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

(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 Medicaid program serving individuals with intellectual and developmental disabilities who receive care in intermediate care facilities other than a state supported living center.

(7) "ICF-IID program" means a program under the Medicaid program serving individuals with intellectual and
developmental disabilities 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" means an authority defined by Section 531.002(11), Health and Safety Code.

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

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

(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 intellectual and developmental disabilities:

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

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

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

(D) the Texas home living (TxHmL) 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.

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.
Sec. 534.051. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES. In accordance with this chapter, the commission and the department shall jointly design and implement an acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities that supports the following goals:

1. provide Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to the individuals' needs;

2. improve individuals' access to services 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.

Sec. 534.052. IMPLEMENTATION OF SYSTEM REDESIGN. The commission and department shall, in consultation with the advisory committee, jointly implement the acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities 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.

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 is established to advise the commission and the department 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 and the commissioner of the department shall jointly appoint members of the advisory committee who are stakeholders from the intellectual and developmental disabilities community, including:

(1) individuals with intellectual and developmental disabilities who are recipients of services under the Medicaid waiver programs, individuals with intellectual and developmental disabilities 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 program 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 intellectual and developmental disabilities; 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 intellectual and developmental disabilities.

(b) To the greatest extent possible, the executive commissioner and the commissioner of the department shall appoint members of the advisory committee who reflect the geographic diversity of the state and include members who represent rural Medicaid program 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 program recipient or the relative of a Medicaid program recipient is entitled to a per diem allowance and reimbursement at rates established in the General Appropriations Act.

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

(g) On January 1, 2024:

(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.

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 shall submit a report to the legislature regarding:

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

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

(b) This section expires January 1, 2024.

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

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

Sec. 534.055. REPORT ON ROLE OF LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITIES AS SERVICE PROVIDERS. (a) The commission and department shall submit a report to the legislature not later than December 1, 2014, that includes the following information:

(1) the percentage of services provided by each local intellectual and developmental disability authority to individuals
receiving ICF-IID or Medicaid waiver program services, compared to the percentage of those services provided by private providers;

(2) the types of evidence provided by local intellectual and developmental disability authorities to the department to demonstrate the lack of available private providers in areas of the state where local authorities provide services to more than 40 percent of the Texas home living (TxHmL) waiver program clients or 20 percent of the home and community-based services (HCS) waiver program clients;

(3) the types and amounts of services received by clients from local intellectual and developmental disability authorities compared to the types and amounts of services received by clients from private providers;

(4) the provider capacity of each local intellectual and developmental disability authority as determined under Section 533.0355(d), Health and Safety Code;

(5) the number of individuals served above or below the applicable provider capacity by each local intellectual and developmental disability authority; and

(6) if a local intellectual and developmental disability authority is serving clients over the authority's provider capacity, the length of time the local authority has served clients above the authority's approved provider capacity.

(b) This section expires September 1, 2015.

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

For expiration of this subchapter, see Section 534.111.

SUBCHAPTER C. STAGE ONE: PROGRAMS TO IMPROVE 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) "Provider" means a person with whom the commission
contracts for the provision of long-term services and supports under the Medicaid program to a specific population based on capitation.
Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Sec. 534.102. PILOT PROGRAMS TO TEST MANAGED CARE STRATEGIES BASED ON CAPITATION. The commission and the department may develop and implement pilot programs in accordance with this subchapter to test one or more service delivery models involving a managed care strategy based on capitation to deliver long-term services and supports under the Medicaid program to individuals with intellectual and developmental disabilities.
Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Sec. 534.103. STAKEHOLDER INPUT. As part of developing and implementing a pilot program under this subchapter, the department shall develop a process to receive and evaluate input from statewide stakeholders and stakeholders from the region of the state in which the pilot program will be implemented.
Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 1.01, eff. September 1, 2013.

Sec. 534.104. MANAGED CARE STRATEGY PROPOSALS; PILOT PROGRAM SERVICE PROVIDERS. (a) The department shall identify private services providers that are good candidates to develop a service delivery model involving a managed care strategy based on capitation and to test the model in the provision of long-term services and supports under the Medicaid program to individuals with intellectual and developmental disabilities through a pilot program established under this subchapter.

(b) The department shall solicit managed care strategy proposals from the private services providers identified under Subsection (a). In addition, the department may accept and approve a managed care strategy proposal from any qualified entity that is a private services provider if the proposal provides for a
comprehensive array of long-term services and supports, including case management and service coordination.

