GOVERNMENT CODE

TITLE 4. EXECUTIVE BRANCH

SUBTITLE I. HEALTH AND HUMAN SERVICES

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

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 534.001. DEFINITIONS. In this chapter:

(1) "Advisory committee" means the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053.

(2) "Basic attendant services" means assistance with the activities of daily living, including instrumental activities of daily living, provided to an individual because of a physical, cognitive, or behavioral limitation related to the individual's disability or chronic health condition.

(3) "Comprehensive long-term services and supports provider" means a provider of long-term services and supports under this chapter that ensures the coordinated, seamless delivery of the full range of services in a recipient's program plan. The term includes:

(A) a provider under the ICF-IID program; and

(B) a provider under a Medicaid waiver program.

(3-a) "Consumer direction model" has the meaning assigned by Section 531.051.

(4) "Functional need" means the measurement of an individual's services and supports needs, including the individual's intellectual, psychiatric, medical, and physical support needs.

(5) "Habilitation services" includes assistance provided to an individual with acquiring, retaining, or improving:

(A) skills related to the activities of daily living; and

(B) the social and adaptive skills necessary to enable the individual to live and fully participate in the

community.

(6) "ICF-IID" means the program under Medicaid serving individuals with an intellectual or developmental disability who receive care in intermediate care facilities other than a state supported living center.

(7) "ICF-IID program" means a program under Medicaid serving individuals with an intellectual or developmental disability who reside in and receive care from:

(A) intermediate care facilities licensed under Chapter 252, Health and Safety Code; or

(B) community-based intermediate care facilities operated by local intellectual and developmental disability authorities.

(8) "Local intellectual and developmental disability authority" has the meaning assigned by Section 531.002, Health and Safety Code.

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

(10) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 2.287(17), eff. April 2, 2015.

(11) "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 an intellectual or developmental disability:

(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 with multiple disabilities (DBMD) waiver program; and

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

(11-a) "Residential services" means services provided to an individual with an intellectual or developmental disability through a community-based ICF-IID, three- or four-person home or host home setting under the home and community-based services (HCS)

waiver program, or a group home under the deaf-blind with multiple disabilities (DBMD) waiver program.

(12) "State supported living center" has the meaning assigned by Section 531.002, Health and Safety Code.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.241, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.287(17), eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 6, eff. September 1, 2019.

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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

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

Sec. 534.051. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. In accordance with this chapter, the commission shall 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;

(2) improve individuals' access to services and supports by ensuring that the individuals receive information about all available programs and services, including employment and least

restrictive housing assistance, and how to apply for the programs and services;

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

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

(5) promote individualized budgeting based on an assessment of an individual's needs and person-centered planning;

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

(7) improve acute care and long-term services and supports outcomes, including reducing unnecessary institutionalization and potentially preventable events;

(8) promote high-quality care;

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

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

(11) promote independent service coordination and independent ombudsmen services; and

(12) ensure that individuals with the most significant needs are appropriately served in the community and that processes are in place to prevent inappropriate institutionalization of individuals.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.242, eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 7, eff. September 1, 2019.

Sec. 534.052. IMPLEMENTATION OF SYSTEM REDESIGN. The commission shall, in consultation and collaboration with the advisory committee, implement the acute care services and long-term

services and supports system for individuals with an intellectual or developmental disability in the manner and in the stages described in this chapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.243, eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 7, eff. September 1, 2019.

For expiration of this section, see Subsection (g).

Sec. 534.053. INTELLECTUAL AND DEVELOPMENTAL DISABILITY SYSTEM REDESIGN ADVISORY COMMITTEE. (a) The Intellectual and Developmental Disability System Redesign Advisory Committee shall advise the commission on the implementation of the acute care services and long-term services and supports system redesign under this chapter. Subject to Subsection (b), the executive commissioner shall appoint members of the advisory committee who are stakeholders from the intellectual and developmental disabilities community, including:

(1) individuals with an intellectual or developmental disability who are recipients of services under the Medicaid waiver programs, individuals with an intellectual or developmental disability who are recipients of services under the ICF-IID program, and individuals who are advocates of those recipients, including at least three representatives from intellectual and developmental disability advocacy organizations;

