A Better Life for Low-Income Elders in Austin

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A Better Life for Low-Income Elders in Austin

Project Directed by

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List of Acronyms and Definitions

ACA	Affordable Care Act of 2010
ADL	Activities of Daily Living
CBMLTSS	Community-Based Managed Long Term Services and Support
CMS	Center for Medicare & Medicaid Services (federal agency that runs the Medicare program and partners with the states to run the Medicaid program)
DADS	Department of Aging and Disability Services
FFS	Fee for Service
GSA	Gerontological Society of America
HCBS	Home and Community-Based Services
HHSC	Texas Health and Human Services Commission (provides administrative oversight of Texas health and human services programs and direct administration of some programs)
ICHP	Institute for Child Health Policy
IDT	Interdisciplinary Team
LBB	Texas Legislative Budget Board
LTSS	Long Term Services and Supports
MCO	Managed Care Organization
NF	Nursing Facility
NPA	National PACE Association
PACE	Programs of All-Inclusive Care for the Elderly
PBM	Pharmacy Benefit Manager
PMPM	Per Member Per Month
SAA	State Administering Agency
SFY	State Fiscal Year
UPL	Upper Payment Limit

Definitions

Capitation: A system of medical reimbursement where the provider is paid an annual fee per covered patient by an insurer or other financial source, and for which aggregate fees are intended to reimburse all provided services.

Capitated Rate: A predetermined rate (the cap) at which state administering agencies make prospective monthly payments to a healthcare provider.

Community-based Alternatives: Home- and community-based services to people who are elderly and to adults with disabilities as a cost-effective alternative to living in a nursing home.

Contract Year: The term of a PACE Program Agreement, which is a calendar year, except that a PACE organization's initial contract year may be from 12 to 23 months, depending on the effective date of program implementation.

Dual Eligibles: Individuals who are entitled to Medicare Part A and/or Part B and are also eligible for some form of Medicaid benefit.

Interdisciplinary Team (IDT): A group of knowledgeable clinical and non-clinical PACE center staff, employed or contracted, responsible for the holistic needs of the participant who work in an interactive and collaborative manner in order to control the delivery, quality, and continuity of care for each participant.

Long-Term Services and Supports: LTSS is defined as assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) provided to older people and other adults with disabilities that cannot perform these activities on their own due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time, typically 90 days or more. Long term services and supports include human assistance, supervision, cueing and standby assistance, assistive technologies/devices and environmental modifications, health maintenance tasks (e.g., medication management and ostomy care), information, and care and service coordination for people who live in their own home, a residential setting, or a nursing facility. Long-term services and supports also include supports provided to family members and other unpaid caregivers.

Managed Care Organization (MCO): an organization that combines the functions of health insurance, delivery of care, and administration. Examples include the independent practice association, third-party administrator, management service organization, and physician-hospital organization.

Medicare Beneficiary: An individual who is entitled to Medicare Part A benefits or enrolled under Medicare Part B, or both.

Medi-Cal: Medi-Cal is California's Medicaid program, providing needed health care services for low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and low-income people with specific diseases such as tuberculosis, breast cancer, or HIV/AIDS. Medi-Cal is financed equally by the state and federal government.

On Lok, Inc: On Lok, Inc., is a not-for-profit organization founded in the early 1970s by a group of citizens concerned about the plight of elders and the lack of long-term options in the community. On Lok, Inc., serves as the administrative arm of a group of five affiliated non-profit organizations. Its functions include research and development, human resources, fundraising, and management information systems.

PACE Center: A facility that includes a primary care clinic and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining, and which serves as the focal point for coordination and provision of most PACE services.

PACE Medicaid Participant: An individual determined eligible for Medicaid who is enrolled in a PACE program.

PACE Medicare Participant: A Medicare beneficiary who is enrolled in a PACE program.

PACE Organization: An entity that has in effect a PACE Program Agreement to operate a PACE program.

PACE Participant (or Participant): An individual enrolled in a PACE program.

PACE Program Agreement: An agreement between a PACE organization, CMS, and the State Administering Agency for the operation of a PACE program.

Private Pay: The individual does not have Medicare or Medicaid to cover the cost of PACE and must use other resources to pay for participation in the program.

Provider: A commonly used term meant to encompass all health care professionals, except pharmacists, who provide medically necessary health care to enrollees.

SCAN Foundation (Senior Care Action Network): A nonprofit based in California with the goal of transforming care for older adults.

Services: Medical care and items such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital RPCH or SNF facilities.

STAR+PLUS: A Texas Medicaid managed care program for people who have disabilities or are age 65 or older. People in STAR+PLUS get Medicaid health care and long-term care services and support through a medical plan that they choose.

STAR+PLUS Dual Demonstration: The Dual Demonstration serves people who are eligible for both Medicare and Medicaid, known as dual eligibles. The goal of the project is to better coordinate the care the dual-eligible members receive. The project, also known as "the demonstration," is testing an innovative payment and service delivery model to improve coordination of services for dual-eligibles, enhance quality of care, and reduce costs for both the state and the federal government. By having one Medicare-Medicaid health plan, Medicare and Medicaid benefits work together to better meet the member's health care needs.

Texas Department of Aging and Disability Services: DADS was created to administer long-term services and supports for people who are aging as well as for people with intellectual and physical disabilities. DADS also licenses and regulates providers of these services, and administers the state's guardianship program; DADS began formal operations on Sept. 1, 2004.

Upper Payment Limit (UPL): A federal limit placed on fee-for-service reimbursement of Medicaid providers. Specifically, UPL is the maximum a given state Medicaid program may pay a type of provider in the aggregate, statewide in Medicaid fee-for-service. Medicaid programs cannot claim federal matching dollars for provider payments in excess of the applicable UPL.

Foreword

The Lyndon B. Johnson School of Public Affairs emphasizes interdisciplinary research on policy problems in the graduate public affairs program. A major part of this program is the nine-month policy research project, in which faculty members direct the research of a small group of graduate students on a policy issue of concern to a government, private, or nonprofit client. This client relationship brings the students face to face with administrators, legislators, and other officials active in the policy process and demonstrates that research in a policy environment demands special talents. It also illuminates the difficulties of applying research findings in the world of complex problems and political differences.

This report describes a policy research project conducted in the 2015-16 academic year with support from the St. David's Foundation and Central Health, and government client the Texas Health and Human Services Commission. The study addresses how to care for elderly, vulnerable county residents in the community. As baby boomers approach retirement age nationwide, the share of Austin's elderly population is growing as well. Austin and Travis County are facing new challenges in providing services to a growing share of frail and disabled older residents. The core objective of this project is to offer options for community-based long-term care in an equitable and cost-effective manner.

As part of this objective, the project team examined existing community-based, long-term care and social services programs in Texas and California for dually eligible Medicaid and Medicare enrollees, including Texas's managed care option, STAR+PLUS, and the Program of All Inclusive Care for the Elderly (PACE). PACE provides comprehensive medical care and social services to persons 55 and older who require nursing home care, but prefer to live in the community. The study examines other community-based long-term care alternatives that could be introduced in Austin and the characteristics of what makes PACE and other alternatives work for dual-eligible older persons. The study includes a cost analysis from the perspectives of the state and program provider, an analysis of participant satisfaction in each program, and an in-depth qualitative analysis of the barriers to success for PACE sites in Texas and California. The study also explores ways of leveraging community resources in Austin.

The curriculum of the LBJ School is intended not only to develop effective public servants but also to produce research that will inform those already engaged in the policy process. This research project accomplishes both tasks. This report follows the charge of Texas House Bill 3823, 84th Legislature, Regular Session, which charges the Texas Health and Human Services Commission with examining rate-setting processes for the STAR+PLUS and PACE programs to develop an accurate comparison of program costs and outcomes. The report also informs the work of the Texas Senate Interim Committee on Health and Human Services.

Angela Evans
Dean

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Acknowledgements and Disclaimer

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Finally, it should be noted that neither the LBJ School of Public Affairs nor The University of Texas at Austin nor the persons interviewed for this project necessarily endorse the views or findings of this report.

Executive Summary

This policy research project carried out by students at the LBJ School of Public Affairs compared the cost and effectiveness of three public options in community care available to dual-eligible older Texans. These included STAR+PLUS, the state's Medicaid Managed Care Program for individuals with disabilities or who are older; the Program of All-Inclusive Care of the Elderly (PACE); and a dual-eligible demonstration project providing "financial alignment" of Medicaid and Medicare community-based health and long-term services and supports (LTSS). The motivation was to determine whether the PACE model offered a cost-effective option in Austin. The program is of interest to policymakers and advocates for seniors since it potentially provides optimal autonomy for the most frail seniors who need nursing home care in a cost-effective manner.

PACE began as a non-governmental, nonprofit local program in the San Francisco Bay area in 1971. Its objective was to provide comprehensive care for older Asians who needed nursing home care but who preferred to remain in the community. The success of this local effort led Congress to pass legislation in 1997 under the Balanced Budget Act making this prototype a permanent part of the Medicaid and Medicare programs. Today, 116 PACE programs serve individuals age 55 or older who live in the programs' service areas. Three of these operate in Texas, in Amarillo, El Paso, and Lubbock. PACE provides the full range of health care, personal care, and supportive services that allow an older person with serious functional limitations to remain in the community. These services are coordinated by an interdisciplinary team of health care and service delivery professionals who works with family caregivers.

The Texas Legislature recognized PACE's potential cost savings in a June 17, 2014, public hearing concerning the implementation of provisions in Senate Bill 7 (83R). The purpose of SB 7 was to expand and improve the delivery of community-based long-term care services in a cost-effective manner. As a result of the hearings, the Texas Health and Human Services Commission transferred additional general revenue funds from the Texas Medicaid program to PACE to serve more participants at existing and tentative new sites in Dallas, Houston, and San Antonio.

The objectives of this policy research project were to:

1. Compare the cost of the PACE model to that of STAR+PLUS and the dual-eligible demonstration project (dual demonstration) to determine whether PACE could be introduced at a comparable or lower cost given the mandated rate methodology and other legislative constraints.

2. Investigate what procedures and investments would be needed to create a PACE program in Austin if the model was determined to be cost-effective.

3. Identify which organizations would be well positioned to implement any model that is determined to be the most cost-effective in Austin and outline ways in which a foundation could support such efforts.

In order to address these aims, we examined state-level Medicaid rate data and reviewed existing research on quality improvements, cost effectiveness, and health outcomes related to the three options available to the dual-eligible population in Texas. We then compared each program's strengths and weaknesses in providing community-based LTSS to seriously impaired older individuals with complex needs. In addition, we evaluated the opportunities and challenges of co-locating affordable senior housing with community-based services for the most vulnerable seniors in Austin.

Our economic analysis examined the costs and benefits, to the extent possible, of each program from four different perspectives: state, Center for Medicaid and Medicare Services (federal), provider, and program participant. The state perspective employs a comparative cost analysis focused on the payment rates and rate-setting methodology for each program. Due to data limitations preventing a full cost analysis, for the federal perspective we assessed existing research on the Medicare savings and costs of each program. To better understand how these state and federal payment rates affect PACE providers, we conducted an analysis of operational provider costs and startup provider costs. Because the STAR+PLUS HCBS plan and dual demonstration programs are operated by insurers rather than providers, we excluded them from the provider perspective. Finally, we considered the program participant's perspective using existing participant health outcomes research and patient satisfaction surveys, to the extent they are available.

Qualitative data collected from On Lok in San Francisco, the first PACE program in the nation, and three PACE sites in Texas were used to ascertain the challenges of establishing a PACE program in Austin.

For the state, the cost of PACE is, by definition, lower than other Medicaid community-based options. This is because the Texas Medicaid State Plan establishes a rate-setting methodology that pays PACE no more than 95 percent of the cost of other non-PACE options. The rate may be adjusted further to keep costs within the state's budget appropriations.

Not unexpectedly, then, the quantitative data show that the cost to the state of all three existing PACE sites is lower than that of the two Medicaid community care alternatives (STAR+PLUS and dual demonstration). In 2015, all three PACE sites were reimbursed at 88.5 percent of the cost of Medicaid community care alternatives. However, because of the lack of individual-level encounter data with controls for frailty we cannot determine definitively how PACE compares to the two other programs.

