GOVERNMENT CODE

TITLE 4. EXECUTIVE BRANCH

SUBTITLE I. HEALTH AND HUMAN SERVICES

CHAPTER 542. SYSTEM REDESIGN FOR DELIVERY OF MEDICAID ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 542.0001. DEFINITIONS. In this chapter:

(1) "Advisory committee" means the intellectual and developmental disability system redesign advisory committee established under Section 542.0052.

(2) "Basic attendant service" means a service provided to an individual to assist the individual with an activity of daily living, including an instrumental activity of daily living, 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) an ICF-IID program provider; and

(B) a Medicaid waiver program provider.

(4) "Consumer direction model" has the meaning assigned by Section 546.0101.

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

(6) "Habilitation service" includes a service provided to an individual to assist the individual with acquiring, retaining, or improving:

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

(B) the social and adaptive skills necessary for

the individual to live and fully participate in the community.

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

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

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

(B) a community-based intermediate care facility operated by a local intellectual and developmental disability authority.

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

(10) "Managed care organization" has the meaning assigned by Section 543A.0001.

(11) "Medicaid waiver program" means only the following programs that are authorized under Section 1915(c) of the Social Security Act (42 U.S.C. Section 1396n(c)) for the provision of services to individuals 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.

(12) "Potentially preventable event" has the meaning assigned by Section 543A.0001.

(13) "Residential service" means a service 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.

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

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0002. 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 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0003. DELAYED IMPLEMENTATION AUTHORIZED. Notwithstanding any other law, the commission may delay implementing a provision of this chapter without additional investigation, adjustment, or legislative action if the commission determines implementing the provision would adversely affect the system of services and supports to persons and programs to which this chapter applies.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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

Sec. 542.0051. REDESIGN OF ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. 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 an individual's needs and preferences in the most integrated and least restrictive setting;

(2) improve access to services and supports by ensuring that an individual receives information about all

available programs and services, including employment and least restrictive housing assistance, and the manner of applying for the programs and services;

(3) improve the assessment of an individual's needs and available supports, including the assessment of an individual's 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 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 the inappropriate institutionalization of an individual.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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

Sec. 542.0052. INTELLECTUAL AND DEVELOPMENTAL DISABILITY SYSTEM REDESIGN ADVISORY COMMITTEE. (a) The intellectual and developmental disability system redesign advisory committee shall advise the commission on implementing the acute care services and long-term services and supports system redesign under this chapter.

(b) The executive commissioner shall appoint stakeholders

from the intellectual and developmental disabilities community to serve as advisory committee members, including:

(1) individuals with an intellectual or developmental disability who receive services under a Medicaid waiver program;

(2) individuals with an intellectual or developmental disability who receive services under an ICF-IID program;

(3) representatives who are advocates for individuals described by Subdivisions (1) and (2), including at least three representatives from intellectual and developmental disability advocacy organizations;

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

(A) physicians who are primary care providers;

(B) physicians who are specialty care providers;

(C) nonphysician mental health professionals; and

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

(5) representatives of entities with responsibilities for delivering Medicaid long-term services and supports or for 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 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

(6) representatives of managed care organizations that contract with this state to provide services to individuals with an intellectual or developmental disability.

(c) To the greatest extent possible, the executive

commissioner shall appoint members to the advisory committee who reflect the geographic diversity of this state and include members who represent rural Medicaid recipients.

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

(e) The advisory committee must meet at least quarterly or more frequently if the presiding officer determines that more frequent meetings are necessary to address planning and development needs related to implementation of the acute care services and long-term services and supports system. The advisory committee may establish work groups that meet at other times to study and make recommendations on issues the advisory committee considers appropriate.

(f) An advisory committee member serves without compensation. An advisory committee member 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.

(g) Chapter 551 applies to the advisory committee.

(h) On the second anniversary of the date the commission completes implementation of the transition required under Section 542.0201:

(1) the advisory committee is abolished; and

(2) this section expires.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0053. IMPLEMENTATION OF SYSTEM REDESIGN. The commission shall, in 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 by this chapter.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

The following section was amended by the 89th Legislature. Pending

publication of the current statutes, see H.B. 4666, 89th Legislature, Regular Session, for amendments affecting the following section.

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

Sec. 542.0054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not later than September 30 of each year, the commission, in collaboration with the advisory committee, shall prepare and submit to the legislature a report that includes:

(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;

(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:

(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 an individual'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 federal law.

(b) This section expires on the second anniversary of the date the commission completes implementation of the transition

required under Section 542.0201.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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

Sec. 542.0101. 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 participant" means an individual who is enrolled in and receives services through the pilot program.