(2) representatives of Medicaid managed care and nonmanaged care health care providers, including:

(A) physicians who are primary care providers and physicians who are specialty care providers;

(B) nonphysician mental health professionals; and

(C) providers of long-term services and supports, including direct service workers;

(3) representatives of entities with responsibilities

for the delivery of Medicaid long-term services and supports or other Medicaid service delivery, including:

(A) representatives of aging and disability resource centers established under the Aging and Disability Resource Center initiative funded in part by the federal Administration on Aging and the Centers for Medicare and Medicaid Services;

(B) representatives of community mental health and intellectual disability centers;

(C) representatives of and service coordinators or case managers from private and public home and community-based services providers that serve individuals with an intellectual or developmental disability; and

(D) representatives of private and public ICF-IID providers; and

(4) representatives of managed care organizations contracting with the state to provide services to individuals with an intellectual or developmental disability.

(b) To the greatest extent possible, the executive commissioner shall appoint members of the advisory committee who reflect the geographic diversity of the state and include members who represent rural Medicaid recipients.

(c) The executive commissioner shall appoint the presiding officer of the advisory committee.

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

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

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

(f) The advisory committee is subject to the requirements of Chapter 551.

(g) On the second anniversary of the date the commission completes implementation of the transition required under Section 534.202:

(1) the advisory committee is abolished; and

(2) this section expires.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.244, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.17, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.17, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 1117 (H.B. 3523), Sec. 3, eff. June 19, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 8, eff. September 1, 2019.

Reenacted and amended by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 9, eff. September 1, 2019.

For expiration of this section, see Subsection (b).

Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not later than September 30 of each year, the commission, in consultation and collaboration with the advisory committee, shall prepare and submit a report to the legislature that must include:

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

(2) recommendations regarding implementation of and improvements to the system redesign, including recommendations regarding appropriate statutory changes to facilitate the

implementation; and

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

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

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

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

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

(E) the efficiency and use of funding;

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

(G) employment assistance and customized, integrated, competitive employment options; and

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

(b) This section expires on the second anniversary of the date the commission completes implementation of the transition required under Section 534.202.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.245, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1117 (H.B. 3523), Sec. 4, eff. June 19, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 10, eff. September 1, 2019.

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

Sec. 534.101. DEFINITIONS. In this subchapter:

(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) "Pilot program" means the pilot program established under this subchapter.

(3) "Pilot program workgroup" means the pilot program workgroup established under Section 534.1015.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.247, eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 12, eff. September 1, 2019.

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

(b) The pilot program workgroup is composed of:

(1) representatives of the advisory committee;

(2) stakeholders representing individuals with an intellectual or developmental disability;

(3) stakeholders representing individuals with similar functional needs as those individuals described by Subdivision (2); and

(4) representatives of managed care organizations that contract with the commission to provide services under the STAR+PLUS Medicaid managed care program.

(c) Chapter 2110 applies to the pilot program workgroup.

Added by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 13, eff. September 1, 2019.

Sec. 534.102. PILOT PROGRAM TO TEST PERSON-CENTERED MANAGED CARE STRATEGIES AND IMPROVEMENTS BASED ON CAPITATION. The

commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall 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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.248, eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 14, eff. September 1, 2019.

Sec. 534.103. STAKEHOLDER INPUT. As part of developing and implementing the pilot program, the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop a process to receive and evaluate:

(1) input from statewide stakeholders and stakeholders from a STAR+PLUS Medicaid managed care service area in which the pilot program will be implemented; and

(2) other evaluations and data.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 14, eff. September 1, 2019.

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

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

Added by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 15, eff. September 1, 2019.

Sec. 534.104. PILOT PROGRAM DESIGN. (a) The pilot program must be designed to:

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

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

(3) promote:

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

(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;

(7) promote employment assistance and customized, integrated, and competitive employment;

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

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

(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, Estates Code.