The results of a systematic literature review reveal that participants like PACE because of its comprehensive coverage. On the whole, other research indicates that PACE participants have more positive outcomes than comparable populations in fee-for-service home and community-based care. PACE participants have fewer unnecessary hospitalizations and emergency room admissions, reduced nursing home use, better overall health, and superior ratings of participant satisfaction compared to those who receive STAR+PLUS services. Since PACE providers must assume any cost of care that exceeds the capitated payment, they are motivated to keep the participants healthy.

Although PACE has many documented benefits, the question remains as to whether the program is economically viable in different contexts. The state's desire to control the cost of providing community-based long-term care to seriously impaired older individuals presents PACE programs with serious budgetary limitations that have slowed their expansion. The projected Medicaid rates for 2016-2017 may be too low to sustain PACE operations. There are currently no new sites that have been approved. Given these funding limitations, the potential for the PACE model to be expanded in Texas remains in question.

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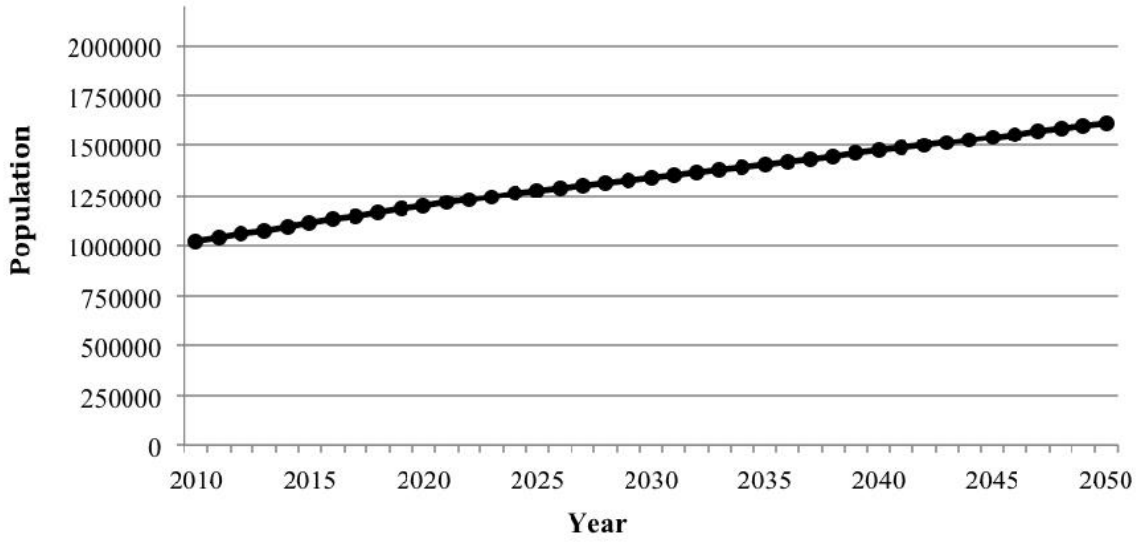
Chapter 1.
Introduction: Aligning Affordable Housing with Senior Services, Housing, and Operating Needs

Problem Statement

Austin, Texas, is the fastest-growing big city in America. Projections show that from 2015 to 2030 Travis County's population will grow by more than 20 percent, to 1.3 million residents (see Figure 1.1).[1] The city's rapid expansion is the result of growth in every age group, but nowhere is the surge more pronounced than among seniors aged 65 and older.[2] Indeed, the population of individuals 65 and older in Travis County is projected to almost double between 2015 and 2030 (see Figure 1.2). In ten years, one out of five Austin residents will be 65 or older.[3] The acute and long-term needs of the older population in Travis County—and in particular the low-income, frail older population—present unique challenges to local policymakers. This research project therefore examines options in co-locating housing and community-based services for the region's low-income, Medicaid-eligible senior population.

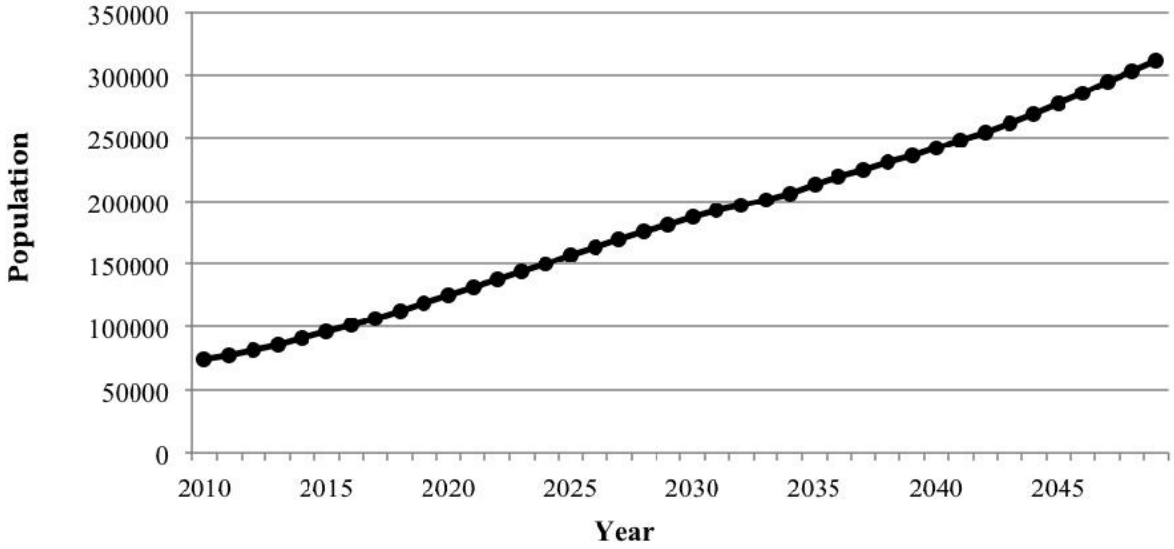
Figure 1.1. Travis County Project Population, 2010-2050



Source: Office of the State Demographer. Texas State Data Center. "2014 Population Projections Data Downloads." Accessed March 10, 2016. http://osd.texas.gov/data/tpepp/projections/.

[1] Office of the State Demographer, "2014 Population Projections Data Downloads."
[2] Ibid.
[3] Ibid.

Figure 1.2. Travis County Project Population over Age 65, 2010-2050

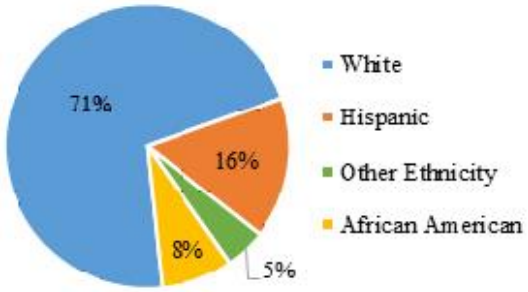


Source: Office of the State Demographer. Texas State Data Center. "2014 Population Projections Data Downloads." Accessed March 10, 2016. http://osd.texas.gov/data/tpepp/projections/.

Austin's older population is undergoing demographic changes, indicating that in the near future there will be significantly more elderly adults who are both poor and frail. This is primarily apparent in the older population's increasing diversity. It is projected that by 2040, African Americans and Latinos will account for 38 percent of Travis County's total older population, a 14 percent increase from 2010 (see Figures 1.3 and 1.4).[4] Latinos of Mexican origin are expected to make up the largest segment of this growing minority senior population. As a group, Latinos of Mexican origin tend to have less wealth, lower incomes, and less access to private health insurance than non-Hispanics.[5] Minority seniors report disproportionately high levels of functional incapacity and chronic disease, and nowhere is this more pronounced than among Latinos of Mexican origin who make up the vast majority of Latinos in Austin. The increased ethnic diversity in the senior population therefore indicates that in the coming decades Travis County's senior population will have greater and more challenging health and housing needs than current residents.[6]

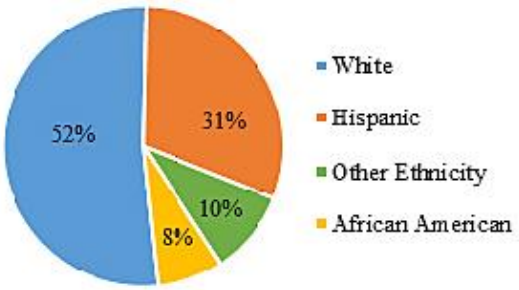
[4] Ibid.
[5] Angel, Angel, and Hill, "Longer Lives, Sicker Lives?"
[6] Mayor's Task Force on Aging, "Embracing an Age Diverse Austin."

Figure 1.3. Travis County Projected Population Aged 65 Years and Older, by Race/Ethnicity, 2010



Source: Office of the State Demographer. Texas State Data Center. "2014 Population Projections Data Downloads." Accessed March 10, 2016. http://osd.texas.gov/data/tpepp/projections/

Figure 1.4. Travis County Project Population Aged 65 Years and Older, by Race/Ethnicity, 2040



Source: Office of the State Demographer. Texas State Data Center. "2014 Population Projections Data Downloads." Accessed March 10, 2016. http://osd.texas.gov/data/tpepp/projections/.

To see that Austin's older population is becoming poorer and frailer, one can also look at overall U.S. Census data trends. In the decade from 2000 to 2010, the number of Travis County seniors living in poverty increased 42 percent, and today one-fifth of the population over 50 lives at or below 200 percent of poverty.[7,8] Low-income seniors have unique and costly health care needs—according to the 2014 American Community Survey, 41 percent of seniors living in poverty have a disability, compared to 33 percent of other seniors.[9] Furthermore, although 98 percent of Austinites ages 65 and older are covered by health insurance, serious health concerns and access to care remain intractable problems. Even with coverage, adequate care is often unavailable. Low-income elderly residents who are eligible for dual coverage through Medicare and Medicaid

[7] Ibid.
[8] U.S. Census Bureau, "American Community Survey 5-Year Estimates."
[9] Ibid.

frequently have difficulty finding doctors.[10] Overall, this research indicates that within the Austin region there is a population of poor, frail seniors that is growing in size more rapidly and with more acute health needs than the rest of the elderly population.

Travis County's population of low-income, frail seniors also experiences pronounced housing cost burdens, and available government programs are only meeting a small portion of the total need. This trend is clear on a national level: almost half of the poorest 65 and older population across the country pays more than 50 percent of their income on housing, and 90 percent of Section 202 Supportive Housing for the Elderly properties have a waiting list.[11,12] This unmet need is particularly clear in Austin, which has the most expensive rental market in Texas. The majority of Austin seniors prefer to continue living in their own homes, but the reality of sharply rising property taxes, utility costs, and home maintenance expenses make this increasingly difficult for seniors on fixed incomes.[13,14] Affordable senior apartment complexes exist in Austin but current demand far exceeds capacity. In addition, assisted living programs are typically too expensive for most seniors. Even seniors who manage to remain in their homes may require assistance with personal care activities, home maintenance, and daily tasks.[15]

In their totality, these demographic and economic facts about Austin's senior population call for an investigation into ways in which policymakers can best serve the region's poor, frail, elderly individuals. Seniors who require specialized care due to their income and disability statuses are more likely to rely on public resources, and their unprecedented growth underscores the need for further qualitative and quantitative research into which programs most efficiently secure their well-being.

One promising solution to the increasing needs of Austin's elderly, low-income, and frail population is to link affordable housing with health and supportive services. This research project will investigate two main approaches to this health and housing co-location approach. The Program of All-Inclusive Care for the Elderly (PACE) is one potential option for combining housing and social services targeted to the most vulnerable elders. This federally recognized program serves low-income individuals 55 and older who need nursing home care but who prefer to remain in the community. At the same time, Texas continues to expand access to long-term and acute managed care for nursing home-eligible seniors in its STAR+PLUS Home and Community Based Services (HCBS) waiver.

