APPENDIX B

Medicaid payments to the Program of All-Inclusive Care for the Elderly

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The Balanced Budget Act (BBA) of 1997 requires the Medicare Payment Advisory Commission (MedPAC) to comment on Medicaid payment methods and amounts for the Program of All-Inclusive Care for the Elderly (PACE). This appendix primarily focuses on payment methods. Before commenting on payment amounts, MedPAC will wait for additional information on payment methods and until the Health Care Financing Administration's study of PACE's cost effectiveness to Medicaid has been released.

This appendix begins with an overview of Medicaid capitation rates to PACE and follows with a discussion of selected issues involved in setting these rates. These issues are:

- Selecting a comparison group that accurately reflects the use of services in the local market by people eligible to enroll in PACE,
- Identifying the services used by PACE enrollees and comparing them with those used by the reference population, and
- Determining the need for risk adjusters.

Medicaid capitation: an overview

Most PACE enrollees are covered by both Medicare and Medicaid, which make capitation payments to PACE sites. Each state's Medicaid agency negotiates its portion of the capitation payment with the PACE plan. As a result, no uniform method exists for setting the Medicaid capitation rate. Nonetheless, the rate is designed to supply providers with enough resources to provide enrollees with a wide array of acute and long-term care services.

States participating in PACE base the capitation rate on an estimate of how much Medicaid would pay for PACE enrollees, under the traditional Medicaid program, in an alternative setting—typically a nursing facility (NF) or a home- and community-based program.[1] Home- and community-based services (HCBS) are provided under waiver programs authorized in section 1915(c) and 1915(d) of Medicaid law. The provisions allow the states to offer certain long-term care services in homes and communities to people who otherwise would require nursing home care or other institutional care financed by Medicaid. Notwithstanding the goal of HCBS, research suggests that community-based programs serve populations that have a relatively low risk of nursing home placement (Kemper et al. 1987).

PACE Medicaid rates are intended to reflect spending on services for comparable populations as defined by each state. For example, Colorado uses a blended rate that reflects the cost of care for the NF and HCBS populations. Most states, including California and Michigan, view PACE as an alternative to NF care and base the rate on spending for the NF population. In Oregon, PACE is also considered an alternative to NF care; however, based on its experience to date, the state has selected one subgroup of the assisted-living population as the most appropriate reference point for rate-setting purposes. (Assisted-living facilities offer help with activities such as eating, bathing, dressing, doing laundry, and housekeeping for people who need assistance but who want to live as independently as possible for as long as possible. Assisted living is not an alternative to a nursing facility but an intermediate level of long-term care appropriate for many seniors.)

1 The Omnibus Budget Reconciliation Act of 1987 eliminated the Medicaid program's previous distinction between skilled nursing facilities and intermediate care facilities and established a single nursing facility category.

A few states adjust the Medicaid rate to reflect enrollee characteristics, or case mix. For example, the Wisconsin Medicaid rate is based on the average county NF rate, minus the statewide average recipient liability, plus additional cost of caring for the NF population. This rate is case-mix adjusted. The NF rate is adjusted based on the percentage of enrollees needing different levels of care—a skilled nursing facility versus an intermediate care facility—at the time of enrollment. The additional cost component is adjusted based on the age of the enrollees. All states discount the reference rate by 5 percent to 15 percent to reflect the anticipated savings from the PACE plan's coordination of acute and long-term care services. (See Table B-1 for a detailed summary of PACE Medicaid rates and methods).

A small group of sites are organized around the PACE model and have

TABLE B-1

PACE Medicaid rates, cost comparisons, and methods, February 1999

	PACE monthly rate	Comparison group for the PACE population	Average monthly cost to Medicaid for the PACE comparison group	PACE rate as a percentage of comparison group costs	Summary of the rate method
California (San Francisco Bay Area) [a,b]	$2,213	NF	$2,604	85%	The rate is based on the state's spending for the NF population in a comparable geographic area. The payment rate is adjusted by PACE enrollees' age, sex, and Medicare status. The rate is discounted by 15%.
Colorado[a]	1,786	NF, HCBS	1,880	95	The rate is based on the state's spending for the NF and HCBS populations in a comparable geographic area—weighted 40% NF and 60% HCBS, based on PACE enrollees' residential status. The rate is discounted by 5%.
Massachusetts	2,129	NF	2,717	78	The rate is set at 67% of the average NF rate. Historically, the rate was negotiated based on providers' costs and compared with the state's net spending for NF, HCBS, and adult foster care populations. The result was 67% of the NF rate (78% of comparison group costs).
Michigan[a]	2,182	NF	2,297	95	The rate is based on the state's spending for the NF population. Statewide rather than county-specific data are used. The rate is discounted by 5%.
New York (Bronx)	4,301	NA	NA	NA	NA
New York (Rochester)	2,796	NA	NA	NA	NA