(b) An individual is not required to use an innovative technology described by Subsection (a)(10). If an individual chooses to use an innovative technology described by that subdivision, the commission shall ensure that services associated with the technology are delivered in a manner that:

(1) ensures the individual's privacy, health, and well-being;

(2) provides access to housing in the most integrated and least restrictive environment;

(3) assesses individual needs and preferences to promote autonomy, self-determination, the use of the consumer direction model, and privacy;

(4) increases personal independence;

(5) specifies the extent to which the innovative technology will be used, including:

(A) the times of day during which the technology will be used;

(B) the place in which the technology may be used;

(C) the types of telemonitoring or remote monitoring that will be used; and

(D) for what purposes the technology will be used;

(6) is consistent with and agreed on during the

person-centered planning process;

(7) ensures that staff overseeing the use of an innovative technology:

(A) review the person-centered and implementation plans for each individual before overseeing the use of the innovative technology; and

(B) demonstrate competency regarding the support needs of each individual using the innovative technology;

(8) ensures that an individual using an innovative technology is able to request the removal of equipment relating to the technology and, on receipt of a request for the removal, the equipment is immediately removed; and

(9) ensures that an individual is not required to use telemedicine at any point during the pilot program and, in the event the individual refuses to use telemedicine, the managed care organization providing health care services to the individual under the pilot program arranges for services that do not include telemedicine.

(c) The pilot program must 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 payment methodologies that include:

(1) the payment of a bundled amount without downside risk to a comprehensive long-term services and supports provider for some or all services delivered as part of a comprehensive array of long-term services and supports;

(2) enhanced incentive payments to comprehensive long-term services and supports providers based on the completion of predetermined outcomes or quality metrics; and

(3) any other payment models approved by the commission.

(d) An alternative payment rate or methodology described by Subsection (c) may 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.

(e) In developing an alternative payment rate or

methodology described by Subsection (c), the commission, managed care organizations, and comprehensive long-term services and supports providers shall 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.

(f) An alternative payment rate or methodology described by Subsection (c) may not reduce 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) The pilot program must allow a comprehensive long-term services and supports provider for individuals with an intellectual or developmental disability or similar functional needs that contracts with the commission to provide services under Medicaid before the implementation date of the pilot program to voluntarily participate in the pilot program. A provider's choice not to participate in the pilot program does not affect the provider's status as a significant traditional provider.

(h) Under the pilot program, a participating managed care organization shall 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.

(i) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall analyze information provided by the managed care organizations participating in the pilot program and any information collected by the commission 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.

(j) The analysis under Subsection (i) must include an assessment of the effect of the managed care strategies implemented in the pilot program on the goals described by this section.

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.249, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1117 (H.B. 3523), Sec. 5, eff. June 19, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 16, eff. September 1, 2019.

Sec. 534.1045. PILOT PROGRAM BENEFITS AND PROVIDER QUALIFICATIONS. (a) Subject to Subsection (b), the commission shall 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;

(6) other nonresidential long-term services and supports that the commission, 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; and

(7) dental services benefits in accordance with Subsection (a-1).

(a-1) In developing the pilot program, the commission shall:

(1) evaluate dental services benefits provided

through Medicaid waiver programs and dental services benefits provided as a value-added service under the Medicaid managed care delivery model;

(2) determine which dental services benefits are the most cost-effective in reducing emergency room and inpatient hospital admissions due to poor oral health; and

(3) based on the determination made under Subdivision (2), provide the most cost-effective dental services benefits to pilot program participants.

(b) A comprehensive long-term services and supports provider may 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) A comprehensive long-term services and supports provider may 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) Day habilitation services listed under Subsection (a)(4)(C) may be delivered by a provider who contracts or subcontracts with the commission to provide day habilitation services under the home and community-based services (HCS) waiver program or the ICF-IID program.

(e) A comprehensive long-term services and supports provider participating in the pilot program shall 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. A comprehensive long-term services and supports provider may be reimbursed by a managed care organization for coordinating with care coordinators under this subsection.

(f) Before implementing the pilot program, the commission,

in consultation and collaboration with the advisory committee and pilot program workgroup, shall:

(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).

Added by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 17, eff. September 1, 2019.

Sec. 534.105. PILOT PROGRAM: MEASURABLE GOALS. (a) The commission, 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, shall identify measurable goals to be achieved by the pilot program.