Structure of the Report

A comparison between the relative advantages of the PACE and STAR+PLUS programs serves as the core motivation for this report. We begin with a detailed review of extant literature written about the impacts of PACE and HCBS-like managed care programs. This section provides an academic foundation for our discussion, as well as a justification for our focus on programs that

[10] Aging Services Council of Central Texas, "A Growing Senior Population in Central Texas."
[11] Lipman, Lubell, and Salomon, "Housing an Aging Population."
[12] AARP Public Policy Institute, "Developing Appropriate Rental Housing for Low-income Older Persons."
[13] Toohey, "Austin Property Taxes Jump 38% Over Past Decade."
[14] U.S. Department of Housing and Urban Development, "Measuring the Costs and Savings of Aging in Place."
[15] Aging Services Council of Central Texas , "A Growing Senior Population in Central Texas."

provide managed, integrative care and encourage the co-location of health and housing services. After the literature review, our research findings are organized into two main sections. The first features a quantitative cost analysis of the PACE model compared to two STAR+PLUS plans for individuals eligible for both Medicare and Medicaid (so called "dual-eligibles") to determine whether such a program could be financially viable given structural and legislative constraints. The second step of our research includes a qualitative analysis of the procedures and investments that underlie a successful PACE program. This facet of the research is based on qualitative data collected from On Lok in San Francisco, the first PACE program established in the nation.

The final chapters of the report utilize these qualitative and quantitative results to offer recommendations for addressing anticipated service needs in Travis County. We also summarize possible ways in which a foundation could help establish and support cost-effective models in Austin. Finally, we describe what services these organizations would be well positioned to help implement and how local policymakers can bolster their impact.

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Chapter 2.
Evaluating Community Care Programs for Dual-Eligible Beneficiaries in Texas: A Literature Review

Providing adequate, high-quality care to the frail, low-income elderly has been an ongoing struggle with payment systems and care models continuously evolving in an effort to provide the best services possible at the lowest price. Today, managed care models with capitation payments have become increasingly popular and the state of Texas has many different care options that fall under this general umbrella. In this literature review, we examine the Program for All-Inclusive Care for the Elderly, the Medicaid STAR+PLUS Home and Community Based Services Waiver (HCBS), and the STAR+PLUS Dual Demonstration Project. Emphasis is placed on cost-effectiveness and patient outcomes, since these are arguably at the core of what makes a successful care model. Sources include academic peer-reviewed studies, primary source data released by governing bodies overseeing the programs, and results and analyses commissioned from a secondary source by the aforementioned governing bodies.

Overview of the Program for All-Inclusive Care for the Elderly

The Program for All-Inclusive Care for the Elderly (PACE) is a comprehensive, community-based care model that serves nursing-home-eligible older adults with disabilities that impair multiple activities of daily living. PACE originated in the Chinatown neighborhood in San Francisco in 1971 as a solution to cultural barriers to care. Chinese families have culturally frowned upon placing their older family members in nursing home care, resulting in a disproportionate burden on family members providing for frail individuals. On-Lok, the first PACE site, was developed as a compromise straddling these two issues, a service model that allows participants to remain in their communities with their families while still receiving the level of care they require. The first decade of PACE proved to be a success in offering comprehensive medical care and the federal government recognized the model by issuing waivers funding ten new sites across the country, an act that marked the beginning of a wave of new PACE sites opening soon afterwards.[16]

To be eligible for PACE, an individual must be 55 years of age or older, live in the service area of a PACE organization, be eligible for nursing home care, and be able to live safely in the community. PACE is considered a Medicaid option, so a potential participant also has to disenroll from other Medicaid services to enroll in PACE. Once enrolled in PACE, the participant no longer sees their former primary care and other providers in exchange for a care coordination team that handles all aspects of their medical care and long-term services and supports. Through this care coordination, the PACE program features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs. The PACE organization finances these services by collecting capitation payments (monthly payments of a set amount) from the federal government (Medicare) and the

[16] Hirth, Baskins, and Dever-Bumba, "Program of All-Inclusive Care (PACE): Past, Present, and Future."

state (Medicaid). Medical services that participants require beyond those rates are the fiscal responsibility of the PACE organization. In this way, the PACE program is unique in that it takes the role of both the insurer *and* the provider.[17]

Proponents of PACE often cite cost-effectiveness and improved health outcomes as the core benefits offered by the model. Requiring PACE provider sites to take on all the medical responsibility of its patients provides an incentive to deliver preventative care in an effort to avoid costly conditions down the road, thus improving health outcomes *and* keeping costs down.

Patient Outcomes

Literature exploring health outcomes find that the PACE model helps to improve mood and functional outcomes, though the data is mixed on whether it improves mortality and survival rates. The PACE staffing model including a care coordination team was associated with better short-term functional outcomes and self-assessed health outcomes[18] and the overall structure of a PACE site in Missouri was associated with a significant improvement in mood and reduction in depression for PACE enrollees after nine months in the program.[19]

A comprehensive study performed in 1998 by the Center for Medicare & Medicaid Services (CMS) found that the PACE program, compared to an alternative community-based model, led to more attendance at a day health center, lower hospital and nursing home admissions, shorter hospital stays, more ambulatory visits (likely attributable to the fact that these are covered under the capitation rate), increased probability of survival, and overall self-reported higher quality of health status, life, and satisfaction.[20]

A more recent, more comprehensive literature review requested by the U.S. Department of Health and Human Services and several related federal organizations examined some of the strongest studies on PACE outcomes over the years and showed mixed results. While most demonstrated fewer hospitalizations for PACE participants, there were a handful of studies that showed otherwise. The data were mixed on nursing home admissions, with PACE often being associated with higher admission levels but shorter stays overall. Despite the mixed results, the literature does appear to show a consistent trend of the PACE model leading to better health outcomes than traditional fee-for-service care.[21]

Cost-Effectiveness

The cost-effectiveness of the PACE program relative to the fee-for-service model is a point of comparison often studied in the literature. Early studies of the program found that PACE led to savings for both Medicare and Medicaid, with costs 16 to 38 percent lower for the federal government[22] and 5 to 15 percent lower for states over traditional fee-for-service care.[23] A more

[17] Center for Medicare & Medicaid Services, "Programs of All-Inclusive Care for the Elderly (PACE) Manual."
[18] Mukamel et al., "Program Characteristics and Enrollees' Outcomes."
[19] Vouri et al., "Changes in Mood in New Enrollees."
[20] Chatterji et al., "Evaluation of the Program of All-Inclusive Care for the Elderly (PACE) Demonstration."
[21] Ghosh, Orfield, and Schmitz, "Evaluating PACE: A Review of the Literature."
[22] White, "The Effect of PACE on Costs to Medicare."

recent study directly comparing PACE to fee-for-service long-term care found that average long-term costs for a PACE enrollee over one year were $27,648, 28 percent below the lower limit of similar Medicaid fee-for-service long-term care costs of $36,620.[24] While these numbers seem promising, more research is required to see just how affordable PACE is compared to fee-for-service care because the majority of the studies in the more recent comprehensive literature review cited earlier show that PACE is actually *more* expensive than projected fee-for-service Medicaid payments (with a few outliers), and there was no consensus on cost savings for Medicare, with studies showing that PACE payments were less, equal to, and greater than projected Medicare payments.[25]

Overview of STAR+PLUS Home and Community Based Services Waiver

All of these studies compare the cost-effectiveness of the PACE program to fee-for-service models, which may no longer be applicable with the changes Texas recently made to its Medicaid offerings. As of September 2015, Texas began offering a new iteration of the STAR+PLUS Home and Community Based Services (HCBS) waiver, a program that serves the same population as PACE with similar medical and LTSS benefits through a capitated Medicaid payment model. In this report, we will be focusing on the STAR+PLUS HCBS waiver population that is eligible for both Medicare and Medicaid and who are nursing-home-eligible but choose to remain in the community. A small number of dual-eligible enrollees will be between the ages 21-64 because receiving Social Security disability insurance makes an individual eligible for Medicare, but the majority of the population that the HCBS waiver serves closely mirrors the population that the PACE program serves.

STAR+PLUS HCBS offers similar service benefits as the PACE program (excluding non-medical transportation but including bonus features like pest extermination and home remodeling among others), but unlike the PACE program it functions solely as an insurer. The STAR+PLUS program contracts with managed care organizations in each of its counties who offer remote medical service coordination to enrollees, ensuring that each member gets the care he or she needs without having to come into a care facility each day. These managed care organizations receive the capitated payment rate and take on the risk associated with the participants, then they contract out with providers whom they pay a contracted fee-for-service rate. Any funds from the capitation payment that remain each month stay with the managed care organization who can treat them as revenue or as funds to pay for medical services a participant needs after their capitation payment has been spent. Through this payment methodology, STAR+PLUS HCBS is able to deliver long-term services and supports through the Medicaid capitation payments while coordinating with Medicare to provide acute care under the fee-for-service models, ultimately creating care plans for enrollees and arranging for them to receive care while remaining in their communities.[26]

At first look, STAR+PLUS HCBS appears to be a middle ground incorporating capitation payments and extensive benefits lists like PACE without the drawbacks. Participants often

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[23] Bodenheimer, "Long-Term Care for Frail Elderly People—The On Lok Model."
[24] Wieland et al., "Does Medicaid Pay More."
[25] Ghosh, Orfield, and Schmitz, "Evaluating PACE: A Review of the Literature."
[26] Texas Health and Human Services Commission, "Overview of STAR PLUS."

complain that the PACE program 1) reduces physician choice by forcing participants to abandon their former providers in favor of PACE providers when they enroll,[27] and 2) reduces individual freedoms by requiring that participants frequent the adult day center when they may prefer to receive care in other environments.[28] PACE administrators lament the challenges associated with combining the role of insurer and provider.[29] STAR+PLUS uses remote service coordination rather than an on-site team. A service coordinator works with a participant's providers, helps to arrange appointments, and sets up medical transportation. This allows participants to continue seeing their original providers and remain in the comfort of their own homes when medical care is not required (contrary to PACE, which requires daily attendance at an adult day health center regardless of their appointment schedules). While this may be more convenient for the participant, this also defers more responsibility onto the enrollees to be responsive and direct their own care, which can place a burden on participants and their caregivers.

Patient Outcomes

There are few formal studies assessing the outcomes and cost-effectiveness of the STAR+PLUS HCBS program. A study published in 2015 comparing the outcomes for adults with disabilities enrolled in the Texas STAR+PLUS HCBS Medicaid Only program compared to the traditional fee-for-service model found that HCBS demonstrated "large and sustained improvements in care following both heart attack and COPD exacerbation" but there were no noticeable differences for other conditions like diabetes, asthma, or high cholesterol.[30] Another study of an early iteration of the STAR+PLUS program found that enrollees had higher rates of personal care and utilization of adult day health services as well as lower hospitalizations and emergency room visits.[31]

Cost-Effectiveness

We can attempt to compensate for the dearth in STAR+PLUS HCBS-specific literature on cost-effectiveness by examining the effects of Medicaid managed care programs across the United States. When the Robert Wood Johnson Foundation, an early investor in the PACE program, conducted a literature review examining the outcomes in programs nationwide, they found that there were no consistent cost savings for the state through the utilization of capitation payments and that there were mixed results regarding improved patient access to care. States that did see savings were states that had traditionally high reimbursement rates under fee-for-service plans, which suggests that states who have negotiated lower reimbursement rates have less to gain from adopting capitated payments. Studies that showed improved access to care also appeared to be state-specific, suggesting that patient outcomes depend more on program policy than payment model.[32]

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[27] Poku, "The Program of All-Inclusive Care for the Elderly Model."
[28] Hirth, Baskins, and Dever-Bumba, "Program of All-Inclusive Care (PACE): Past, Present, and Future."
[29] Sloane et al., "Challenges to Cost-Effective Care of Older Adults with Multiple Chronic Conditions."
[30] Wegman et al., "Quality of Care for Chronic Conditions Among Disabled Medicaid Enrollees."
[31] Grabowski and Bramson, "State Initiatives to Integrate the Medicare and Medicaid Programs."
[32] Sparer, "Medicaid Managed Care: Costs, Access, and Quality of Care."