(4) "Pilot program work group" means the pilot program work group established under Section 542.0104.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0102. PILOT PROGRAM TO TEST PERSON-CENTERED MANAGED CARE STRATEGIES AND IMPROVEMENTS BASED ON CAPITATION. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall develop and implement a pilot program to test the delivery of long-term services and supports to pilot program participants through the STAR+PLUS Medicaid managed care program.

(b) A managed care organization participating in the pilot program shall provide Medicaid long-term services and supports to individuals with an intellectual or developmental disability and individuals with similar functional needs to test the organization's managed care strategy based on capitation.

(c) The pilot program must be designed to:

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

(2) improve the 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 best funding use based on a pilot program participant'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 a pilot program participant's needs and preferences;

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

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

(9) 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;

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

(11) ensure the timely initiation and consistent provision of long-term services and supports in accordance with a pilot program participant's person-centered plan;

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

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

(14) promote independence, self-determination, the

use of the consumer direction model, and decision making by pilot program participants by using alternatives to guardianship, including a supported decision-making agreement as defined by Section 1357.002, Estates Code; and

(15) promote sufficient flexibility to achieve, through the pilot program, the goals listed in:

(A) this subsection;

(B) Subsection (b); and

(C) Sections 542.0103, 542.0110(a), 542.0113, and 542.0116(c).

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0103. ALTERNATIVE PAYMENT RATE OR METHODOLOGY. (a) The pilot program must be designed to test the use of innovative payment rates and methodologies for the provision of long-term services and supports to achieve the goals of the pilot program. The payment methodologies must 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 model the commission approves.

(b) An alternative payment rate or methodology 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.

(c) In developing an alternative payment rate or methodology, 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.

(d) An alternative payment rate or methodology may not reduce the minimum payment a provider receives for delivering long-term services and supports under the pilot program to an amount that is less than the fee-for-service reimbursement rate the provider received for delivering those services before participating in the pilot program.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0104. PILOT PROGRAM WORK GROUP. (a) The executive commissioner, in consultation with the advisory committee, shall establish a pilot program work group to assist in developing and provide advice on the operation of the pilot program.

(b) The pilot program work group 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 the 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 work group.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0105. STAKEHOLDER INPUT. As part of developing and implementing the pilot program, the commission, in collaboration with the advisory committee and pilot program work group, shall develop a process to receive and evaluate:

(1) input from:

(A) statewide stakeholders; and

(B) 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 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0106. MEASURABLE GOALS. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall:

(1) identify, 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, measurable goals the pilot program is to achieve;

(2) develop specific strategies and performance measures for achieving the identified goals; and

(3) 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.

(b) A strategy proposed under Subsection (a)(2) may be evidence-based if an evidence-based strategy is available for meeting the identified goals.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0107. MANAGED CARE ORGANIZATION SELECTION. The commission shall:

(1) in collaboration with the advisory committee and pilot program work group, develop criteria regarding the selection of a managed care organization to participate in the pilot program; and

(2) 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 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0108. MANAGED CARE ORGANIZATION PARTICIPATION REQUIREMENTS. The commission shall require that a managed care organization participating in the pilot program:

(1) ensures that 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;

(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 the inappropriate institutionalization of pilot program participants; and

(4) ensures the timely initiation and consistent provision of services in accordance with a pilot program participant's person-centered plan.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0109. REQUIRED BENEFITS. (a) 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 collaboration with the advisory committee and pilot program work group, determines are appropriate and consistent with requirements governing the Medicaid waiver programs, person-centered approaches, home and community-based setting requirements, and achievement of the most integrated and

least restrictive setting based on an individual's needs and preferences; and

(7) dental services benefits in accordance with Subsection (b).

(b) 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 resulting from 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.

(c) Before implementing the pilot program, the commission, in collaboration with the advisory committee and pilot program work group, shall:

(1) for pilot program purposes 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 the commission determines to be appropriate under Subsection (a)(6).

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0110. PROVIDER PARTICIPATION. (a) 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 Medicaid services before the date the pilot program is implemented 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.

(b) For the duration of the pilot program, the commission shall ensure that comprehensive long-term services and supports providers are:

(1) considered significant traditional providers; and

(2) included in the provider network of a managed care organization participating in the pilot program.

(c) 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) Sections 542.0109(a)(2)(A) and (D);

(2) Sections 542.0109(a)(3)(B), (C), (D), (G), (H), (J), (K), (L), and (M); and

(3) Section 542.0109(a)(4).

(d) A comprehensive long-term services and supports provider may deliver services listed under Sections 542.0109(a)(5) and (6) only if the managed care organization in the network of which the provider participates agrees, in a contract with the provider, to the provision of those services.

(e) Day habilitation services listed under Section 542.0109(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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0111. CARE COORDINATION. (a) 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 daily delivery of acute care and long-term services and supports in accordance with a pilot program participant's plan of care.