continued on next page

TABLE B-1

PACE Medicaid rates, cost comparisons, and methods, February 1999

continued

	PACE monthly rate	Comparison group for the PACE population	Average monthly cost to Medicaid for the PACE comparison group	PACE rate as a percentage of comparison group costs	Summary of the rate method
Oregon	$1,812	Assisted Living (Level 5)	1,907	95	The rate is based on the state's spending for the assisted living Level 5 population. The rate is discounted by 5%.
South Carolina[a]	2,308	NF	2,429	95	The rate is based on the spending for the NF population in a comparable geographic region. The rate is discounted by 5%.
Tennessee[a]	1,989	NF	2,094	95	The rate is based on a weighted average of the NF rate, minus the average patient liability, plus the capitation rates paid for acute care and behavioral health care. The rate is discounted 5%.
Texas[a]	2,085	NF	2,195	95	The rate is based on the average NF rate by county, minus the statewide average recipient liability (resident payment), plus the average additional costs for the NF population. The rate is discounted by 5%.
Washington	3,093	NF	3,273	95	The rate is based on the average NF rate by county, plus the cost of covered services for the NF population. The rate is discounted by 5%.
Wisconsin (Milwaukee)	2,132	NF	2,244	95	The rate is based on the average NF rate by county, minus the statewide average recipient liability, plus additional costs for NF population. This rate is case-mix adjusted: NF component is based on the percentage of enrollees at the SNF versus the ICF level at the time of enrollment. The additional cost component is adjusted based on age of enrollee. The rate is discounted by 5%.

Note: NA (not available). NF (nursing facility). HCBS (home and community-based services). SNF (skilled nursing facility). ICF (intermediate care facility).

[a] The state's capitation payment to PACE and the cost of Medicaid for the comparison group have been reduced by the enrollees' share of the cost.
[b] The Oakland and Sacramento rates are $2,245 and $1,864, respectively (van Reenen 1999).

Source: National PACE Association. PACE Medicaid Rates, methodologies, and cost comparisons, San Francisco, On Lok, 1999.

qualified to receive capitation payments from Medicaid but not Medicare. Currently, half of these "pre-PACE" sites receive a blended rate that reflects the costs of care for the NF and HCBS populations. Pre-PACE sites operate under Medicaid prepaid health plan (PHP) authority, and Medicare pays for covered services on a fee-for-service basis. Under this PHP authority, states can capitate providers on a limited risk basis. Specifically, states may not contract with a pre-PACE provider for more than two Medicaid mandated benefits. Most states capitate nursing facility care and all or some physician services (On Lok 1998).

Medicare beneficiaries can choose whether to receive Medicare-covered services from the pre-PACE site or from other providers. The goal of pre-PACE plans is to move toward the full PACE system by providing long-term care and primary care services under a capitationpayment. With this payment method, plans have the advantage of operating under the PACE model of care before assuming financial responsibility for all services (On Lok 1998). Because PACE has become a permanent program under Medicare, newly emerging PACE sites also have the option of immediately receiving capitation payments from both Medicare and Medicaid, thus eliminating the pre-PACE financial arrangement.

Issues in setting rates

Among the issues that must be addressed in determining the capitation rate are selecting a comparison group, identifying the services the payment is expected to cover, and determining the need for risk adjusters.

Selecting a comparison group

The starting point for setting a capitation rate is identifying a population comparable to the PACE population. PACE serves frail Medicaid or Medicare beneficiaries who are at least age 55 and meet the states' criteria for nursing facility level of care. Therefore, the comparison group also should meet these criteria.

An obvious comparison group is the NF population. Many states use this population as the reference group; some also compare the PACE population with people who use HCBS. Like PACE, the purpose of HCBS is to prevent or postpone NF placement. Unlike PACE, which continues to enroll individuals when they are institutionalized, HCBS programs require participants to exit the programs when they need NF placement. As a result, if a community population is used as a comparison group, that population must be tracked across settings to generate an estimate of the cost to Medicaid of care for the comparison group.