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

1. increase access to long-term services and supports;
2. improve quality of acute care services and long-term services and supports;
3. promote meaningful outcomes by using person-centered planning, individualized budgeting, and self-determination, and promote community inclusion and customized, integrated, competitive employment;
4. promote integrated service coordination of acute care services and long-term services and supports;
5. promote efficiency and the best use of funding;
6. promote the placement of an individual in housing that is the least restrictive setting appropriate to the individual's needs;
7. promote employment assistance and supported employment;
8. provide fair hearing and appeals processes in accordance with applicable federal law; and
9. promote sufficient flexibility to achieve the goals listed in this section through the pilot program.

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

1. the proposed strategy satisfies the requirements of this section; and
2. the private services provider that submitted the proposal has a demonstrated ability to provide the long-term services and supports appropriate to the individuals who will receive services through the pilot program based on the proposed strategy, if implemented.

(e) Based on the evaluation performed under Subsection (d), the department may select as pilot program service providers one or
more private services providers.

(f) For each pilot program service provider, the department shall develop and implement a pilot program. Under a pilot program, the pilot program service provider shall provide long-term services and supports under the Medicaid program to persons with intellectual and developmental disabilities to test its managed care strategy based on capitation.

(g) The department shall analyze information provided by the pilot program service providers and any information collected by the department during the operation of the pilot programs for purposes of making a recommendation about a system of programs and services for implementation through future state legislation or rules.

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

Sec. 534.105. PILOT PROGRAM: MEASURABLE GOALS. (a) The department, in consultation with the advisory committee, shall identify measurable goals to be achieved by each pilot program implemented under this subchapter. The identified goals must:

(1) align with information that will be collected under Section 534.108(a); and

(2) be designed to improve the quality of outcomes for individuals receiving services through the pilot program.

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

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

Sec. 534.106. IMPLEMENTATION, LOCATION, AND DURATION.

(a) The commission and the department shall implement any pilot programs established under this subchapter not later than September 1, 2016.

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

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

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

Sec. 534.1065. RECIPIENT PARTICIPATION IN PROGRAM VOLUNTARY. Participation in a pilot program established under this subchapter by an individual with an intellectual or developmental disability is voluntary, and the decision whether to participate in a program and receive long-term services and supports from a provider through that program may be made only by the individual or the individual's legally authorized representative.

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

Sec. 534.107. COORDINATING SERVICES. In providing long-term services and supports under the Medicaid program to individuals with intellectual and developmental disabilities, a pilot program service provider shall:

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

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

(B) a Medicaid waiver program; or

(C) a community-based ICF-IID operated by local authorities;

(2) collaborate with managed care organizations to provide integrated coordination of acute care services and long-term services and supports, including discharge planning from acute care services to community-based long-term services and supports;
have a process for preventing inappropriate institutionalizations of individuals; and

accept the risk of inappropriate institutionalizations of individuals previously residing in community settings.

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

Sec. 534.108. PILOT PROGRAM INFORMATION. (a) The commission and the department shall collect and compute the following information with respect to each pilot program implemented under this subchapter to the extent it is available:

(1) the difference between the average monthly cost per person for all acute care services and long-term services and supports received by individuals participating in the pilot program while the program is operating, including services provided through the pilot program and other services with which pilot program services are coordinated as described by Section 534.107, and the average monthly cost per person for all services received by the individuals before the operation of the pilot program;

(2) the percentage of individuals receiving services through the pilot program who begin receiving services in a nonresidential setting instead of from a facility licensed under Chapter 252, Health and Safety Code, or any other residential setting;

(3) the difference between the percentage of individuals receiving services through the pilot program who live in non-provider-owned housing during the operation of the pilot program and the percentage of individuals receiving services through the pilot program who lived in non-provider-owned housing before the operation of the pilot program;

(4) the difference between the average total Medicaid cost, by level of need, for individuals in various residential settings receiving services through the pilot program during the operation of the program and the average total Medicaid cost, by level of need, for those individuals before the operation of the program;
the difference between the percentage of
individuals receiving services through the pilot program who obtain and maintain employment in meaningful, integrated settings during the operation of the program and the percentage of individuals receiving services through the program who obtained and maintained employment in meaningful, integrated settings before the operation of the program;

(6) the difference between the percentage of individuals receiving services through the pilot program whose behavioral, medical, life-activity, and other personal outcomes have improved since the beginning of the program and the percentage of individuals receiving services through the program whose behavioral, medical, life-activity, and other personal outcomes improved before the operation of the program, as measured over a comparable period; and

(7) a comparison of the overall client satisfaction with services received through the pilot program, including for individuals who leave the program after a determination is made in the individuals' cases at hearings or on appeal, and the overall client satisfaction with services received before the individuals entered the pilot program.