(b) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop specific strategies and performance measures 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.

(c) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall 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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 18, eff. September 1, 2019.

Sec. 534.106. IMPLEMENTATION, LOCATION, AND DURATION.

(a) The commission shall implement the pilot program on September 1, 2023.

(b) The pilot program shall operate for at least 24 months.

(c) The pilot program shall be conducted in a STAR+PLUS Medicaid managed care service area selected by the commission.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1117 (H.B. 3523), Sec. 6, eff. June 19, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 18, eff. September 1, 2019.

Sec. 534.1065. RECIPIENT ENROLLMENT, PARTICIPATION, AND ELIGIBILITY. (a) 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.

(b) To ensure prospective pilot program participants are able to make an informed decision on whether to participate in the pilot program, the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall 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. The commission shall establish a timeline and process for the development and distribution of the materials and shall 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) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop pilot program participant eligibility criteria. The criteria must ensure pilot program participants:

(1) include individuals with an intellectual or developmental disability or a cognitive disability, including:

(A) individuals with autism;

(B) individuals with significant complex behavioral, medical, and physical needs who are receiving home and community-based services through the STAR+PLUS Medicaid managed care program;

(C) individuals enrolled in the STAR+PLUS Medicaid managed care program who:

(i) are on a Medicaid waiver program interest list;

(ii) meet the criteria for an intellectual or developmental disability; or

(iii) have a traumatic brain injury that

occurred after the age of 21; and

(D) other individuals with disabilities who have similar functional needs without regard to the age of onset or diagnosis; and

(2) do not include individuals who are receiving only acute care services under the STAR+PLUS Medicaid managed care program and are enrolled in the community-based ICF-IID program or another Medicaid waiver program.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 18, eff. September 1, 2019.

Sec. 534.107. COMMISSION RESPONSIBILITIES. (a) The commission shall require that a managed care organization participating in the pilot program:

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

(2) demonstrates to the commission's satisfaction that the organization's network of acute care, long-term services and supports, and comprehensive long-term services and supports providers have experience and expertise in providing services for individuals with an intellectual or developmental disability and individuals with similar functional needs;

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

(4) ensures the timely initiation and consistent provision of services in accordance with an individual's person-centered plan.

(b) For the duration of the pilot program, the commission shall 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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.250, eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 18, eff. September 1, 2019.

Sec. 534.108. PILOT PROGRAM INFORMATION. (a) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall 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.

(b) For the duration of the pilot program, a managed care organization participating in the pilot program shall submit to the commission and the advisory committee quarterly reports on the services provided to each pilot program participant that include information on:

(1) the level of each requested service and the authorization and utilization rates for those services;

(2) timelines of:

(A) the delivery of each requested service;

(B) authorization of each requested service;

(C) the initiation of each requested service; and

(D) each unplanned break in the delivery of requested services and the duration of the break;

(3) the number of pilot program participants using employment assistance and supported employment services;

(4) the number of service denials and fair hearings and the dispositions of fair hearings;

(5) the number of complaints and inquiries received by the managed care organization and the outcome of each complaint; and

(6) the number of pilot program participants who choose the consumer direction model and the reasons why other participants did not choose the consumer direction model.

(c) The commission shall ensure that the mechanisms to report and track the information and data required by this section are established before implementing the pilot program.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1117 (H.B. 3523), Sec. 7, eff. June 19, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 18, eff. September 1, 2019.

Sec. 534.109. PERSON-CENTERED PLANNING. The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall 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. The consumer direction model must be an available option for individuals to achieve self-determination, choice, and control.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.251, eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 18, eff. September 1, 2019.

Sec. 534.110. TRANSITION BETWEEN PROGRAMS; CONTINUITY OF SERVICES. (a) During the evaluation of the pilot program required under Section 534.112, the commission may continue the pilot program to ensure continuity of care for pilot program participants. If the commission does not continue the pilot program following the evaluation, the commission shall 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.

(b) A transition plan under Subsection (a) shall be developed in consultation and collaboration with the advisory committee and pilot program workgroup and with stakeholder input as described by Section 534.103.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.252, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1117 (H.B. 3523), Sec. 8, eff. June 19, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 19, eff. September 1, 2019.

