
NPA Summary and Response: Medicaid Costs

August 2014

Introduction

Recently the Office of Disability, Aging and Long-Term Care Policy within the Office of the Assistant Secretary for Planning and Evaluation (ASPE) released the results of a Mathematica Policy Research (MPR) study examining the effects of Programs of All-Inclusive Care for the Elderly (PACE®) on Medicare and Medicaid costs, nursing home utilization and mortality. The study focuses on the experience of dual-eligible PACE participants in eight states relative to comparison groups composed of beneficiaries using Home and Community-Based Services (HCBS) or nursing home (NH) care. The National PACE Association (NPA) provides this summary and response to address the study’s findings related to Medicaid costs.¹

The study’s Medicaid cost findings address policy considerations related to the appropriate role and potential expansion of PACE relative to other long-term services and supports (LTSS). Unfortunately, confidence in the study’s analysis and findings is limited by the following concerns:

- As acknowledged by the authors, the absence of data on beneficiaries’ functional and cognitive status for the PACE and comparison populations calls into question the validity of the population to which PACE is compared.
- Errors in Medicaid expenditure data for PACE enrollees result in PACE costs being significantly overstated in at least one of the eight states, representing 18% of the study’s total sample.
- State-specific factors influencing the cost of PACE relative to other LTSS options underscore the limits in generalizing the study’s findings beyond the few states (three out of 31 states with a PACE program) for which detailed analyses are presented.

¹ NPA also has produced summaries and responses related to the study’s Medicare cost and quality findings. These are available at www.npaonline.org.
While both costs and measures of quality are analyzed in the study, the two are not combined to assess the relative value of PACE, i.e., the relationship between the cost and outcomes achieved by PACE as compared to other LTSS options.

Because our concerns with the study’s methodology fundamentally limit our confidence in its Medicaid cost findings, we begin our summary and response with these. Following a discussion of the study’s methodology and results, policy implications of the findings from the study are addressed.

Study Methodology and Results

The study compares capitated Medicaid per beneficiary per month (PBPM) costs for PACE enrollees to predicted PBPM costs had they not enrolled in PACE and remained in a fee-for-service (FFS) option. More specifically, the study identified dual-eligible PACE enrollees in eight states (CA, CO, MA, MI, NM, NY, OR, PA) who enrolled between July 2006 and December 2008 and matched them to FFS dual-eligible beneficiaries who were either new HCBS waiver enrollees or NH entrants during the same time period. Matching was done on the basis of numerous factors, including age; gender; race/ethnicity; presence (but not severity) of certain chronic diseases such as Alzheimer’s disease or dementia, coronary artery disease, congestive heart failure, depression, diabetes and stroke; number of chronic diseases; and measures of prior Medicare service use and cost.

The predicted PBPM costs for PACE enrollees had they not enrolled in PACE are based on the FFS cost experience of a matched comparison group drawn from NH entrants and new HCBS waiver enrollees. Differences in Medicaid PBPM expenditures for the PACE and comparison groups are compared for successive six-month periods. The study looks at the collective experience across all eight states and at the individual experience of three states (CA, MA, NY).

Across all eight states, the study found that, on average, Medicaid PBPM expenditures for PACE exceeded the FFS comparison group’s predicted PBPM expenditures, with the magnitude of the difference remaining stable over the study period at approximately $600 PBPM. The reported differences between PACE and FFS PBPM expenditures varied considerably across the three states for which state-specific analyses were performed:

- California: PACE PBPM costs were reported to be significantly higher than FFS PBPM costs. However, as discussed further below, it appears inaccuracies in the study’s cost data substantially overstate PACE costs.
- Massachusetts: PACE PBPM costs initially exceed FFS PBPM costs, with the difference diminishing to insignificant levels midway through the study period.
- New York: PACE PBPM costs were significantly lower than FFS PBPM costs.

The study improves upon prior analyses in two important ways:

1. In contrast to previous studies in which the PACE comparison group has been limited to HCBS waiver enrollees only, in this study the primary comparison

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2 Although the report focused on the comparison of PACE costs to those of a blended HCBS/NH comparison group, the cost study also compared PACE enrollees’ costs to those of a second comparison group made up of new HCBS waiver enrollees only.
group against which PACE enrollees’ cost experience is compared is made up of both HCBS waiver enrollees and NH entrants. This approach to developing the comparison group reflects PACE’s role as an immediate alternative to both HCBS waiver programs and nursing homes for individuals requiring LTSS. NPA shares the authors’ belief that “a comparison group consisting of both HCBS waiver enrollees and NH entrants seems to provide a well-balanced counterfactual of beneficiaries residing either in the community or in a nursing home for evaluating PACE programs.”

