BILL ANALYSIS

C.S.H.B. 4552
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Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Texas operates the Community Based Alternatives (CBA) program under a Medicaid waiver, which allows a person who otherwise would be placed in a nursing facility to be served at home or in other community settings. Unlike institutional placements, CBA services are not an entitlement and are not available statewide to all who qualify.

Medicaid law requires cost neutrality. Therefore, under the CBA waiver, the federal government requires that the state not expend any more funds for this program in the aggregate than otherwise would have been spent on nursing facility care for all of the individuals enrolled. Most clients are served in the community for less than the cost would have been in a nursing facility. Cost caps on a person's individual plan of care were put in place to manage the aggregate costs so that the waiver is cost-neutral for the state.

In 2007, the Centers for Medicaid & Medicare Services, a federal Medicaid agency, informed Texas that the state must have a strict policy with regards to entry into CBA, or the state would lose federal funding. The executive commissioner of the Health and Human Services Commission (HHSC) no longer is allowed to waive the cost cap on a case-by-case basis even if the client's health and safety would be endangered by moving the person to an institutional placement.

In order to ensure the state meets the cost neutrality provision and complies with the Centers for Medicaid & Medicare Services edict, the 80th Legislature, Regular Session, 2007, included a rider in the appropriations bill (Department of Aging and Disability Services Rider 45) that established an individual cost cap, not to exceed 200 percent of the cost that would have been expended for that individual in a nursing facility.

With the new federal limitation, in order to allow the state to continue to make exceptions to the limit when an individual's health and safety cannot be protected in an institution, Rider 45 authorized the expenditure of general revenue for these clients whose costs exceed 200 percent of the cost cap.

The Department of Aging and Disability Services (DADS) operates the CBA program, but in most urban areas of the state, CBA services are provided instead through the STAR+PLUS program operated by HHSC. The STAR+PLUS program was expanded from Harris County to the major urban areas of the state in February 2007. Because the legislature had demonstrated the intent to allow for the cost cap to be exceeded in limited circumstances in DADS Rider 45, HHSC adopted this policy for the STAR+PLUS program.

The overwhelming majority of individuals can be served within the 200 percent cost cap for the existing Medicaid waivers, and most of the remaining individuals can be served under Rider 45. However, there are a small number of medically fragile individuals in Texas who require a hospital level of care to remain at home. These individuals typically have chronic and acute medical conditions that require continuous skilled monitoring and intervention. Currently, under Rider 45, general revenue funds are used to serve medically fragile individuals whose care plans exceed the 200 percent cost ceilings for the existing Medicaid waiver programs, which is costly to the state.

C.S.H.B. 4552 expands the meaning of "medical assistance waiver program" with regard to certain home- and community-based services by removing the limitation that such a program be administered by DADS and authorizes HHSC to use general revenue funds under certain conditions regardless of whether federal matching funds are available for such Medicaid waiver programs. The bill requires HHSC to apply for a waiver under the Social Security Act to provide Medicaid services outside the scope, amount, or duration of nonwaiver services available to certain medically fragile individuals who require a hospital level of care under the Medicaid program.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 3 of this bill.

ANALYSIS

Section 531.0055, Government Code, as amended by Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, expressly grants to the executive commissioner of the Health and Human Services Commission (HHSC) all rulemaking authority for the operation of and provision of services by the health and human services agencies. Similarly, Sections 1.16-1.29, Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, provide for the transfer of a power, duty, function, program, or activity from a health and human services agency abolished by that act to the corresponding legacy agency. To the extent practicable, this bill analysis is written to reflect any transfer of rulemaking authority and to update references as necessary to an agency's authority with respect to a particular health and human services program.

C.S.H.B. 4552 amends the Human Resources Code to require HHSC to apply for a home- and community-based services waiver under the federal Social Security Act to provide Medicaid services outside the scope, amount, and duration of non-waiver services available to medically fragile individuals who are at least 21 years of age and who require a hospital level of care under Medicaid. The bill authorizes the waiver program to include coverage for case management services, adaptive aids and medical supplies, nursing services, attendant services, in-home support services, specialized therapies, respite services, adult foster care, companion care, and consumer-directed service options. The bill establishes a medically fragile individual's eligibility for the waiver program only if the individual meets the medical and functional criteria specified in the waiver, the projected cost of providing services to the individual over a 12-month period exceeds the individual cost limit specified in another medical assistance waiver program, and the individual otherwise would be eligible for services funded by general revenue under the exception to the individual cost limitation on Medicaid services in certain alternative community-based settings.