State Medicaid agencies and PACE sites should question the extent to which people who are eligible for PACE are at risk of entering a NF. It may be the case that—in the absence of PACE—those who would have enrolled in the program may choose an alternative form of care not represented by the reference group(s) selected. In one study that compared PACE participants with a sample of individuals in the 1985 National Nursing Home Survey, PACE participants were less dependent in activities of daily living than people in nursing homes (On Lok 1993). Wiener and Skaggs (1995) have proposed that the differences found in this study may reflect systematic differences between PACE participants and nursing home residents, such as the two groups' motivation or ability to continue living in the community. Hence, the assumption that 100 percent of PACE enrollees otherwise would have entered a nursing facility might be inappropriate.

Identifying covered services

The second issue that states must address in determining a capitation rate is identifying which services the payment is expected to cover. There are distinct differences and some overlap in the benefits that NFs, HCBS, and PACE offer. PACE sites also offer a broad range of services beyond the scope of traditional Medicare, Medicaid, and HCBS. The program is able to do this by substituting nontraditional services for traditional services, based on enrollee needs. Nontraditional services may include, but are not limited to, meals, respite care, case management, companion services, nutritional counseling, extended personal care, transportation, and escort services (Eng et al. 1997).[2]

Nursing facilities provide skilled nursing care, rehabilitation services, and health-related care and services to individuals who, because of their mental or physical condition, require care and services available only at institutional facilities (Congressional Research Service 1993). HCBS programs offer a wide variety of nonmedical, social, and supportive services. Services that states may cover in a home- and community-based program include case management, homemaker and home health aide services, personal care, adult day health care, habilitation services, respite care, and other services requested by the state and approved by the Secretary (Congressional Research Service 1993).[3] Medicaid HCBS waiver programs do not cover therapies, such as physical therapy, or stays in a hospital or nursing facility, but for dually eligible beneficiaries Medicare covers inpatient hospital stays, therapies, and up to 100 days of care in a skilled nursing facility per spell of illness.

2 Transportation services include transportation between center and residence and transportation to physician appointments and other locations from either the PACE center or from enrollees' homes. In escort services, staff accompany enrollees to medical appointments or other locations to provide supervision or assistance (On Lok 1996).

3 Habilitation services are designed to help people who have mental retardation and developmental disabilities in acquiring, retaining, and improving the self-help, socialization, and adaptive skills they need to live successfully in the community.

States need to recognize differences in the services used by the reference population and PACE enrollees. The PACE program, by definition, offers a broad range of services that are beyond the scope of traditional Medicare, Medicaid, and HCBS. Although the majority of participating states use the cost of care for the nursing facility population as a basis for rate setting, some states adjust the capitation rate to account for HCBS use, which is one step closer to the PACE model of care. In any case, differences in service use across programs can translate into unexpected differences in spending on care for the reference population and for the PACE population.

Determining risk adjusters

When determining the Medicaid payment, state agencies use the reference population as a proxy for the PACE population, assuming that care for the PACE population would have cost about the same as care for the reference population. This justification is predicated on the assumption that the reference population and the PACE population are fundamentally the same in terms of their demographic and risk profiles; however, PACE sites may encounter advantageous or adverse selection from the pool of eligibles compared with the reference group.

To reduce the probability of incorrectly estimating the cost of PACE to Medicaid, states can adjust the capitation rate to reflect differences between enrollees and the comparison group used for rate setting or to reflect the mix of enrollees at different sites within a state. If a state chooses to implement a risk-adjustment mechanism, Medicaid agencies must identify available risk adjusters, evaluate their success at predicting the cost of caring for the PACE population, and decide how often the chosen risk adjuster should be updated (see Chapter 5).

Future research

Critical questions about payment methods need to be addressed before MedPAC comments on payment amounts to PACE. The first is whether Medicaid is paying an appropriate amount for the care of the reference population. State Medicaid agencies set the capitation rate for PACE assuming that an appropriate amount is spent on care for the reference population, but this assumption may not be correct. Even if Medicaid pays an appropriate amount, a second, related question is whether PACE enrollees and beneficiaries using NFs and HCBS have systematic differences in health characteristics, family support, income, and unobservable characteristics. Information about such differences would help states assess whether the reference population is an adequate proxy for the PACE population.

Finally, more information is needed on whether states view PACE as a substitute for NF care or as a program to offer the spectrum of care for frail Medicare and Medicaid beneficiaries. States committed to offering alternatives to NF care might prove to be more diligent than other less committed states in setting payment rates that accurately reflect the market cost of caring for frail Medicaid beneficiaries. If this is the case, unexpected differences in spending on care for the reference population and for the PACE population may reflect the state's commitment to the program, rather than inaccurate payment methods. ■

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