The bifurcated nature of the STAR+PLUS HCBS program (with Medicare taking on the costs for acute care and Medicaid covering long-term services and supports) can lead to issues of accountability. Each program has an incentive to minimize its own expenses and has no innate responsibility to take responsibility for quality of care.[33] The introduction of a service coordination team into the most recent iteration of STAR+PLUS aims to bridge that divide, but studies have not been performed to determine care quality and there have been concerns about inconsistent monitoring.[34] The payment model is one of the core differences between the PACE program and STAR+PLUS HCBS. In the PACE program, where the insurer also functions as the provider, the site receives capitation payments from *both* Medicaid and Medicare, removing the incentive to push costs onto an outside party (like Medicaid MCOs could be compelled to do with Medicare) and introducing an incentive to take an active role in case management. Indeed, evidence has suggested that care is provided more frequently in fully capitated health care delivery models compared to fee-for-service payments.[35] STAR+PLUS HCBS splits the difference, with Medicare functioning as a fee-for-service insurer and Medicaid covering most long-term services through a capitation rate, and then covering other services (like prolonged nursing facility stays) and whatever is left as patient responsibility for Medicare services (such as through co-pays and deductibles) outside of the set payment rate.

Overview of the STAR+PLUS Dual Demonstration Project

STAR+PLUS HCBS is the current default option for most members of the dual-eligible, nursing-home-eligible population in Texas because the PACE program is available in very few counties in Texas. The Texas Health and Human Services Commission (HHSC) is piloting a new, innovative care model that could potentially solve the issue of cost-shifting between Medicare and Medicaid. In April 2015, they rolled out the dual demonstration Medicare-Medicaid plan in six demonstration counties. In this plan, *both* Medicare and Medicaid pay capitation payments to managed care organizations with service coordinators similar to the STAR+PLUS HCBS program. The objectives of this new payment model are to "make it easier for clients to get care, promote independence in the community, eliminate cost shifting between Medicare and Medicaid, [and] achieve cost savings for the state and federal government through improvements in care and coordination."[36]

The dual demonstration also serves the same nursing-home-eligible population as PACE and the HCBS waiver, with the caveat that PACE offers services to those 55 and over, allowing the rare person in who is not dual-eligible but willing to pay the difference. (STAR+PLUS HCBS dual-eligible and the dual demonstration provide services to everyone who is dual-eligible over the age of 21, but Medicare utilization prior to age 65 is uncommon.) We included the HCBS waiver in our study because it is the closest program resembling PACE offered by the state of Texas in Travis County, but the dual demonstration project is more similar to PACE overall.

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[33] Grabowski and Bramson, "State Initiatives to Integrate the Medicare and Medicaid Programs."

[34] Wegman et al., "Quality of Care for Chronic Conditions Among Disabled Medicaid Enrollees."

[35] Quast, Sappington, and Shenkman, "Does the quality of care in Medicaid MCOs vary with the form of physician compensation?"

[36] Texas Health and Human Services Commission, "State of Texas Medicaid Managed Care Rate Setting Dual Eligibles Integrated Care Demonstration Project."

Patient Outcomes and Cost Effectiveness

The dual demonstration project in Texas is too new to have any published outcomes, but we can look to other states that have done something similar to get a feel for what it could potentially offer. Minnesota launched the Minnesota Senior Health Options (MSHO) in 1997 in an attempt to provide acute and long-term care to their vulnerable elderly population under a combined Medicaid/Medicare capitated payment model. An outcomes study found that community-based MSHO enrollees were more likely to receive preventative care, had fewer preventable emergency room visits, and received more therapy services and fewer diagnostic tests (such as X-rays and MRIs), but other statistics on utilization appeared to be similar to those in the control out-group. From a costs perspective, the capitation rates were significantly higher than fee-for-service.[37] A study that Washington performed on the state's version of the dual demonstration project found a decrease in per member, per month Medicare spending and suggested that the program is improving access to care and Medicaid costs, though it was too early in the program's lifespan to say so conclusively.[38]

Although it may be tempting to apply these results to the Texas dual demonstration, it is important to remember the lessons learned from the Robert Wood Johnson systematic literature review. Changes in access to care and cost savings are often very state- and program-dependent, so it is difficult to draw conclusions from studies like these without either 1) studying the state of interest, in this case Texas, or 2) studying multiple states with a similar model. We include this study to demonstrate what the dual demonstration project in Texas could do, not necessarily what it will do.

How Our Research Fits into the Literature

There are many studies comparing comprehensive care models with capitation payments to fee-for-service care, however there is a huge lack of information comparing comprehensive managed care models to each other. Our research aims at getting to the core of the pros, cons, and general differences of the options available in Texas. To do this, we analyze cost-effectiveness from multiple perspectives (state, federal, and provider) in addition to determining patient outcomes and access to services to assess which option is strongest from both a financial and quality-of-care standpoint. From a patient perspective, we expand on the literature that focuses on health outcomes by also measuring patient satisfaction—an element of care that is often overlooked. Finally, we performed qualitative research at On Lok in San Francisco, a successful PACE site, to see what elements of co-located comprehensive care could be a good fit for Austin. At the close of the study, we bring the research home and describe what a comprehensive care model best suited for Austin could look like.

The next few chapters give detailed accounts of our research on each of the programs and their differences, which can sometimes be subtle. Table 2.1 is a brief summary outlining some of the basic differences between the programs studied in this report.

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[37] Kane and Homyak, "Multi State Evaluation of Dual Eligibles Demonstration."

[38] Walsh et al., "Measurement, Monitoring, and Evaluation of the Financial Alignment Initiative of Medicare-Medicaid Enrollees."

Table 2.1. Comparison of Community Care Programs for Dual-Eligible Beneficiaries

	Program for All-Inclusive Care for the Elderly (PACE)	STAR+PLUS HCBS Waiver for Dual Eligibles	STAR+PLUS Dual Demonstration Project
Brief Description	A comprehensive care model that offers daily mandatory on-site care with a coordinated service team. The site takes on the full financial risk of their enrollees' medical care and each site has a cap on the number of enrollees they can take on.	The current Medicaid option for low-income, high-risk individuals. STAR+PLUS offers service coordination, value-added benefits, and community-based services. This differs from PACE in that it does not have a single site where it offers care.	A dual demonstration project being launched in six Texas counties. The dual demonstration offers the same services as HCBS, but it has capitation payments from *both* Medicaid and Medicare, similar to PACE.
Payment Model	Includes capitation payments from both Medicaid and Medicare; PACE provider responsible for services required over capitation limits.	Capitation payment from Medicaid, FFS from Medicare, with Medicaid stepping in to pay its portion of cost-sharing for acute services—a cost that is *not* included in the capitation rate. The contracted MCO (not the state) takes responsibility for services over capitation limits.	Capitation payments from both Medicaid and Medicare. The contracted MCO takes responsibility for services required over capitation limits.
Enrollment Limit	Slot System	None	None
Level of Care Requirement	Nursing home eligible	Nursing home eligible	Aged or disabled
Nursing Facility Integration	Included in the capitation rate	Separate risk rate	Separate risk rate
Licensing	Provider-Based (not a licensed insurance company)	Insurance company	Insurance company
Non-Medical Transportation	Covered	Not included	Not included
Current Status	There are PACE sites in Amarillo/Canyon, El Paso and Lubbock.	STAR+PLUS HCBS is offered statewide to any dual-eligible individual who medically qualifies.	The dual demonstration has been launched in Bexar, Dallas, El Paso, Harris, Hidalgo ,and Tarrant Counties..
Challenges to Expansion	Significant startup cost to provider, financial risk to provider that is made worse by uncertain enrollee caps, legislative barriers.	STAR+PLUS HCBS is already statewide.	A new program that could or could not be expanded based on decisions by the legislature. Currently, there are no plans to expand.

Source: Butler, Rachel, and William Warburton. Texas Health and Human Services Commission. Presentation at the LBJ School, October 20, 2015.

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Chapter 3.
Cost Analysis of Managed Long-Term Services and Supports

Introduction

The Texas PACE program was established as a cost effective alternative to the Medicaid fee-for-service system for eligible Medicaid participants who live in PACE service areas and require long-term care services. With the implementation of the STAR+PLUS managed care program, the fee-for-service model has been slowly phased out over the last three years. STAR+PLUS, which became available statewide on September 1, 2014, has replaced fee-for-service and integrated the delivery of acute care and long-term services and support for Texas Medicaid clients.

Prior to the advent of STAR+PLUS, PACE Medicaid rates were set at an amount less than the cost of providing services to a comparable population in the Medicaid fee-for-service system, but not managed care. This change in the service management and delivery of Texas Medicaid has prompted questions as to whether PACE remains a cost-effective or even cost-neutral program for Medicaid participants compared to STAR+PLUS managed care. These questions have led to a closer examination of the payment methodology between the two programs and their respective total costs for providing care to like populations.

The objective of our analysis is to identify how options in community-based long-term care can be employed to improve long-term care services and support to frail, older residents in need in Travis County. To meet this objective, we first analyze the rate methodology for PACE, STAR+PLUS, and the STAR+PLUS Dual Demonstration, the three Medicaid options available for older county residents who are both dual-eligible and nursing-home-eligible, to understand the costs of each option to the state. We then analyze costs to the federal agency responsible for administering Medicare, the Center for Medicare & Medicaid Services, and, to the extent possible benefits. Lastly, we consider the costs of PACE providers during startup and ongoing operations and the benefits of each program from the participant's perspective. The first two perspectives provide a more complete cost analysis of PACE at both the federal and state level. The last two perspectives further our understanding of the full costs and benefits of these programs to providers and participants.

For our report, we obtained data on startup costs, operating income, capitated rates, and participant surveys from the National Pace Association. We obtained supplementary data on capitated payments and program characteristics from Texas Health and Human Services. To perform the cost-benefit-analysis between PACE and STAR+PLUS from the state perspective, we relied primarily on report data from the Texas Legislative Budget Board and rate methodology and actuarial data from Texas Health and Human Services and the Center for Medicare & Medicaid Services.

Our analysis was limited by the unavailability of certain data. The lack of per member per month STAR+PLUS costs disaggregated by enrollee subgroups made it difficult for us to directly

compare program costs for similar participants. The lack of complete revenue and expenditure data for the Texas PACE sites limited our ability to assess cost and income trends over multiple periods. Further, because we were unable to obtain comparable health outcomes data for STAR+PLUS and PACE in Texas, we could not fully incorporate the benefits of improved health outcomes in a cost-benefit analysis. Finally, since we lacked comparable participant satisfaction data for STAR+PLUS and PACE, we drew on previous literature to fill in gaps for our comparison.

Methodology

PACE Medicaid Rates

This section provides a description of the methodology that CMS follows in determining the amount of payment PACE organizations receive for coverage benefits for participants enrolled in their plan. Describing the payment methodology for PACE, we provide a fundamental overview of the different elements involved in capitated payments that are contained in Chapter 13, "Payments to PACE Organizations," of the CMS PACE manual (see Appendix A).

The following characteristics distinguish the PACE funding model:

- Obligation for payments is shared by Medicare, Medicaid, and individuals who do not participate in Medicare and Medicaid;
- Medicare, Medicaid, and private payments for acute, long term-care, and other services are pooled;
- The capitation rates paid by Medicaid are designed to result in cost savings relative to expenditures that would otherwise be paid for a comparable nursing facility-eligible population not enrolled under the PACE program;
- Medicare rates are pre-Affordable Care Act (ACA) rates, unadjusted for Indirect Medical Education, and adjusted for risk and frailty;
- The PACE organization accepts the capitation payment amounts as payment in full from Medicare and Medicaid.[39]

Capitated payments are paid monthly for each eligible participant enrolled in PACE. Before processing payments, a PACE organization must 1) verify at the time of enrollment whether the participant is dually eligible for Medicare and Medicaid and whether the participant has Medicare Part A and/or Part B, 2) submit risk adjustment and encounter data to CMS, 3) identify payers that are primary to Medicare and determine the amounts payable by each, and 4) coordinate benefits to Medicare participants with the benefits of primary payers.