(b) A managed care organization may reimburse a comprehensive long-term services and supports provider for coordinating with care coordinators under this section.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0112. PERSON-CENTERED PLANNING. The commission, in collaboration with the advisory committee and pilot program work group, shall ensure that each pilot program participant or the participant's legally authorized representative has access to a comprehensive, facilitated, person-centered plan that identifies outcomes for the participant and drives the development of the individualized budget. The consumer direction model must be an available option for a participant to achieve self-determination, choice, and control.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0113. USE OF INNOVATIVE TECHNOLOGY. A pilot program participant is not required to use an innovative technology described by Section 542.0102(c)(9). If a participant chooses to use an innovative technology described by that subdivision, the commission shall ensure that:

(1) services associated with the technology are delivered in a manner that:

(A) ensures the participant's privacy, health, and well-being;

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

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

(D) increases personal independence;

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

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

(ii) the place in which the technology is authorized to be used;

(iii) the types of telemonitoring or remote

monitoring that will be used; and

(iv) the purposes for which the technology will be used; and

(F) is consistent with and agreed on during the person-centered planning process;

(2) staff overseeing the use of the innovative technology:

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

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

(3) a participant using the innovative technology is able to request the removal of equipment associated with the technology and, on receipt of a request for the removal, the equipment is immediately removed; and

(4) a participant is not required to use telemedicine at any point during the pilot program and, if the participant refuses to use telemedicine, the managed care organization providing pilot program health care services to the participant arranges for services that do not include telemedicine.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0114. INFORMATIONAL MATERIALS. (a) To ensure that prospective pilot program participants are able to make an informed decision on whether to participate in the pilot program, the commission, in collaboration with the advisory committee and pilot program work group, shall develop and distribute informational materials that describe the pilot program's benefits and impact on current services and other related information.

(b) The commission shall establish a timeline and process for developing and distributing the informational materials and ensure that:

(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) at a minimum, the materials explain that:

(A) on the pilot program's conclusion, each pilot program participant will be asked to provide feedback on the participant's experience, including feedback on whether the pilot program was able to meet the participant's unique support needs;

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

(C) a pilot program participant who, during the pilot program's operation, is offered enrollment in a Medicaid waiver program may accept the enrollment, transition, or diversion offer; and

(D) a pilot program participant has 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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0115. IMPLEMENTATION, LOCATION, AND DURATION. The commission shall:

(1) implement the pilot program on September 1, 2023;

(2) conduct the pilot program in a STAR+PLUS Medicaid managed care service area the commission selects; and

(3) operate the pilot program for at least 24 months.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0116. RECIPIENT ENROLLMENT, PARTICIPATION, AND ELIGIBILITY. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall develop pilot program participant eligibility criteria. The criteria must ensure that 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.

(b) An individual who is eligible to participate in the pilot program will be enrolled automatically. The decision to opt out of participating may be made only by the individual or the individual's legally authorized representative.

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

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01,

eff. April 1, 2025.

Sec. 542.0117. PILOT PROGRAM INFORMATION COLLECTION AND ANALYSIS. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall determine the information to collect from a managed care organization participating in the pilot program for use in conducting the evaluation and preparing the report under Section 542.0119.

(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. The reports must include information on:

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

(2) timelines of:

(A) the authorization of each requested service;

(B) the initiation of each requested service;

(C) the delivery 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 the fair hearings;

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

(6) the number of pilot program participants who choose the consumer direction model and the reasons 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 Subsections (a) and (b) are established before implementing the pilot program.

(d) For purposes of making a recommendation about a system of programs and services for implementation through future state legislation or rules, the commission, in collaboration with the advisory committee and pilot program work group, shall analyze:

(1) information provided by managed care organizations participating in the pilot program; and

(2) any information the commission collects during the operation of the pilot program.

(e) The analysis under Subsection (d) must include an assessment of the effect of the managed care strategies implemented in the pilot program on the goals described by Sections 542.0102(b) and (c), 542.0103, 542.0110(a), 542.0113, and 542.0116(c).

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0118. PILOT PROGRAM CONCLUSION; PUBLICATION OF CONTINUATION. On September 1, 2025, the pilot program is concluded unless the commission continues the pilot program under Section 542.0120. If the commission continues the pilot program, the commission shall publish notice of that continuation in the Texas Register not later than September 1, 2025.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

The following section was amended by the 89th Legislature. Pending publication of the current statutes, see H.B. 4666, 89th Legislature, Regular Session, for amendments affecting the following section.

Sec. 542.0119. EVALUATIONS AND REPORTS. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall review and evaluate the progress and outcomes of the pilot program and submit, as part of the annual report required under Section 542.0054, a report on the pilot program's status that includes recommendations for improving the pilot program.