C.S.H.B. 4552 expands the meaning of "medical assistance waiver program" by removing the limitation that a program providing certain home- and community-based services be administered by the Department of Aging and Disability Services (DADS). The bill requires HHSC, regardless of the availability of federal matching funds, to use general revenue funds appropriated to DADS to continue to provide certain home- and community-based services to a person receiving those services under a Medicaid waiver program on September 1, 2005, at a cost that exceeded the individual cost limit specified in the program. The bill authorizes HHSC, regardless of the availability of federal matching funds, and in addition to services provided above the individual cost limit, to use general revenue funds appropriated to HHSC to provide services under a Medicaid waiver program to a person if the projected cost of providing services over a 12-month period exceeds the individual cost limit specified in the waiver, federal matching funds are not available to pay for such services, and HHSC determines that the person's health and safety cannot be protected by the services provided within the cost limit

established for the program, there is no other available Medicaid waiver program that can protect the person's health and safety within the cost limit of that program, and there is no other available living arrangement in which the person's health and safety can be protected as evidenced by an assessment conducted by HHSC or DADS clinical staff and supporting documentation, including the person's medical and service records.

C.S.H.B. 4552 prohibits HHSC from expending any funds in order to continue to provide certain home- and community-based services to a person receiving those services under a Medicaid waiver program on September 1, 2005, at a cost that exceeded the individual cost limit specified in the program if the expenditure would affect HHSC compliance with the federal cost-effectiveness requirements applicable to Medicaid waiver programs, including home- and community-based services programs. The bill requires HHSC to employ utilization management and utilization review practices as necessary to ensure that the appropriate scope and level of services are provided to individuals receiving certain Medicaid waiver program services and to ensure compliance with federal cost-effectiveness requirements. The bill establishes that these provisions do not establish an entitlement to services or to funding for services from general revenue funds.

C.S.H.B. 4552 removes provisions that conditioned HHSC's use of general revenue funds appropriated to DADS to continue to provide certain home- and community-based services to a person receiving those services under a Medicaid waiver program on September 1, 2005, at a cost exceeding the program's individual cost limit on the necessity of those services for the person to live in the most integrated setting appropriate to the person's need and on the absence of any impact of those services on the department's compliance with federal average per capita expenditure requirements under the Medicaid waiver program. The bill authorizes HHSC to adopt rules to implement these provisions.

C.S.H.B. 4552 repeals Sections 32.058(d), (e), and (f), Human Resources Code, relating to individual cost limitations on Medicaid in certain alternative community-based settings.

EFFECTIVE DATE

On passage, or, if the act does not receive the necessary vote, the act takes effect September 1, 2009.

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.H.B. 4552 differs from the original by adding provisions requiring the Department of Aging and Disability Services (DADS) to apply for a hospital level of care waiver for certain medically fragile individuals under the federal Social Security Act to provide such individuals Medicaid services outside the scope, amount, and duration of non-waiver services.

C.S.H.B. 4552 adds a clarification not included in the original that general revenue funds required to be used by DADS to continue to provide services to certain persons regardless of whether federal matching funds are available for the Medicaid waiver program are funds appropriated to DADS.

C.S.H.B. 4552 differs from the original by making both the requirement for the Health and Human Services Commission (HHSC) to use appropriated general revenue funds to continue to provide services to a person who was receiving Medicaid waiver program services on September 1, 2005, at a cost exceeding the program-specified individual cost limit and the authorization for HHSC to use appropriated general revenue funds to provide services under a medical assistance waiver program to a person under certain specified conditions applicable regardless of whether federal matching funds are available for the Medicaid waiver program.

C.S.H.B. 4552 differs from the original by adding a determination by HHSC that there is no other available Medicaid waiver program that can protect the person's health and safety within the cost limit of that program to the conditions that must be satisfied for HHSC to use general revenue funds appropriated to DADS to provide services above the individual cost limit in addition to other services.

C.S.H.B. 4552 retains statutory language removed by the original relating to HHSC's authority to continue to provide services above the individual cost limit under a Medicaid waiver program other than a home- and community-based services program to an individual who otherwise would be ineligible for such continued services if certain conditions were not met and retains statutory language removed by the original relating to exemptions from that cost limit that apply under certain circumstances. The substitute differs from the original in nonsubstantive ways by conforming to certain bill drafting conventions.

C.S.H.B. 4552 differs from the original by repealing Sections 32.058(d), (e), and (f), Human Resources Code, relating to limitations on Medicaid in certain alternative community-based settings, whereas the original does not repeal those provisions.