[39] Center for Medicare & Medicaid Services, "Programs of All-Inclusive Care for the Elderly (PACE) Manual, Chapter 13."

PACE Medicaid rates are set biennially by the Texas Health and Human Services Commission (HHSC). Federal Regulations specify that each state must set a prospective monthly capitation rate that meets the following requirements:

- Must be less than the amount that would otherwise have been paid in the state plan if the participants were not enrolled in the PACE program.
- Must take into account the comparative frailty of the PACE participant.
- Must be a fixed amount regardless of changes in the participant's health status during the contract period.
- Can be redetermined on an annual basis.[40]

CMS created an Upper Payment Limit (UPL) approach to Medicaid rate setting to ensure that Medicaid rates comply with federal regulations. The UPL is the estimated amount that Medicaid would have paid for a comparable population in the fee-for-service system and is only a few percentage points higher than the actual capitated amount that Medicaid will pay the PACE organization on a per-member, per-month basis.

Setting the UPL and setting the rate that a PACE organization receives are separate processes. There are two approaches that the state administering agency can use. The first approach is to rely on the UPL to set the rate. Under this method, the UPL represents the estimated costs of serving a comparable fee-for-service population in a fee-for-service setting. When using this approach, the PACE rate is set as a percentage of the corresponding UPL. HHSC uses this method to arrive at its final capitated rate for PACE, however, due to the recent expansion of STAR+PLUS, the proposed payments for fiscal years 2016 and 2017 also incorporate data from managed care systems of the Texas Medicaid program along with fee-for-service data. With the expansion of STAR+PLUS it has become difficult to utilize the fee-for-service comparison groups as more people are served under the managed long-term care model. The table below shows the capitated rates developed for the Texas PACE sites since 2008.

[40] National PACE Association, "PACE Medicaid Rate-Setting: Issues and Considerations for States and PACE Organizations," 4.

Table 3.1. PACE Medicaid Capitation Rate Trend: Texas Sites

State Fiscal Year	PACE Organization	Dual Eligible	Annual Percent Increase	Medicaid-only	Annual Percent Increase
2008	Bienvivir Senior Health Services	$ 2,771.78		$ 3,728.81	
2008	The Basics at Jan Werner	$ 2,266.41		$ 3,393.90	
2009	Bienvivir Senior Health Services	$ 2,771.78	0.0%	$ 3,728.81	0.0%
2009	The Basics at Jan Werner	$ 2,266.41	0.0%	$ 3,393.90	0.0%
2010	Bienvivir Senior Health Services	$ 2,418.00	-12.7%	$ 3,042.00	-18.4%
2010	The Basics at Jan Werner	$ 2,415.81	6.6%	$ 3,204.94	-5.6%
2011	Bienvivir Senior Health Services	$ 2,955.03	22.2%	$ 3,941.51	29.6%
2011	The Basics at Jan Werner	$ 2,415.81	0.0%	$ 3,204.94	0.0%
2011	Silver Star PACE	$ 2,180.28	-	$ 3,234.68	-
2012	Bienvivir Senior Health Services	$ 2,865.00	-3.0%	$ 4,296.00	9.0%
2012	The Basics at Jan Werner	$ 2,294.66	-5.0%	$ 4,188.61	30.7%
2012	Silver Star PACE	$ 2,293.98	5.2%	$ 3,183.79	-1.6%
2014	Bienvivir Senior Health Services	$ 2,853.55	-0.4%	$ 4,323.23	0.6%
2014	The Basics at Jan Werner	$ 2,300.03	0.3%	$ 3,576.76	-14.6%
2014	Silver Star PACE	$ 2,389.89	4%	$ 4,673.18	46.8%
2015	Bienvivir Senior Health Services	$ 2,853.55	0.0%	$ 4,323.23	0.0%
2015	The Basics at Jan Werner	$ 2,300.03	0.0%	$ 3,576.76	0.0%
2015	Silver Star PACE	$ 2,389.89	0.0%	$ 4,673.18	0.0%

Source: National PACE Association. "PACE Medicaid Rate-Setting: Issues and Considerations for States and PACE Organizations." May 2009, 4. Accessed March 2, 2016. http://www.npaonline.org/sites/default/files/uploads/Medicaid%20Rate%20Setting%20Publication.pdf..

We observe positive and negative fluctuations when comparing year-over-year capitated rates for both the dual-eligible and Medicaid-only populations. Although rates are set biennially for PACE, annual adjustments may have been made after the transition from a strictly fee-for-service benchmark to a blended benchmark, incorporating both fee-for-service and managed care cost data. It should be noted that PACE capitation payments represent a premium paid to PACE that accounts for 1) the cost of home and community based services and 2) nursing facility care for each participant. However, although separate rates are derived for each, they are blended together to arrive at a final capitated rate.

Under the second approach an actuarial rate is developed that estimates the cost of operating a PACE organization and is independent of the UPL. The state calculates the PACE rate based on the estimated costs of operating a PACE organization using expected risks and costs of providing care and taking the frailty of the underlying population served into account. Additionally, a margin to develop risk reserves and a managed care efficiency factor are applied before the final rate is determined. Once the final rate is calculated, it is then compared to the UPL to ensure it is less than the CMS limit.

STAR+PLUS Medicaid Rates

For our analysis of STAR+PLUS, we examine the STAR+PLUS Home and Community-Based Services (HCBS) and the STAR+PLUS Nursing Facility rate methodology. In our discussion of the rate methodology, it should be noted that we describe the factors associated with the creation of the base rate for the above-mentioned programs. There are various nuances associated with each respective program (e.g. STAR+PLUS HCBS for dual-eligible enrollees vs. STAR+PLUS HCBS Dual Demo and STAR+PLUS NF vs. STAR+PLUS NF Dual Demo), however, as regards the base rates for each, the methodology involved is the same.

We reference the actuarial analyses conducted by Rudd and Wisdom, Inc., and prepared for the Texas Health and Human Services Commission on June 26, 2015, titled "State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting," "State of Texas Medicaid Managed Care Rate Setting Dual Eligibles Integrated Care Demonstration Project," and "State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting Nursing Facility Carve-In."

Prior to their analyses, Rudd and Wisdom, Inc., gathered data from the following sources: HHSC, its subcontractors, participating Managed Care Organizations (MCOs) and their Pharmacy Benefit Managers (PBMs), and CMS. For HCBS, MCO encounter data serve as the primary data source for rate development. For nursing facility premiums, the primary source is fee-for-service claims data.

To derive the State Fiscal Year (SFY) 2016 premium rates for STAR+PLUS HCBS, the actuarial model used by Rudd and Wisdom relies primarily on health plan financial experience. SFY 2014 historical claims experience data for each health plan by area were analyzed to develop base rates. Base rates were then modified using trend rates and adjusted to account for other plan expenditures such as service coordination, reinsurance, and administrative expenses to derive the 2016 rate.

Prior to March 1, 2015, nursing facility residents and their expenses were carved out from STAR+PLUS and paid on a fee-for-service basis. The model used to develop SFY 2016 STAR+PLUS Nursing Facility rates is similar to that for STAR+PLUS HCBS. Historical claims experience data, primarily fee-for-service, is aggregated from each service area for the period November 2013 to October 2014 and projected forward to SFY 2016 using trend techniques and adjustments mentioned above.

Table 3.2 summarizes capitated rates for SFYs 2015 and 2016 for Medicaid-only and dual-eligible participants receiving HCBS through STAR+PLUS. Amerigroup and Molina are the two STAR+PLUS health plans operating in El Paso county and Lubbock county. We highlight El Paso and Lubbock because they are coincident with Texas PACE service areas. We observe rather large decreases in the Medicaid-only premiums from 2015 to 2016, with less pronounced reductions in the dual eligible premiums.

Table 3.2. STAR+PLUS Medicaid Capitation Rates

Total Premium Rates PMPM	FY 2016 Medicaid-Only HCBS	FY 2016 Dual-Eligible HCBS	FY 2015 Medicaid-Only HCBS	FY 2015 Dual-Eligible HCBS
El Paso – Amerigroup	$3946.69	$1921.98	$5088.72	$1997.81
El Paso – Molina	$3911.65	$1921.98	$4775.31	$1997.81
Lubbock – Amerigroup	$3150.30	$1271.21	$3393.68	$1315.79
Lubbock – Superior	$3395.46	$1271.21	$3504.86	$1315.79

Source: Texas Health and Human Services Commission. "State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting, State Fiscal Year 2016," by Evan L. Dial, Rudd and Wisdom. Austin, Tex., June 2015.

The actuarial model used to set the Medicaid portion of the dual demonstration rates for the rating period (SFY 2016) was based on a projection of dual-eligible cost under fee-for-service. STAR+PLUS is offered statewide, giving participants the option to select from at least two health plans in each service delivery area. The STAR+PLUS Dual Demonstration is offered in the following six Texas counties: Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant.

STAR+PLUS rates are developed and adjusted according to geographic region, risk group, and dual status. When determining the base rate, all MCOs start with the same overall community rate and then adjustments are made to reflect relative acute health status of an MCO's actual membership. For example, provider reimbursement adjustments for acute care services are calculated by applying actual health plan encounter data to the old and new reimbursement basis. The MCOs encounter data serve as the primary data source for rate development (HCBS premium). Rates include provisions for acute care, long-term care, and pharmacy with additional components included for administrative expenses, taxes, and risk margin.

Analysis

The counties where STAR+PLUS and PACE are coincident are El Paso, Lubbock, Potter, and Randall. The county where the STAR+PLUS Dual Demonstration and PACE are coincident is El Paso. We note that the data used to derive the capitated rates for PACE and the Dual Demonstration differ because the Dual Demonstration accepts participants from age 21, while PACE requires that its participants be 55 or older. Differences under the two programs include administrative loads, trending methods, rounding, and adjustments.[41]

The cost differentials between PACE and STAR+PLUS and the STAR+PLUS Dual Demonstration can be broken down into three categories: benefit differences, member differences, and program differences.[42]

[41] Butler and Warburton, Presentation at the LBJ School.
[42] Ibid.

Benefit differences. STAR+PLUS does not cover coinsurance, deductibles, wrap services, or transportation. PACE covers each of these benefits and the Dual Demonstration covers all but transportation. PACE covers both nursing facility care and also care for its members in a community-based setting through a "blended" monthly capitation rate. STAR+PLUS also covers nursing facility care, but receives a separate capitated rate for its participating members.

Member differences. The member populations between the programs also differ. PACE members must be 55 years of age or older, whereas STAR+PLUS has varying age requirements and members in the Dual Demonstration may be 21 years of age or older.

Program differences. STAR+PLUS and the Dual Demonstration are administered through contracted licensed insurance entities with state administrative filing requirements. PACE providers do not carry the same administrative requirements under the state because they are not licensed by the state insurance department. However, due to their greater size, the STAR+PLUS plans exercise greater economies of scale and contracting leverage with participating medical providers than do PACE operators. PACE sites also maintain economies because they are situated in one or more centralized locations.[43] This characteristic allows PACE participants daily access to the center for Day Activity Health Services (DAHS), to be cared for by physicians and other medical staff who can see multiple patients quickly and frequently.

Conclusion

Our objective was to compare both HCBS and Nursing Facility capitated rates between PACE and STAR+PLUS. For this purpose, we procured actuarial data for PACE and STAR+PLUS from Texas HHSC in order to analyze capitated payments. We gathered financial data from Bienvivir and Star Care Specialty Health System for the purpose of analyzing PACE revenues and operating expenditures. Finally, we obtained average per member per month revenue and cost figures and historical capitated payment data from the National PACE Association.

Although the actuarial data obtained from Texas HHSC on PACE and STAR+PLUS allowed us to establish context for comparing each program's respective rates, the intricacies involved in the data collection and distillation for both programs presents tremendous obstacles for arriving at a clear comparison. The various sub layers of data for each element (e.g. encounter claims, including fee-for-service and managed care data for PACE vs. STAR+PLUS) involved in rate development presents challenges for arriving at a definitive conclusion as to whether PACE or STAR+PLUS is more cost-effective. To bring a higher level of clarity to our analysis, we undertake a cost-benefit review of PACE and STAR+PLUS from four distinct perspectives that elucidates characteristics of comparability and examines fiscal impact, program development and operation, and patient satisfaction.