Sec. 534.111. CONCLUSION OF PILOT PROGRAM. (a) On September 1, 2025, the pilot program is concluded unless the commission continues the pilot program under Section 534.110.

(b) If the commission continues the pilot program under Section 534.110, the commission shall publish notice of the pilot program's continuance in the Texas Register not later than September 1, 2025.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1073 (H.B. 3295), Sec. 1, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 20, eff. September 1, 2019.

Sec. 534.112. PILOT PROGRAM EVALUATIONS AND REPORTS. (a) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall 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) Not later than September 1, 2026, the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall prepare and submit to the legislature a written report that evaluates the pilot program based on a comprehensive analysis. The analysis must:

(1) assess the effect of the pilot program on:

(A) access to and quality of long-term services and supports;

(B) informed choice and meaningful outcomes using person-centered planning, flexible consumer-directed services, individualized budgeting, and self-determination, including a pilot program participant's inclusion in the community;

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

(D) employment assistance and customized, integrated, competitive employment options;

(E) the number, types, and dispositions of fair hearings and appeals in accordance with applicable federal and state law;

(F) increasing the use and flexibility of the consumer direction model;

(G) increasing the use of alternatives to guardianship, including supported decision-making agreements as defined by Section 1357.002, Estates Code;

(H) achieving the best and most cost-effective use of funding based on a pilot program participant's needs and preferences; and

(I) attendant recruitment and retention;

(2) analyze the experiences and outcomes of the following systems changes:

(A) the comprehensive assessment instrument described by Section 533A.0335, Health and Safety Code;

(B) the 21st Century Cures Act (Pub. L. No. 114-255);

(C) implementation of the federal rule adopted by the Centers for Medicare and Medicaid Services and published at 79 Fed. Reg. 2948 (January 16, 2014) related to the provision of

long-term services and supports through a home and community-based services (HCS) waiver program under Section 1915(c), 1915(i), or 1915(k) of the federal Social Security Act (42 U.S.C. Section 1396n(c), (i), or (k));

(D) the provision of basic attendant and habilitation services under Section 534.152; and

(E) the benefits of providing STAR+PLUS Medicaid managed care services to persons based on functional needs;

(3) include feedback on the pilot program based on the personal experiences of:

(A) individuals with an intellectual or developmental disability and individuals with similar functional needs who participated in the pilot program;

(B) families of and other persons actively involved in the lives of individuals described by Paragraph (A); and

(C) comprehensive long-term services and supports providers who delivered services under the pilot program;

(4) be incorporated in the annual report required under Section 534.054; and

(5) include recommendations on:

(A) a system of programs and services for consideration by the legislature;

(B) necessary statutory changes; and

(C) whether to implement the pilot program statewide under the STAR+PLUS Medicaid managed care program for eligible individuals.

Added by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 21, eff. September 1, 2019.

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

Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. (a) Subject to Section 533.0025, the commission shall provide acute care Medicaid benefits to individuals with an intellectual or

developmental disability through the STAR + PLUS Medicaid managed care program or the most appropriate integrated capitated managed care program delivery model and monitor the provision of those benefits.

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

(1) include an assessment of the effects on:

(A) access to and quality of acute care services; and

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

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

(3) include recommendations for delivery model improvements and implementation for consideration by the legislature, including recommendations for needed statutory changes.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.253, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1117 (H.B. 3523), Sec. 9, eff. June 19, 2015.

Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR + PLUS MEDICAID MANAGED CARE PROGRAM AND BY WAIVER PROGRAM PROVIDERS. (a) The commission shall:

(1) implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with an intellectual or developmental disability under the STAR + PLUS Medicaid managed care program that maximizes federal funding for the delivery of services for that program and other similar programs; and

(2) provide voluntary training to individuals receiving services under the STAR + PLUS Medicaid managed care program or their legally authorized representatives regarding how to select, manage, and dismiss personal attendants providing basic attendant and habilitation services under the program.