(b) The pilot program service provider shall collect any information described by Subsection (a) that is available to the provider and provide the information to the department and the commission not later than the 30th day before the date the program's operation concludes.

(c) In addition to the information described by Subsection (a), the pilot program service provider shall collect any information specified by the department for use by the department in making an evaluation under Section 534.104(g).

(d) On or before December 1, 2016, and December 1, 2017, the commission and the department, in consultation with the advisory committee, shall review and evaluate the progress and outcomes of each pilot program implemented under this subchapter and submit a report to the legislature during the operation of the pilot programs. Each report must include recommendations for program improvement and continued implementation.
Sec. 534.109. PERSON-CENTERED PLANNING. The commission, in cooperation with the department, shall ensure that each individual with an intellectual or developmental disability who receives services and supports under the Medicaid program through a pilot program established under this subchapter, or the individual's legally authorized representative, has access to a facilitated, person-centered plan that identifies outcomes for the individual and drives the development of the individualized budget. The consumer direction model, as defined by Section 531.051, may be an outcome of the plan.

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

Sec. 534.111. CONCLUSION OF PILOT PROGRAMS; EXPIRATION. On September 1, 2018:

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

(2) this subchapter expires.

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

Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL
DISABILITIES. Subject to Section 533.0025, the commission shall provide acute care Medicaid program benefits to individuals with intellectual and developmental disabilities 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.

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

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

(1) implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with intellectual and developmental disabilities under the STAR + PLUS Medicaid managed care program that maximizes federal funding for the delivery of services 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 intellectual and developmental disabilities.

(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 intellectual and developmental disabilities 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 intellectual and developmental disabilities 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 intellectual and developmental disabilities 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 intellectual and developmental disabilities 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.

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

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

Sec. 534.201. TRANSITION OF RECIPIENTS UNDER TEXAS HOME LIVING (TxHmL) WAIVER PROGRAM TO MANAGED CARE PROGRAM. (a) This section applies to individuals with intellectual and developmental disabilities who are receiving long-term services and supports under the Texas home living (TxHmL) waiver program on the date the commission implements the transition described by Subsection (b).

(b) Not later than September 1, 2017, the commission shall transition the provision of Medicaid program benefits to individuals to whom this section applies to the STAR + PLUS Medicaid
managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as determined by the commission based on cost-effectiveness and the experience of the STAR + PLUS Medicaid managed care program in providing basic attendant and habilitation services and of the pilot programs established under Subchapter C, subject to Subsection (c)(1).

(c) At the time of the transition described by Subsection (b), the commission shall determine whether to:

(1) continue operation of the Texas home living (TxHmL) waiver program for purposes of providing supplemental long-term services and supports not available under the managed care program delivery model selected by the commission; or

(2) provide all or a portion of the long-term services and supports previously available under the Texas home living (TxHmL) waiver 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 program benefits under this section that protects the continuity of care provided to individuals to whom this section applies.

(f) 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 program benefits under this section must contain a requirement that the organization implement a process for individuals with intellectual and developmental disabilities that:

(1) ensures that the individuals have a choice among providers;

(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
Sec. 534.202. TRANSITION OF ICF-IID PROGRAM RECIPIENTS AND CERTAIN OTHER MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM. (a) This section applies to individuals with intellectual and developmental disabilities who, on the date the commission implements the transition described by Subsection (b), are receiving long-term services and supports under:

(1) a Medicaid waiver program other than the Texas home living (TxHmL) waiver program; or

(2) an ICF-IID program.

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

(c) At the time of the transition described by Subsection (b), the commission shall 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 program as provided by Subsection (g); or
subject to Subsection (g), 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 program benefits under this section that protects the continuity of care provided to individuals to whom this section applies.

(f) Before transitioning the provision of Medicaid program 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 intellectual and developmental disabilities. Before transitioning the provision of Medicaid program benefits for adults with intellectual and developmental disabilities 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 intellectual and developmental disabilities.

(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 program benefits under this section must contain a requirement that the organization implement a process for individuals with intellectual and developmental disabilities that:

(1) ensures that the individuals have a choice among providers;

(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.

Sec. 534.203. RESPONSIBILITIES OF COMMISSION UNDER SUBCHAPTER. In administering this subchapter, the commission shall ensure:

(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 department for the reimbursement of ICF-IID service
providers or a group home provider, as applicable; and

(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.

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