Four Perspectives

This section analyzes the costs and benefits of each of the three program from four different points of view: 1) the state perspective, 2) the provider perspective, 3) the perspective of program participants, and 4) the federal perspective.

[43] Ibid.

1. State Perspective

From the perspective of the state, STAR+PLUS and PACE must be fiscally efficient and produce positive and measurable health outcomes for participants. It follows that if two programs offer similar and in some cases near identical services, the state will proceed to make a determination as to which better meets its primary objectives—fiscal efficiency and positive and measureable health outcomes. In this section, we review the primary elements involved in making such a determination.

The "Texas State Government Effectiveness and Efficiency Report," submitted to the 84th Texas Legislature in January 2015, and prepared by the Legislative Budget Board (LBB), outlines important distinctions between the rate development for STAR+PLUS and PACE. Although the objective of our analysis is not to affirm the conclusions of the report, we nevertheless consider its findings relevant to our review. In sum, the report suggests that rates developed for PACE are not cost-neutral when compared to STAR+PLUS and therefore it is unclear whether or not PACE is cost-effective in its use of Medicaid relative to STAR+PLUS. We used the LBB's fiscal analysis as the basis for our review of costs to the state under STAR+PLUS and PACE. The three primary assertions by the LBB are the following:

- The Texas Medicaid rate-setting process for PACE is not structured to ensure it is cost-neutral to serve an individual in PACE instead of STAR+PLUS.

- Current data maintained by the Texas Health and Human Services Commission and the Department of Aging and Disability Services is not congruent between STAR+PLUS and PACE and therefore does not suffice for comparing Medicaid client outcomes.

- If the Health and Human Services Commission cannot ensure it is cost-neutral to serve an individual in PACE instead of STAR+PLUS, and that PACE Medicaid rates are appropriate for its cost structure, the PACE model in Texas may not provide a cost-neutral long-term care option for Texas Medicaid clients.[44]

The analysis done by the LBB serves to define the elemental concerns posed by the state in its determination of a program of best fit for serving Texas participants receiving HCBS and nursing facility care. In addition, its assertions comport with the difficulties we experienced in our analysis and comparison of the programmatic and rate methodology differences between STAR+PLUS and PACE.

Analysis

Regarding the first concern, the LBB states that historical fee-for-service data for certain Medicaid clients, instead of data for clients enrolled in STAR+PLUS, are used to develop the upper payment limit component of the PACE rate-setting process. This is true. However, to further clarify, for SFYs 2016-2017, the rate-setting process utilized a mixture of fee-for-service and managed care data to derive the UPL. Specifically, Texas HHSC uses fiscal year 2013 fee-for-service claims data for participants receiving nursing facility services and managed care data

[44] Legislative Budget Board, "Texas State Government Effectiveness and Efficiency Report."

for participants receiving home and community-based waiver like services in STAR+PLUS to calculate PACE UPLs. Because some managed care data was used, a two-percent reduction factor was applied instead of a five-percent reduction factor to account for the inherent reduction in cost embodied in the managed care claims data. Due to the blended structure of this method, it is difficult to determine whether or not PACE rates are cost effective, cost neutral, or cost imposing compared to STAR+PLUS rates for the same demographic.

Regarding the second and third concerns, to conduct a meaningful analysis between PACE and STAR+PLUS, it is necessary for HHSC and the Department of Aging and Disability Services (DADS) to produce an evaluation that compares like participants across both models and controls for geographic differences. Under the existing framework, PACE rates are composed of a blend of HCBS and nursing facility costs for Medicaid-only and dual-eligible participants. In contrast, separate capitations rates exist for the STAR+PLUS dual-eligibles, STAR+PLUS dual demonstration, and STAR+PLUS Nursing Facility participant populations. In sum, as regards capitation payments, risk groups under STAR+PLUS are apportioned accordingly between HCBS and nursing facility services as opposed to PACE where they are united in a common risk group.

The LBB attempts to address this dilemma in its 2015 report by estimating costs for STAR+PLUS participants who could have been served in PACE and then comparing the costs side by side to the amount actually spent serving those participants in STAR+PLUS.[45] The cost analysis reveals a $1.1 billion savings by applying the lowest PACE capitation rate to the number of member months for PACE eligible participants served in STAR+PLUS. Conversely, if the highest PACE capitation rate is used, the analysis reveals a cost of $718.8 million to Texas Medicaid. It should be noted that the analysis considers a STAR+PLUS participant to be potentially eligible for PACE if they are age 55 and older and receive STAR+PLUS home and community-based waiver-like services. Although the LBB highlights the difficulty of quantifying costs and benefits when comparing PACE and STAR+PLUS, its cost analysis does not provide analytical validity for the reasons stated above.

The following tables compare side-by-side SFY 2016 STAR+PLUS and PACE rates for HCBS and nursing facility care. One can observe at first glance that PACE rates, when broken into their component parts, appear higher on average for home and community-based services but lower for nursing facility care than the corresponding STAR+PLUS rates. This example reflects only two counties due to the limited number of PACE sites in Texas. In terms of fiscal analysis, federal regulations specify that PACE Medicaid rates must be less than the amount that would otherwise have been paid under the Medicaid state plan. Because STAR+PLUS has effectively phased out fee-for-service, it is now the alternative option and the benchmark for PACE rate construction.

[45] Ibid., 222.

Table 3.3. SFY 2016 Capitation Rates Dual Eligible, Dual Demonstration, and PACE

	El Paso		Lubbock	
SFY 2016 Total Premium Rates PMPM	**HCBS**	**NF**	**HCBS**	**NF**
Dual Eligible	$1,921.98	$ 4,112.85	1,271.21	$3,561.89
Dual Demonstration	$2,106.30	$4,167.70	n/a	n/a
PACE (rate before blended with 2% reduction factor)	$2,022.95	$3,763.71	$1,441.83	$3,333.83

Source: Texas Health and Human Services Commission. "State of Texas Medicaid Managed Care Rate Setting, Dual Eligibles Integrated Care Demonstration Project, State Fiscal Year 2016," by David G. Wilkes, Rudd and Wisdom. Austin, Tex., June 2015.

Table 3.4. SFY 2016 Rates for Dual Eligibles, Texas Medicaid Plan

Service Delivery Area	Dual Eligibles HCBS	Nursing Facility Carve-In	Dual Demonstration (effective 1/1/16–8/31/16)	PACE
Bexar	$1,804.11	$4,600.70	$1,977.66	n/a
Dallas	$1,632.93	$4,747.04	$1,778.85	n/a
El Paso	$1,921.98	$4,113.85	$2,106.30	$2,834.74
Harris	$1,779.50	$4,386.62	$1,927.76	n/a
Hidalgo	$2,057.96	$4,973.78	$2,268.02	n/a
Jefferson	$1,525.30	$4,271.23	n/a	n/a
Lubbock	$1,271.21	$5,037.89	n/a	$2,600.93
Nueces	$1,671.77	$5,012.51	n/a	n/a
Tarrant	$1,552.46	$4,411.79	$1,709.27	n/a
Travis	$1,672.61	$4,593.97	n/a	n/a
MRSA Central	$1,608.21	$4,597.18	n/a	n/a
MRSA Northeast	$1,300.87	$4,186.50	n/a	n/a
MRSA West	$1,429.34	$4,893.93	n/a	n/a
Potter and Randall	n/a	n/a	n/a	$2,317.45

Sources: Texas Health and Human Services Commission (HHSC). "State of Texas Medicaid Managed Care Rate Setting, Dual Eligibles Integrated Care Demonstration Project, State Fiscal Year 2016," by David G. Wilkes, Rudd and Wisdom. Austin, Tex., June 2015; HHSC, "State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting, Nursing Facility Carve-In, State Fiscal Year 2016," by David G. Wilkes, Rudd and Wisdom. Austin, Tex., June 2015; and HHSC, "State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting, State Fiscal Year 2016," by Evan L. Dial, Rudd and Wisdom. Austin, Tex., June 2015. PACE data source: Butler, Rachel, and William Warburton. Texas Health and Human Services Commission. Presentation at the LBJ School, October 20, 2015.

Conclusion

As the LBB report implies, even after analyzing the nominal rates between PACE and STAR+PLUS, one must still observe client outcomes across each model in order to discern the relative effectiveness of each program. According to LBB, the current data maintained by Texas HHSC and DADS does not allow the state to compare Medicaid client outcomes across PACE

and STAR+PLUS.[46] Specifically, this dilemma appears when attempting to compare client experience, disenrollment and appeals, and hospital admissions and readmissions. Further, because the general populations in each program are not alike and the total number and type of rendered services differ, it is not possible to conclude with a relevant degree of certainty if PACE delivers its services at a lower cost or vice versa. As an example, STAR+PLUS serves disabled participants ages 21 to 55 in the HCBS waiver (and nursing facilities) who represent higher-cost populations. These severely disabled participants tend to drive rates up under STAR+PLUS.

While this analysis indicates that there are savings to the state for patients enrolled in PACE and STAR+PLUS when compared to fee-for-service delivery of Medicaid, it is not wholly clear which model is more cost-effective for future delivery of long-term services and supports. Due to statewide expansion of the STAR+PLUS managed care program, future PACE participant costs cannot be certified as less than the amount that would otherwise be paid under the Medicaid state plan (STAR+PLUS). To arrive at a true fiscal comparison between STAR+PLUS and PACE, it is necessary to measure all appropriate factors that differentiate program participants and services.

2. Provider Perspective

The provider perspective examines operational and startup costs for PACE. This includes per member per month revenue and cost data and estimated startup costs obtained from the National PACE Association.

Operating Costs

We analyze per member per month cost data to determine major operating and revenue sources. The National PACE Association conducts an annual survey of PACE programs and determines average per member per month revenues and expenses (see Table 3.5). In 2012, 37 programs were surveyed, where the average per member per month net income was $42.00. Based on the average census of the surveyed PACE sites, this amounts to a total annual net income of $201,600. For 2013 and 2014, average total annual income was $514,350 and $771,132, respectively.

Table 3.5. Average PACE Revenue and Operating Costs Per Member Per Month

Average Census	**359**		**381**		**400**
# of Programs	**76**		**64**		**37**
Year	**2014**	**Ann % Inc**	**2013**	**Ann % Inc**	**2012**
Total Revenue	$6,479.00	1%	$6,414.00	6%	$6,026.00
PACE – Medicare	$2,846.00	4%	$2,740.50	4%	$2,638.00
PACE – Medicaid	$3,332.00	-1%	$3,361.00	1%	$3,344.00
Pace – Other	$77.00	12%	$68.50	80%	$38.00
Other	$20.00	48%	$13.50	23%	$11.00
Total Expenses	$6,366.00	4%	$6,094.00	3%	$5,911.00
PACE Center (Subtotal Primary Care & Day Center	$871.00	-2%	$888.50	11%	$803.00

[46] Ibid., 224.

Primary Care	$497.00	-2%	$507.50	8%	$469.00
Day Center	$374.00	1%	$371.50	40%	$265.00
Community Primary Care	$0.00	-	$0.00	-	$0.00
Community Adult Day Care	$0.00	-	$0.00	-	$0.00
Social Services	$112.00	-3%	$115.00	2%	$113.00
Therapy	$186.00	0%	$186.50	10%	$169.00
Home Care	$496.00	-4%	$515.00	-22%	$661.00
Meals	$124.00	-4%	$129.50	16%	$112.00
Transportation	$371.00	-2%	$378.00	25%	$303.00
Outpatient Specialist	$330.00	6%	$312.50	30%	$241.00
Pharmacy	$643.00	9%	$588.50	3%	$570.00
DME and Supplies	$106.00	3%	$102.50	8%	$95.00
Labs and Diagnostics	$53.00	-9%	$58.50	3%	$57.00
Nursing Home	$483.00	-6%	$513.00	6%	$485.00
Hospital	$618.00	-4%	$641.50	5%	$608.50
Sub-Acute Rehabilitation	$0.00	-100%	$30.50	-	$0.00
Housing	$113.00	2%	$111.00	18%	$94.00
Administrative	$720.00	-3%	$740.50	8%	$686.00
Marketing	$54.00	-27%	$73.50	31%	$56.00
Insurance	$36.00	-3%	$37.00	-16%	$44.00
Depreciation	$83.00	-11%	$93.50	9%	$86.00
Facility	$196.00	-5%	$207.00	19%	$174.00
Other Expense	$9.00	-18%	$11.00	-	$0.00
Income (Loss) Operations	$179.00	59%	$112.50	168%	$42.00

Source: Gay, Alan. Director, Data Technology & Measurement Services, National PACE Association. Email message to author. February 16, 2016.