2. In comparison to a 2007 MPR study of PACE costs, the length of time for which Medicaid expenditures for PACE are compared to the cost of alternatives has increased from two to three-and-a-half years post enrollment. While these improvements address some of the limitations of prior studies, we continue to have significant concerns regarding the appropriateness of the comparison population, the length of the study period, the validity of the cost data, the role of state-specific factors, and the lack of a true cost-benefit analysis.

1. The study did not have access to health assessment information that would have allowed it to account for differences in physical and cognitive functioning between new PACE enrollees, new HCBS waiver enrollees and NH entrants. Functional disabilities, as measured by an individual’s performance of activities of daily living (ADL), and cognitive disabilities are known to have a significant impact on the costs of LTSS. While NPA appreciates the challenges in accessing ADL and cognitive functioning data, it is essential to ensuring comparability between the PACE and comparison groups. The absence of comprehensive assessment data with which to match PACE enrollees to comparison group members continues to raise questions regarding the validity of the study findings.

2. Cost data used in the study appear to significantly overstate PACE costs in at least one state – California – that contributes approximately 18% of the study population. It is our understanding that the Actual Mean PBPM amounts for PACE enrollees reported in the study should be consistent with states’ Medicaid capitated rates for PACE. In the detailed analysis presented for California, the calculated average PACE PBPM amounts ranged from $5,296 to $5,896 over the three-and-a-half years included in the study. However, over the same time period, the actual PACE capitation payment rates ranged from $3,321 to $4,400. This suggests costs in the study are substantially overstated for PACE participants in California. Although we did not observe similar discrepancies between reported costs and PACE capitation rates in Massachusetts and New York, it is not possible to determine the accuracy of the cost data for the other five states in the study because state-specific data are not presented. Given the portion (18%) of the study sample obtained from California, the errors in its cost data alone call into question the accuracy of the study’s results – not only for California but for the eight states overall.

3. The limited number of states included in the study, the small sample size for five of the eight states, and the role of state-specific factors related to PACE rate-setting result in findings that cannot be generalized. Of the eight states included in

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3 See page 2 of the study.
the study, only three have adequate sample sizes to provide state-specific results. For the three states for which detailed analyses are presented, the study results are mixed:

- **California**: While the study found PACE costs were higher than the comparison population’s costs, as noted above, the costs used for PACE appear to be significantly in error.
- **Massachusetts**: Initially, the study found higher costs for PACE relative to the comparison population, but the cost difference decreased to “statistically insignificant levels over time.” The study time period is six months shorter for Massachusetts than for other states because of an insufficient sample size for the last (seventh) six-month interval of enrollment. If the last and subsequent intervals had been included in the study, the cost trend line suggests that PACE costs might equal or fall below the comparison population’s costs.
- **New York**: The study found significant cost savings from PACE relative to the comparison population.
- **The remaining five states** in the study (CO, MI, NM, OR, PA) had inadequate sample sizes to present state-specific cost comparisons between the PACE and comparison populations. Given the study’s acknowledgement of the importance of state factors in comparing PACE payments to those for LTSS alternatives, it is difficult to interpret results that combine costs across such a diverse group of states.

4. We remain concerned that the study period is still too short and does not allow for comparison of PACE payments to FFS costs for the entire length of time that PACE enrollees and comparison group members utilize LTSS. For many individuals in the PACE and comparison populations, end-of-life costs – which represent a substantial proportion of overall costs – would not be captured within the study period. While Medicaid payments for PACE enrollees do not increase with changes in the quantity or location of services provided, they do for members of the comparison group, whose costs likely increase significantly toward the end of life. Capturing these costs is important for a full accounting of the total Medicaid costs incurred for PACE enrollees relative to total costs for recipients of other LTSS programs.

5. The study does not address the cost-effectiveness of PACE relative to other long-term care programs, i.e., the relative value of PACE taking into account both cost and quality outcomes. Though the study includes measures of mortality and long-term nursing home placement, the better outcomes achieved by PACE for these measures are not considered in relation to costs for PACE:

- **PACE enrollees** experienced lower mortality rates than a comparison group made up of both HCBS waiver enrollees and NH entrants: 9% vs. 22% after one year of enrollment, 29% vs. 44% after three years, and 43% vs. 51% after five years.
- **PACE enrollees** were less likely to experience long-term NH stays of 90 days or more in comparison to HCBS waiver enrollees. Additionally, PACE enrollees had more frequent short-term recuperative NH stays.

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4 See page ix of the study.
suggesting that PACE may use NH care in place of hospital care. This finding is supported by several studies that have found lower hospital utilization among PACE enrollees.\(^5\) Overall, PACE organizations appear to be more successful than HCBS waiver programs at preventing long-term institutional placement.