(b) Not later than September 1, 2026, the commission, in collaboration with the advisory committee and pilot program work group, 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 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 funding use 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 Social Security Act (42 U.S.C. Section 1396n(c), (i), or (k));

(D) the provision of basic attendant and habilitation services under Section 542.0152; and

(E) the benefits of providing STAR+PLUS Medicaid

managed care services to individuals 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 were pilot program participants;

(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 542.0054; and

(5) include recommendations on:

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

(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 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0120. TRANSITION BETWEEN PROGRAMS; CONTINUITY OF CARE. (a) During the evaluation of the pilot program required under Section 542.0119, the commission may continue the pilot program to ensure continuity of care for pilot program participants. If, following the evaluation, the commission does not continue the pilot program, 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 participation in the pilot program.

(b) A transition plan under Subsection (a) shall be developed in collaboration with the advisory committee and pilot program work group and with stakeholder input as described by Section 542.0105.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01,

eff. April 1, 2025.

Sec. 542.0121. SERVICE TRANSITION REQUIREMENTS. (a) For purposes of implementing the pilot program 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 and transitioning the provision of services described by Section 542.0201 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 are 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 the individuals receive under the Medicaid waiver program.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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

The following section was amended by the 89th Legislature. Pending publication of the current statutes, see H.B. 4666, 89th Legislature, Regular Session, for amendments affecting the following section.

Sec. 542.0151. DELIVERY OF ACUTE CARE SERVICES TO INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. (a) Subject to Sections 540.0701 and 540.0753, the commission shall:

(1) 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

(2) monitor the provision of those benefits.

(b) The commission, in 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 described by Subsection (a). The analysis must:

(1) include an assessment of the effects of the delivery model 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 federal law;

(2) be incorporated into the annual report to the legislature required under Section 542.0054; and

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

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR+PLUS MEDICAID MANAGED CARE PROGRAM AND BY WAIVER PROGRAM PROVIDERS. (a) The commission shall:

(1) implement the option for the delivery of basic attendant and habilitation services to individuals with an intellectual or developmental disability under the STAR+PLUS Medicaid managed care program that:

(A) is the most cost-effective; and

(B) 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 a personal attendant providing basic attendant and habilitation services under the program.

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

(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 commission 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 commission 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 provided to individuals with an intellectual or developmental disability.

(c) The commission shall contract with and make contract payments to local intellectual and developmental disability authorities to:

(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 individuals who are eligible to receive services in a community-based setting, including individuals transitioning to a community-based setting;

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

(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 commission 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) annually provide to the appropriate managed care organization and the commission 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) A local intellectual and developmental disability authority with which the commission contracts under Subsection (c) may subcontract with an eligible person, including a nonprofit entity, to coordinate the delivery of services to 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.

(f) The commission 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 to individuals as described by Subsection (a). The commission has regulatory and oversight authority over the providers with which the commission contracts for the delivery of those services.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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

Sec. 542.0201. TRANSITION OF 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) After implementing the pilot program under Subchapter C and completing the evaluations required by Section 542.0119, the commission, in collaboration with the advisory committee, shall develop a plan for transitioning all or a portion of the services

provided through a Medicaid waiver program or an ICF-IID program to a Medicaid managed care model. The plan must include:

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

(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 based on an evaluation of a separate pilot program the commission, in collaboration with the advisory committee, conducts that operates after the transition process described by Subdivision (1).

(c) Before implementing the transition plan, the commission shall determine whether to:

(1) continue operating 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 the commission selects; 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 Section 542.0202(a); 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 the commission selects.

(d) In implementing the transition plan, the commission shall develop a process to receive and evaluate input from interested statewide stakeholders that is in addition to the input the advisory committee provides.

(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 that 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 the commission selects must demonstrate to the commission's satisfaction that the providers in the organization's provider network have experience and expertise in providing services to children with an intellectual or developmental disability.

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

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0202. RECIPIENT CHOICE OF DELIVERY MODEL. (a) If the commission determines under Section 542.0201(c)(2) that all or a portion of the long-term services and supports previously available under Medicaid waiver programs should be provided through a managed care program delivery model, 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 the commission selects.

(b) A recipient who chooses under Subsection (a) to receive long-term services and supports through a managed care program delivery model may not subsequently choose to receive the services and supports under a Medicaid waiver program.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0203. REQUIRED CONTRACT PROVISIONS. In addition to the requirements of Subchapter F, Chapter 540, a contract between a managed care organization and the commission for the organization to provide Medicaid benefits under Section 542.0201 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 through the use of single-case agreements with out-of-network providers; and

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

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

Sec. 542.0204. RESPONSIBILITIES OF COMMISSION UNDER SUBCHAPTER. In administering this subchapter, the commission shall ensure, on making a determination to transition services

under Section 542.0201:

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

(2) that an ICF-IID services or 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 the commission uses to reimburse an ICF-IID services or group home provider, as applicable;

(3) the establishment of an electronic portal through which an ICF-IID services or 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 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.