Startup Costs

The National PACE Association (NPA) outlines the primary elements included in planning, development and startup of PACE.[47] These elements include:

- Consulting;
- Acquisition of space for the PACE day center;
- Acquisition of equipment for the PACE day center;
- Vans;
- Working capital; and
- Solvency reserves.

As part of our analysis, we reviewed average estimates of low, medium, and high costs for the startup and development of a PACE program.

[47] National PACE Association, "PACE Program Development Considerations," 1.

Table 3.6. PACE Program Startup and Development Costs

Category	Low	Medium	High
Consulting Fees	Planning only: $100,000	Planning and provider application: $220,000	All phases, full time consulting during planning: $420,000
Organizational Assets	Lease and renovate existing building: $500,000		Purchase of building and renovation: $2,300,000
Equipment	Purchase mostly used and some new equipment: $130,000	Purchase mostly new and some used equipment: $200,000	Purchase new equipment: $250,000
Transportation	Contract for service (monthly fees replace need for upfront capital): $0	Contract for services initially; purchase vans after one year: $400,000	Purchase van fleet over two years to serve full enrollment: $500,000
Working Capital For Startup			
Pre-operational staffing	Staff assigned by sponsoring organization to do most of planning and pre-operational development: $80,000	Full-time manager supplemented with part-time team members: $400,000	Full staff hired for program during pre-operational development: $540,000
Losses While Growing Enrollment	Net enrollment growth of five per month: $500,000	Net enrollment growth of four per month: $600,000	Net enrollment growth of three per month: $800,000
Solvency Requirements	Line of credit from sponsoring organization	Cash reserves to ensure stability, with additional line of credit	Cash reserves needed to self-insure for risk
Total	**$1,510,000**	**$3,870,000**	**$5,560,000**

Source: National PACE Association. "PACE Program Development Considerations." Alexandria, VA, 2003.

Analysis

Operations. To model financial performance, PACE organizations focus on several primary factors. These include area demographics, enrollment expectations, service utilization rates, capitated rates, and estimates for operating costs including personnel, contract services, administrative, and debt service. The enrollment rate is generally expected to bring the PACE program to full capacity by the end of the second year after startup. The payer mix is roughly estimated at 90 percent dual-eligible (Medicare and Medicaid) and 6 to 8 percent Medicaid-only, with private pay and, in some instances, End-Stage Renal Disease participants making up the remainder. PACE center attendence is projected to average roughly 2.5 days per week per participant once the program is fully operational.

Other primary considerations include staffing ratios, acute care utilization rates, skilled nursing facility utilizations rates, and assisted living facility and ancillary services utilization rates. Ancillary services include laboratory services and radiology, outpatient services, and routine specialists. In addition, operational budgets must include assumptions for administrative expenses such as office supplies, travel, communications, insurance (including malpractice), consulting fees, information technology and software, and marketing.

Once the viability of a PACE program is confirmed with a feasibility study, the PACE operator must ensure that the capitated rates paid by the state allow the program to produce an operating margin sufficient to account for expense risk associated with its participant population. The consideration is also tied to the CMS requirement that a PACE program maintain a risk reserve. This risk reserve amount can be calculated by subtracting the end-of-year balances for cash, reserves, and investments of the PACE organization from the estimated CMS risk reserve requirement. The general guidelines to meet federal requirements include a reserve balance equal to the sum of one month of revenues and operating expenses.

Startup and Development Costs. Depending on the size and location of the PACE organization, startup experiences between PACE providers will exhibit a variable range in each of these components. Additional factors that may influence startup costs include funding sources and access to capital, existing interest rate and credit market conditions, and competition for home and community-based services within the target market. We present estimates of these startup costs along with per member per month revenue, expense, and net income figures gathered by NPA through an annual survey of existing PACE organizations. Estimates reflect costs of a facility with an enrollment of 300 participants.

New PACE organizations contract with consultants who have experience in developing and operationg PACE programs. Consultant services typically include demographic analyses, market assessments, proforma modeling and financial forecasts, regulatory advising, and business planning for service delivery. According to NPA, fees for these services range from $120,000 to $420,000, which includes all elements of startup and support services during the first year of operation.[48]

The National Institute on Adult Day Care Standards recommends 60 square feet per person served in the program, not including reception or storage areas, offices, restrooms, therapy rooms, passageways, and dining. However, NPA states that PACE organizations typically acquire 100 sqaure feet per participant for program space. Although construction costs will vary depending on location and building design, NPA estimates suggest costs range from $135 to $160 per square foot for new construction and $45 to $55 per square foot for renovation of existing structures.[49]

Demand for services, including the rate at which enrollment occurs, are critical elements of the feasibility study. NPA states that programs typically experience net enrollment growth of five to eight enrollees per month. Loss reserves should be adjusted accordingly in the financial pro forma based on the realistic projections of participant enrollment. Over a two to three year period, operational losses can range from $500,000 to over $800,000.[50] Based on our conversations with directors at On Lok, Inc., and Star Care Specialty Health System and review of a Beinvivir PACE feasibility study, the average break-even time for new PACE sites is roughly two years. Note that break-even forecasts rely on operating income and are separate from capital costs required for purchases of property, buildings, and equipment.

[48] Ibid., 4.
[49] Ibid., 6.
[50] Ibid., 8.

Conclusion

The survey conducted by the National PACE Association reveals that PACE programs, on average, are profitable. This leads one to assume that investing in the startup and development of a new PACE program will inevitably lead to profitability. However, the capitated rates approved by the state are the most critical factor as to whether any PACE program will generate sufficient revenues to cover its operating costs and maintain a margin that covers its operating risk.

A recent feasibility study conducted by Bienvivir All-Inclusive Senior Health for a proposed PACE site in San Antonio, Texas, reveals that the SFY 2016-2017 rates announced by DADS were insufficient to compensate Bienvivir for its initial capital investment and did not support operating income that would allow the program to achieve an adequate financial position given financing liabilities and risk reserve requirements.[51]

The Legislative Budget Board recommended that PACE Medicaid rates should not exceed the reasonable and necessary costs to operate a PACE program and that the program cost be neutral relative to serving a person in the Medicaid STAR+PLUS managed care program.[52] However, in the case of Bienvivir, it is not clear whether the PACE rates developed for the most recent biennium are sufficient to cover the reasonable and necessary costs to operate a PACE program. Additionally, Bienvivir holds that the cost of PACE is less than the cost of STAR+PLUS for comparable populations for the reasons that PACE is more proficient at preventing acute episodes and avoiding the high cost of institutional care.[53] These contradictions highlight the need for establishing a determinative model for comparing the costs of serving like populations between PACE and STAR+PLUS.

3. Participant Perspective

Methodology

We use a different methodology for the participant perspective—one that differs from the other three perspectives. While the economic cost analysis for the federal, provider, and state points of view examine the costs of the programs, the participant point of view solely examines the quality of service. Participants for both PACE and STAR+PLUS healthcare programs evaluate the services they receive by completing patient satisfaction surveys. Since there is no national model for what these surveys should evaluate or how they should be evaluated, these surveys differ for each health care service option. The services evaluated in the patient satisfaction surveys for PACE do not necessarily match the services evaluated by STAR+PLUS participants and vice versa (these surveys also measure participant satisfaction from year to year). STAR+PLUS report cards measure items like "getting timely care," "talking with doctor," or overall "performance measures," while PACE surveys evaluate items such as "staff members are easy to talk to" or "staff members listen to me carefully." While individual items like "talking with doctor" and "staff members listen to me carefully" seem similar enough to compare, they are

[51] Castillo, Letter to Texas Department of Aging and Disability Services.
[52] Legislative Budget Board, "Texas State Government Effectiveness and Efficiency Report," 221.
[53] Castillo, Letter to Texas Department of Aging and Disability Services.

fundamentally different categories. Our research aims to evaluate the difference, if any, and nuances embodied between each healthcare option.

Since satisfaction surveys differ dramatically from program to program, comparing surveys across different programs becomes somewhat problematic. One program might focus on evaluating quality of care, while another program might decide to evaluate the access to or frequency of care. The differences across each survey, however, do highlight exactly what each healthcare option prioritizes. For example, surveys that evaluate the quality of care show a healthcare option that might value how their participants receive care—whether or not they find the services effective—while surveys that evaluate access to care show a healthcare option that prioritizes accessibility and options of services.

Our research does not evaluate participant surveys directly, but rather conducts a meta-analysis of several national research reports that have evaluated how the two programs evaluate participant satisfaction. In addition to the research, we are able to compare different report cards published online by DADS. In doing so, we aim to evaluate exactly what services each healthcare option finds the most important.

Our research limitations include a lack of access to the data regarding the newly rolled-out STAR+PLUS HCBS that includes nursing home care and the new STAR+PLUS dual demonstration project only available in six Texas counties.

STAR+PLUS Dual Demonstration

Our research compares the LTSS services options of PACE, the STAR+PLUS HCBS, and the newer STAR+PLUS Dual Demonstration Project. For the purposes of this section of the research, we will not be analyzing the participant viewpoint for STAR+PLUS Dual Demonstration. Since the program is still only a demonstration project—only rolled out in six Texas counties—there is a lack of information to adequately examine how participants rate the recent program.

Starting March 1, 2015, STAR+PLUS HCBS expanded services so that participants who did not have access to nursing facility services now have their long-term care services covered by STAR+PLUS Medicaid. The studies analyzed from the participant perspective do not measure participant satisfaction since the expansion. These surveys were conducted pre-expansion—meaning the results do not take into account the additional nursing home facility services dual-eligible participants can currently receive.

Overview of Participant Satisfaction Studies

There are two main studies conducted by third-party groups that analyze participant satisfaction—one that studies STAR+PLUS and the other PACE. Both of these studies utilize participant satisfaction surveys uniquely made for each respective study. By creating a third-party survey—ones that are neither used by STAR+PLUS nor PACE—they are able to give a less biased approach to surveying patient satisfaction.

The Gerontological Society of America published "Older Adults' Satisfaction with Integrated Capitated Health and Long-Term Care" in 2004.[54] This study analyzed participant satisfaction in the PACE program in order to see how programs funded by capitated payments affect quality of care for aging participants. The study focuses more on the development of the most successful ways to survey a vulnerable aging population—taking into account that participants find a difference between items like "staff members are easy to talk to" and "staff members listen to me carefully." While it may seem that the two survey questions resemble each other, the study recognizes that the participant population finds it to be a necessary distinction. The study conducted 402 interviews across eleven different PACE sights and compared satisfaction among PACE enrollees, non-PACE enrollees, and their family members.

The Institute for Child Health Policy (ICHP) at the University of Florida and the Texas External Quality Review Organization published "The Texas STAR+PLUS Program Adult Member Survey Report" in 2012.[55] The study measures information taken from September 2010 through August 2011 and aimed to interview 3,000 participants from ten different MCO/SA groups in Texas. For the purposes of this study, we will only present the results regarding the dual-eligible population.

These two reports use similar categories to survey participants. Even though the surveys ask slightly different questions, they cover similar enough topics allowing for a sound comparison.

Finally, we examine a final report submitted to the Center for Medicare & Medicaid Services by Mathematica Policy Research, Inc.[56] The 2008 report directly compares participant satisfaction of PACE participants to those in HCBS programs across eight different states—California, Colorado, Maryland, Massachusetts, Ohio, South Carolina, Texas, and Wisconsin. Although the study does not compare PACE directly to Texas HCBS options, the HCBS Medicaid programs in other states are comparable to STAR+PLUS HCBS—making the broader scope of the study applicable to our findings in Texas.

