended by  
 5-19 S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015,  
 5-20 is amended to read as follows:

5-21 Sec. 534.110. TRANSITION BETWEEN PROGRAMS. (a) The  
 5-22 commission shall ensure that there is a comprehensive plan for  
 5-23 transitioning the provision of Medicaid benefits between a Medicaid  
 5-24 waiver program or an ICF-IID program and a pilot program under this  
 5-25 subchapter to protect continuity of care.

5-26 (b) The transition plan shall be developed in consultation  
 5-27 and collaboration with the advisory committee and with stakeholder  
 5-28 input as described by Section 534.103.

5-29 SECTION 9. Section 534.151, Government Code, as amended by  
 5-30 S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015,  
 5-31 is amended to read as follows:

5-32 Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES FOR  
 5-33 INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. (a)  
 5-34 Subject to Section 533.0025, the commission shall provide acute  
 5-35 care Medicaid benefits to individuals with an intellectual or  
 5-36 developmental disability through the STAR + PLUS Medicaid managed  
 5-37 care program or the most appropriate integrated capitated managed  
 5-38 care program delivery model and monitor the provision of those  
 5-39 benefits.

5-40 (b) The commission and the department, in consultation and  
 5-41 collaboration with the advisory committee, shall analyze the  
 5-42 outcomes of providing acute care Medicaid benefits to individuals  
 5-43 with an intellectual or developmental disability under a model  
 5-44 specified in Subsection (a). The analysis must:

5-45 (1) include an assessment of the effects on:

5-46 (A) access to and quality of acute care services;  
 5-47 and

5-48 (B) the number and types of fair hearing and  
 5-49 appeals processes in accordance with applicable federal law;

5-50 (2) be incorporated into the annual report to the  
 5-51 legislature required under Section 534.054; and

5-52 (3) include recommendations for delivery model  
 5-53 improvements and implementation for consideration by the  
 5-54 legislature, including recommendations for needed statutory  
 5-55 changes.

5-56 SECTION 10. The heading to Section 534.152, Government  
 5-57 Code, is amended to read as follows:

5-58 Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR  
 5-59 + PLUS MEDICAID MANAGED CARE PROGRAM AND BY WAIVER PROGRAM  
 5-60 PROVIDERS.

5-61 SECTION 11. Section 534.152, Government Code, is amended by  
 5-62 adding Subsection (g) to read as follows:

5-63 (g) The department may contract with providers  
 5-64 participating in the home and community-based services (HCS) waiver  
 5-65 program, the Texas home living (TxHmL) waiver program, the  
 5-66 community living assistance and support services (CLASS) waiver  
 5-67 program, or the deaf-blind with multiple disabilities (DBMD) waiver  
 5-68 program for the delivery of basic attendant and habilitation  
 5-69 services described in Subsection (a) for individuals to which that

6-1 subsection applies. The department has regulatory and oversight  
6-2 authority over the providers with which the department contracts  
6-3 for the delivery of those services.

6-4 SECTION 12. Section 534.201, Government Code, is amended by  
6-5 amending Subsections (b) and (e), as amended by S.B. No. 219, Acts  
6-6 of the 84th Legislature, Regular Session, 2015, amending Subsection  
6-7 (d), and adding Subsection (g) to read as follows:

6-8 (b) On [~~Not later than~~] September 1, 2018 [~~2017~~], the  
6-9 commission shall transition the provision of Medicaid benefits to  
6-10 individuals to whom this section applies to the STAR + PLUS Medicaid  
6-11 managed care program delivery model or the most appropriate  
6-12 integrated capitated managed care program delivery model, as  
6-13 determined by the commission based on cost-effectiveness and the  
6-14 experience of the STAR + PLUS Medicaid managed care program in  
6-15 providing basic attendant and habilitation services and of the  
6-16 pilot programs established under Subchapter C, subject to  
6-17 Subsection (c)(1).

6-18 (d) In implementing the transition described by Subsection  
6-19 (b), the commission, in consultation and collaboration with the  
6-20 advisory committee, shall develop a process to receive and evaluate  
6-21 input from interested statewide stakeholders [~~that is in addition~~  
6-22 ~~to the input provided by the advisory committee~~].

6-23 (e) The commission, in consultation and collaboration with  
6-24 the advisory committee, shall ensure that there is a comprehensive  
6-25 plan for transitioning the provision of Medicaid benefits under  
6-26 this section that protects the continuity of care provided to  
6-27 individuals to whom this section applies.

6-28 (g) The commission, in consultation and collaboration with  
6-29 the advisory committee, shall analyze the outcomes of the  
6-30 transition of the long-term services and supports under the Texas  
6-31 home living (TxHmL) Medicaid waiver program to a managed care  
6-32 program delivery model. The analysis must:

6-33 (1) include an assessment of the effect of the  
6-34 transition on:

6-35 (A) access to long-term services and supports;

6-36 (B) meaningful outcomes using person-centered  
6-37 planning, individualized budgeting, and self-determination,  
6-38 including a person's inclusion in the community;

6-39 (C) the integration of service coordination of  
6-40 acute care services and long-term services and supports;

6-41 (D) employment assistance and customized,  
6-42 integrated, competitive employment options; and

6-43 (E) the number and types of fair hearing and  
6-44 appeals processes in accordance with applicable federal law;

6-45 (2) be incorporated into the annual report to the  
6-46 legislature required under Section 534.054; and

6-47 (3) include recommendations for improvements to the  
6-48 transition implementation for consideration by the legislature,  
6-49 including recommendations for needed statutory changes.

6-50 SECTION 13. Section 534.202(b), Government Code, as amended  
6-51 by S.B. No. 219, Acts of the 84th Legislature, Regular Session,  
6-52 2015, is amended to read as follows:

6-53 (b) After implementing the transition required by Section  
6-54 534.201, on [~~but not later than~~] September 1, 2021 [~~2020~~], the  
6-55 commission shall transition the provision of Medicaid benefits to  
6-56 individuals to whom this section applies to the STAR + PLUS Medicaid  
6-57 managed care program delivery model or the most appropriate  
6-58 integrated capitated managed care program delivery model, as  
6-59 determined by the commission based on cost-effectiveness and the  
6-60 experience of the transition of Texas home living (TxHmL) waiver  
6-61 program recipients to a managed care program delivery model under  
6-62 Section 534.201, subject to Subsections (c)(1) and (g).

6-63 SECTION 14. If before implementing any provision of this  
6-64 Act a state agency determines that a waiver or authorization from a  
6-65 federal agency is necessary for implementation of that provision,  
6-66 the agency affected by the provision shall request the waiver or  
6-67 authorization and may delay implementing that provision until the  
6-68 waiver or authorization is granted.

6-69 SECTION 15. Except as otherwise provided by this Act:

7-1 (1) this Act takes effect immediately if it receives a  
7-2 vote of two-thirds of all the members elected to each house, as  
7-3 provided by Section 39, Article III, Texas Constitution; and  
7-4 (2) if this Act does not receive the vote necessary for  
7-5 immediate effect, this Act takes effect September 1, 2015.

7-6

\* \* \* \* \*