BILL ANALYSIS

Senate Research Center

H.B. 3823
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Health & Human Services
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The program of all-inclusive care for the elderly, or PACE, is a Medicaid and Medicare program serving individuals who are 55 or older, are living with certain health care needs, are eligible by the state to receive nursing home care, and can live safely in the community. If appropriate, PACE provides all services covered by Medicare and Medicaid as well as additional services, such as adult day care, occupational and recreational therapies, and home health and personal care, that are determined necessary by a health care team to improve and maintain the participant's overall health status. Interested parties explain that PACE is a capitated program with fixed monthly rates for each individual admitted to the program regardless of whether the individual's health deteriorates, at which point the program will cover the increase in health care costs. This is in contrast to the STAR + PLUS Medicaid managed care program, which places all the risk on the state by adjusting rates in conjunction with the individual's current health status.

Evaluations have shown that individuals who are admitted to the PACE program typically have better outcomes than those in other programs, but current data does not allow the state to compare Medicaid client outcomes across the PACE and the STAR + PLUS programs. H.B. 3823 seeks to provide for such a comparison.

H.B. 3823 amends current law relating to rate-setting and data collection processes under the program of all-inclusive care for the elderly.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Sections 32.0532, 32.0533, and 32.0534, as follows:

Sec. 32.0532. PACE PROGRAM REIMBURSEMENT METHODOLOGY. (a) Defines "PACE program."

(b) Requires the executive commissioner of the Health and Human Services Commission, in setting the reimbursement rates under the PACE program, to ensure that:

(1) reimbursement rates for providers under the program are adequate to sustain the program; and

(2) the program is cost-neutral or costs less when compared to the cost to serve a population in the STAR + PLUS Medicaid managed care program that is comparable in:

(A) age;

(B) eligibility factors, including income level, health status, and impairment level;

(C) geographic location;

(D) living environment; and

(E) other factors determined to be necessary.

(c) Requires the Health and Human Services Commission (HHSC), for purposes of Subsection (b)(2), to consider data on the cost of services provided to comparable recipients enrolled in the STAR + PLUS Medicaid managed care program to calculate the upper payment limit component of the PACE program reimbursement rates. Provides that the cost of those services includes the Medicaid capitation payment per recipient and Medicaid payments made on a fee-for-service basis for services not covered by the capitation payment.

Sec. 32.0533. DATA COLLECTION: PACE AND STAR + PLUS MEDICAID MANAGED CARE PROGRAMS. Requires HHSC, in collaboration with the Department of Aging and Disability Services (DADS) and appropriate stakeholder groups, to modify the methods by which HHSC and DADS collect data for evaluation of the PACE and STAR + PLUS Medicaid managed care programs to allow comparison of recipient outcomes between the programs. Requires that the modification to data collection methods include changes to:

(1) survey instruments that measure recipient experience;

(2) compilation of the same or similar complaint, disenrollment, and appeals data; and

(3) compilation of the same or similar hospital admissions and readmissions data.

Sec. 32.0534. EVALUATION AND REPORT COMPARING PACE AND STAR + PLUS MEDICAID MANAGED CARE PROGRAMS. (a) Requires HHSC, in collaboration with DADS and appropriate stakeholder groups, to conduct an evaluation of the PACE program that compares Medicaid costs and client outcomes under the PACE program to Medicaid costs and client outcomes under the STAR + PLUS Medicaid managed care program. Requires HHSC to design the evaluation in a manner that:

(1) compares similar recipient types between the programs in terms of recipient:

(A) age;

(B) eligibility factors, including income level, health status, and impairment level; and

(C) living environment; and

(2) accounts for differences among recipients in geographic location, health care acuity, and other factors determined to be necessary.

(b) Requires that the evaluation required under this section include an assessment of future cost implications if HHSC fails to establish a reimbursement methodology under the PACE program in accordance with Section 32.0532.

(c) Requires HHSC to compile a report on the findings of the evaluation under this section. Requires HHSC to submit the report to the Legislative Budget Board and the governor not later than December 1, 2016.

(d) Provides that this section expires September 1, 2017.

SECTION 2. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes a delay of implementation until such a waiver or authorization is granted.

SECTION 3. Effective date: upon passage or September 1, 2015.