By not jointly considering the cost and quality results for PACE, HCBS and nursing homes, the study cannot draw conclusions regarding the relative value of PACE vis-à-vis these LTSS alternatives. The study is clear that such a cost-effectiveness analysis is beyond its scope. However, Medicaid programs’ consideration of the LTSS options made available to their beneficiaries requires a weighing of costs relative to outcomes in order to determine value.

**Summary of the NPA Response**

While NPA is appreciative of the current study’s efforts to address the composition of the comparison group, including both HCBS waiver enrollees and NH entrants, and to extend the length of the study period, we continue to have fundamental concerns regarding the validity of the study’s findings due to the following:

1. Lack of Confidence in the Comparison Population: PACE is compared to a population for which differences in physical and cognitive functioning have not been adjusted. Given the significance of these factors in determining beneficiaries’ need for services and corresponding Medicaid costs, the validity of the study’s findings is questionable.

2. Inaccurate Cost Data: Cost data for California – and possibly other states in the study – significantly overstate the monthly amounts paid by the Medicaid program to PACE organizations. Notably, California represents approximately 18% of the study’s entire sample and is one of only three states for which state-specific results are presented. For the other two states with state-specific results, the study found significant savings to Medicaid in one (New York) and costs that converged with the costs of the FFS comparison population in the other (Massachusetts).

3. Unaccounted for State Factors: State Medicaid rate-setting, eligibility criteria and benefit design factors largely determine how PACE costs compare to other LTSS options. The impact of these factors limits the generalizability of the study’s findings across states. In fact, state-specific results are presented for only three states, with mixed findings. For the other five states, due to small sample sizes, only combined results are available. Combining costs across states without accounting for state differences in rate-setting and LTSS benefits does not provide meaningful information with which states can assess their Medicaid options.

4. Comparisons Are Limited to Cost, Not Value: The study finds PACE extends longevity and reduces long-term nursing home placements for its participants.

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\(^5\) Compared to dual-eligible waiver enrollees who are aged or disabled, PACE enrollees had lower hospitalization rates: 539 vs. 962 discharges per 1,000 person-years. Compared to dual-eligible beneficiaries 65 years of age and over, PACE enrollees experienced lower 30-day readmission rates: 19.3% vs. 22.9%. [Segelman, M., et al. (2014). Hospitalizations in the Program of All-Inclusive Care for the Elderly, *Journal of the American Geriatrics Society*, 62 (2).]
However, these benefits are not considered relative to the cost of the program in order to arrive at a true assessment of the PACE program’s value to Medicaid.

**Medicaid Policy Implications**

It is difficult to speak to the policy implications of the study’s results in light of the significance of outstanding questions related to the study’s methodology and data concerns. In short, the study does not provide reliable results with respect to the relationship between PACE and FFS costs for comparable PACE and FFS populations. With this overarching caveat in mind, the following observations may be helpful to Medicaid policy-makers:

- Drawing state-specific conclusions on the basis of the experience of the relatively small subset of states included in the study is not advised, as doing so ignores the wide variation in and high impact of state-specific factors related to PACE and FFS. These factors include the design of states’ Medicaid programs, clinical and financial eligibility criteria, the balance between institutional and community-based care, relative payment rates, and the presence of other capitated LTSS programs. Findings for one or a subset of states are not easily transferable to other states.

- Increasingly, states are looking to enroll dual-eligible individuals with LTSS needs in managed care and moving away from FFS. This is evidenced by the development of Medicare-Medicaid Plans in the 11 states participating in the Financial Alignment Demonstration of the Centers for Medicare & Medicaid Services (CMS) and the expansion of Medicaid managed long-term care in others. In addition to comparing PACE rates to FFS costs, future studies should include a comparison of PACE rates to Medicaid managed care rates when possible, taking into account differences in benefits covered and the level of financial risk assumed. The Mathematica study’s time period is before many of the states developed their managed LTSS programs.

- It is important to point out that the study’s findings relative to mortality and long-term nursing home use suggest that PACE participants’ outcomes in these two key dimensions are better than those for HCBS enrollees and NH residents. Consequently, PACE may provide better “value for money” than other LTSS options, even if these options cost less.

- The study’s authors and NPA agree that future research to address the limitations of the study would be extremely beneficial. Most importantly, future studies comparing outcomes, including costs, for PACE enrollees to outcomes for a comparable group outside PACE must include timely and comprehensive data on beneficiaries’ health status, physical and cognitive functioning, and other determinants of utilization, cost and quality outcomes to assure comparability between the two groups. Sources of these data include assessment data collected by states in order to verify beneficiaries’ eligibility for nursing home level of care, MDS data for NH residents, and survey information.

*For more information, contact the National PACE Association at 703-535-1565 or visit www.npaonline.org.*