(b) The commission shall require that each managed care organization that contracts with the commission for the provision of basic attendant and habilitation services under the STAR + PLUS Medicaid managed care program in accordance with this section:

(1) include in the organization's provider network for the provision of those services:

(A) home and community support services agencies licensed under Chapter 142, Health and Safety Code, with which the department has a contract to provide services under the community living assistance and support services (CLASS) waiver program; and

(B) persons exempted from licensing under Section 142.003(a)(19), Health and Safety Code, with which the department has a contract to provide services under:

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

(ii) the Texas home living (TxHmL) waiver program;

(2) review and consider any assessment conducted by a local intellectual and developmental disability authority providing intellectual and developmental disability service coordination under Subsection (c); and

(3) enter into a written agreement with each local intellectual and developmental disability authority in the service area regarding the processes the organization and the authority will use to coordinate the services of individuals with an intellectual or developmental disability.

(c) The department shall contract with and make contract payments to local intellectual and developmental disability authorities to conduct the following activities under this section:

(1) provide intellectual and developmental disability service coordination to individuals with an intellectual or developmental disability under the STAR + PLUS Medicaid managed

care program by assisting those individuals who are eligible to receive services in a community-based setting, including individuals transitioning to a community-based setting;

(2) provide an assessment to the appropriate managed care organization regarding whether an individual with an intellectual or developmental disability needs attendant or habilitation services, based on the individual's functional need, risk factors, and desired outcomes;

(3) assist individuals with an intellectual or developmental disability with developing the individuals' plans of care under the STAR + PLUS Medicaid managed care program, including with making any changes resulting from periodic reassessments of the plans;

(4) provide to the appropriate managed care organization and the department information regarding the recommended plans of care with which the authorities provide assistance as provided by Subdivision (3), including documentation necessary to demonstrate the need for care described by a plan; and

(5) on an annual basis, provide to the appropriate managed care organization and the department a description of outcomes based on an individual's plan of care.

(d) Local intellectual and developmental disability authorities providing service coordination under this section may not also provide attendant and habilitation services under this section.

(e) During the first three years basic attendant and habilitation services are provided to individuals with an intellectual or developmental disability under the STAR + PLUS Medicaid managed care program in accordance with this section, providers eligible to participate in the home and community-based services (HCS) waiver program, the Texas home living (TxHmL) waiver program, or the community living assistance and support services (CLASS) waiver program on September 1, 2013, are considered significant traditional providers.

(f) A local intellectual and developmental disability authority with which the department contracts under Subsection (c) may subcontract with an eligible person, including a nonprofit

entity, to coordinate the services of individuals with an intellectual or developmental disability under this section. The executive commissioner by rule shall establish minimum qualifications a person must meet to be considered an "eligible person" under this subsection.

(g) The department may contract with providers participating in the home and community-based services (HCS) waiver program, the Texas home living (TxHmL) waiver program, the community living assistance and support services (CLASS) waiver program, or the deaf-blind with multiple disabilities (DBMD) waiver program for the delivery of basic attendant and habilitation services described in Subsection (a) for individuals to which that subsection applies. The department has regulatory and oversight authority over the providers with which the department contracts for the delivery of those services.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.254, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1117 (H.B. 3523), Sec. 10, eff. June 19, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1117 (H.B. 3523), Sec. 11, eff. June 19, 2015.

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

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

(a) This section applies to individuals with an intellectual or developmental disability who are receiving long-term services and supports under:

(1) a Medicaid waiver program; or

(2) an ICF-IID program.

(b) Subject to Subsection (g), after implementing the pilot

program under Subchapter C and completing the evaluation under Section 534.112, the commission, in consultation and collaboration with the advisory committee, shall 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. The plan must include:

(1) a process for transitioning the services in phases as follows:

(A) beginning September 1, 2027, the Texas home living (TxHmL) waiver program services;

(B) beginning September 1, 2029, the community living assistance and support services (CLASS) waiver program services;

(C) beginning September 1, 2031, nonresidential services provided under the home and community-based services (HCS) waiver program and the deaf-blind with multiple disabilities (DBMD) waiver program; and

(D) subject to Subdivision (2), the residential services provided under an ICF-IID program, the home and community-based services (HCS) waiver program, and the deaf-blind with multiple disabilities (DBMD) waiver program; and

(2) a process for evaluating and determining the feasibility and cost efficiency of transitioning residential services described by Subdivision (1)(D) to a Medicaid managed care model that is based on an evaluation of a separate pilot program conducted by the commission, in consultation and collaboration with the advisory committee, that operates after the transition process described by Subdivision (1).

(c) Before implementing the transition described by Subsection (b), the commission shall, subject to Subsection (g), determine whether to:

(1) continue operation of the Medicaid waiver programs or ICF-IID program only for purposes of providing, if applicable:

(A) supplemental long-term services and supports not available under the managed care program delivery model selected by the commission; or

(B) long-term services and supports to Medicaid

waiver program recipients who choose to continue receiving benefits under the waiver programs as provided by Subsection (g); or

(2) provide all or a portion of the long-term services and supports previously available under the Medicaid waiver programs or ICF-IID program through 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 to receive and evaluate input from interested statewide stakeholders that is in addition to the input provided by the advisory committee.

(e) The commission shall 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.

(f) Before transitioning the provision of Medicaid benefits for children under this section, a managed care organization providing services under the managed care program delivery model selected by the commission must demonstrate to the satisfaction of the commission that the organization's network of providers has experience and expertise in the provision of services to children with an intellectual or developmental disability. Before transitioning the provision of Medicaid benefits for adults with an intellectual or developmental disability under this section, a managed care organization providing services under the managed care program delivery model selected by the commission must demonstrate to the satisfaction of the commission that the organization's network of providers has experience and expertise in the provision of services to adults with an intellectual or developmental disability.

(g) If the commission determines that all or a portion of the long-term services and supports previously available under the Medicaid waiver programs should be provided through a managed care program delivery model under Subsection (c)(2), the commission shall, at the time of the transition, allow each recipient

receiving long-term services and supports under a Medicaid waiver program the option of:

(1) continuing to receive the services and supports under the Medicaid waiver program; or

(2) receiving the services and supports through the managed care program delivery model selected by the commission.

(h) A recipient who chooses to receive long-term services and supports through a managed care program delivery model under Subsection (g) may not, at a later time, choose to receive the services and supports under a Medicaid waiver program.

(i) In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission for the organization to provide Medicaid benefits under this section must 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;

(2) to the greatest extent possible, protects those individuals' continuity of care with respect to access to primary care providers, including the use of single-case agreements with out-of-network providers; and

(3) provides access to a member services phone line for individuals or their legally authorized representatives to obtain information on and assistance with accessing services through network providers, including providers of primary, specialty, and other long-term services and supports.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.256, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1117 (H.B. 3523), Sec. 13, eff. June 19, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 23,

eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 24, eff. September 1, 2019.

Sec. 534.203. RESPONSIBILITIES OF COMMISSION UNDER SUBCHAPTER. In administering this subchapter, the commission shall ensure, on making a determination to transition services under Section 534.202:

(1) that the commission is responsible for setting the minimum reimbursement rate paid to a provider of ICF-IID services or a group home provider under the integrated managed care system, including the staff rate enhancement paid to a provider of ICF-IID services or a group home provider;

(2) that an ICF-IID service provider or a group home provider is paid not later than the 10th day after the date the provider submits a clean claim in accordance with the criteria used by the commission for the reimbursement of ICF-IID service providers or a group home provider, as applicable;

(3) the establishment of an electronic portal through which a provider of ICF-IID services or a group home provider participating in the STAR+PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as appropriate, may submit long-term services and supports claims to any participating managed care organization; 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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 25, eff. September 1, 2019.

SUBCHAPTER F. OTHER IMPLEMENTATION REQUIREMENTS AND RESPONSIBILITIES

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

Added by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 26, eff. September 1, 2019.

Sec. 534.252. REQUIREMENTS REGARDING TRANSITION OF SERVICES. (a) 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, the commission shall:

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

(2) must 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) may not be 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) On transitioning services under a Medicaid waiver program to a Medicaid managed care delivery model, the commission shall ensure that individuals do not lose benefits they receive under the Medicaid waiver program.

Added by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 26, eff. September 1, 2019.