In addition to reports and studies published about PACE and STAR+PLUS, we will utilize information published on the DADS website that measure participant satisfaction for STAR+PLUS. The information published online allows potential and current participants to compare services and satisfaction among the different MCO groups—giving the participant the ability to compare the different ways in which STAR+PLUS services are rendered.

PACE vs. STAR+PLUS

While PACE and STAR+PLUS offer almost identical services, the way in which they provide said services differs considerably. PACE provides the majority of its services from a central location—meaning the participant can go to one place for his or her doctor appointments, meals, or physical therapy. By centralizing the location, the participant does not have to coordinate transportation to several different locations to receive the variety of needed services. PACE

[54] Atherly, Kane, and Smith, "Older Adults' Satisfaction with Integrated Capitated Health and Long-Term Care."
[55] Institute for Child Health Policy at the University of Florida and Texas External Quality Review Organization, "The Texas STAR+PLUS Program, Adult Member Survey Report."
[56] Beauchamp et al. "The Effect of the Program of All-Inclusive Care for the Elderly (PACE) on Quality."

participants also do not have to personally coordinate the services they need directly. Rather, PACE participants work with their interdisciplinary team (IDT) team to get the services they need. This aspect of PACE care makes surveys slightly different. In addition to evaluating the quality of services, the surveys evaluate the coordination of services. They must evaluate how the IDTs organize participant health plans, taking into account the way in which they schedule and prioritize participants' varying needs.

STAR+PLUS, on the other hand, is the Medicaid option and participants receive services through several different MCOs. For example, the online report cards for Travis County give scores for both Amerigroup and UnitedHealthcare. The participant survey results differ for each MCO. By comparing the two MCOs side-by-side, potential and current participants can assess the MCOs' ability to provide satisfactory healthcare options.

Our research aims to explain exactly what services participants value the most, the quality of those services that they receive, and how the participant satisfaction differs from PACE to STAR+PLUS. In doing so, we are able to understand the effectiveness of each program from the participant's point of view—showing us how government dollars translate into peoples' well-being.

Table 3.7 presents the quality of care measures used to evaluate PACE participants in the GSA study with some of the categories evaluated in the ICHP study. We have put similar categories next to each in order to compare exactly how each survey asked their respective participants about the services they received.

Table 3.7. PACE vs. STAR+PLUS Evaluation Categories

PACE	STAR+PLUS
I can see a doctor whenever I need to	Getting care quickly
The doctors and nurses understand my problems and special situations	Satisfaction with doctors' communication
All the people involved in my care work well together	Good access to service coordination
Staff members spend enough time with me when I have a problem	Getting needed care
I am confident of getting the services I need when I need them	Health plan approval
I can get as much help as I need at home	Activities of daily living
Decision making	Seeking help and advice
Perceived access	Member awareness of service coordination

Sources: Atherly, Adam, Robert L. Kane, and Maureen Smith. "Older Adults' Satisfaction with Integrated Capitated Health and Long-Term Care." *The Gerontologist* 44 (2004): 348-357. Accessed March 2, 2016. doi: 10.1093/geront/44.3.348; and Institute for Child Health Policy at the University of Florida and Texas External Quality Review Organization. "The Texas STAR+PLUS Program, Adult Member Survey Report." January 2012. Accessed April 5, 2016. http://www.hhsc.state.tx.us/reports/2012/EQRO-Texas-STARPLUS-Audlt-Member-Survey-FY2011-Attachment-1.pdf.

Table 3.7 reveals that slight differences emerge between PACE and STAR+PLUS. For example, the GSA survey asked PACE whether "all the people involved in my care work well together,"

while the ICHP study asks STAR+PLUS participants whether they had "good access to service coordination." Since the PACE program provides each participant with an individualized IDT, their involvement and coordination becomes an important aspect that affects the overall quality of care. If a participant senses that his or her IDT is not working with each other, this will inevitably affect their quality of care. He or she might experience a gap in communication that may cause confusion about the necessary steps to continue care. Since STAR+PLUS participants have access to service coordination rather than a personalized team, the participants rated this access instead of measuring how their different doctors or caretakers work with each other, thus STAR+PLUS participants must measure the quality in which someone else coordinates their services for them.

PACE Participant Satisfaction

Participant satisfaction surveys show that many older adults are unable to physically complete a survey or have access to take such a survey online.[57] This study is based on personal interviews in order to compensate for certain individuals' inability to take surveys either online, or even physically in person. For those who had no means to take the survey, they interviewed family members in attempts to still gather information about the participants satisfaction.

Since the study's main focus was to develop the best means to survey an aging, vulnerable population, the outcomes show how PACE participants viewed "perceived access" and "perceived interpersonal quality" for a variety of different items, such as the ones outlined in Table 3.7. This means PACE participants who took the survey measure how they perceived their ability to receive adequate care and how they perceived their IDT's personable skills, such as how they related to them on a personal level. The study then compared the results to the non-PACE participants. They found a clear distinction between PACE and non-PACE participants in "perceived access" and "perceived interpersonal quality," showing that PACE participants felt greater access to the necessary care they needed. While it may seem obvious that PACE participants felt greater access to care than non-PACE participants, it is important to note that all non-PACE participants actively chose another care option besides PACE.

This particular study highlights the importance of inventing a single, nationally used, and participant-friendly survey to analyze the aging, vulnerable population. The study focuses on the PACE populations, since the majority of its participants are considered to be highly vulnerable. Even though PACE programs must conduct participant surveys, there is not a standardized survey used across different PACE sites. By conducting a variety of different surveys across different PACE sites, it becomes difficult to analyze exactly how effective different PACE sites are in providing care.

STAR+PLUS Participant Satisfaction

A second study focuses on four different survey categories including "access to and timeliness of care," "patient-centered medical home," "service coordination," and "health plan information

[57] Atherly, Kane, and Smith, "Older Adults' Satisfaction with Integrated Capitated Health and Long-Term Care."

and customer service."[58] But because this study analyzes STAR+PLUS in general, rather than analyzing a specific population within STAR+PLUS, we cannot directly compare the data to PACE. For example, the PACE population average will inevitably be considered more fragile or vulnerable since being so is a requirement of enrolling.

Table 3.8, based on data from the ICHP study, presents the overall satisfaction rates of the STAR+PLUS dual-eligible population. While 80 percent or more of participants believe they have "good access to urgent care" or "good access to routine care have," only 49 percent or fewer participants believe they have "no delays for health plan approval" or "no exam room wait greater then fifteen minutes." Although participants believe they are receiving the care they need, they also contend they are not receiving it in the desired timeframe.

Table 3.8. STAR+PLUS Participant Satisfaction Results

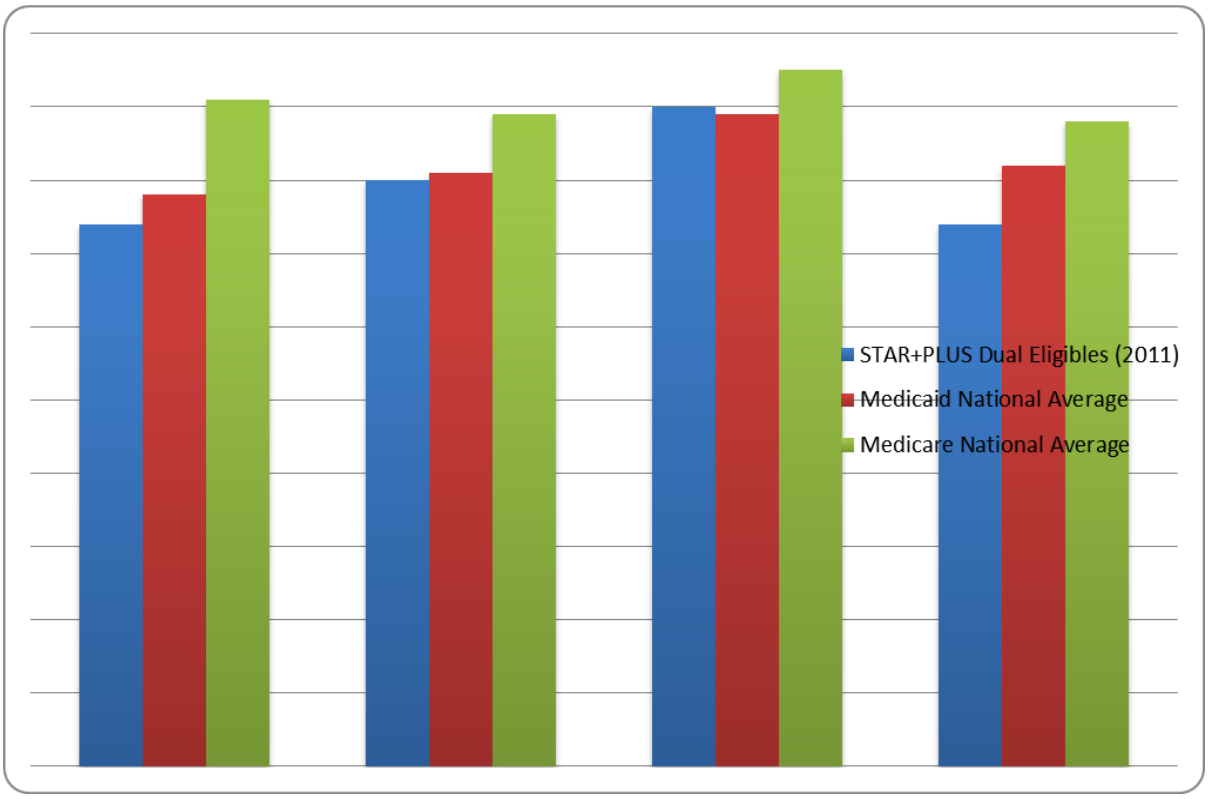
STAR+PLUS Dual Eligibles	2010	2011
Good access to urgent care	84%	81%
Good access to specialist referral	75%	78%
Good access to routine care	80%	80%
No delays for health plan approval	49%	49%
No exam room wait greater than 15 minutes	31%	33%
Good access to special therapies	74%	53%
Advising smokers to quit	61%	66%

Source: Institute for Child Health Policy at the University of Florida and Texas External Quality Review Organization. "The Texas STAR+PLUS Program, Adult Member Survey Report." January 2012. Accessed April 5, 2016. http://www.hhsc.state.tx.us/reports/2012/EQRO-Texas-STARPLUS-Audlt-Member-Survey-FY2011-Attachment-1.pdf.

Figure 3.1 illustrates how participant satisfaction compares to Medicaid and Medicare averages.

[58] Institute for Child Health Policy at the University of Florida and Texas External Quality Review Organization, 2012.

Figure 3.1. Medicaid and Medicare National Averages



Source: Institute for Child Health Policy at the University of Florida and Texas External Quality Review Organization. "The Texas STAR+PLUS Program, Adult Member Survey Report." January 2012. Accessed April 5, 2016. http://www.hhsc.state.tx.us/reports/2012/EQRO-Texas-STARPLUS-Audlt-Member-Survey-FY2011-Attachment-1.pdf.

In almost every category, STAR+PLUS falls below the Medicaid and Medicare national averages. This may show a need to improve care so that it reaches the national averages of participant satisfaction.

As mentioned previously, the report cards directly compare two different MCOs. If participants know which aspect of care they perceive as the most important to them, they might be able to use these report cards to determine which MCO would be best suited for their needs. STAR+PLUS issues annual health report cards online. These report cards give potential and current participants the ability to both evaluate overall STAR+PLUS care while also giving them a means to express concerns—hopefully instigating future change. This gives the participants an opportunity to review both in order to choose the best health care plan. Health plan report card ratings are created by asking participants in the respective MCO groups about their overall quality of care.

Table 3.9 presents the different types of preferences in care delivery ranging on a scale from one to three stars for two different MCOs: one star represents below average, two stars average, and three stars above average.

Table 3.9. MCO STAR+PLUS Comparisons

Topic	Amerigroup	UnitedHealthcare
Getting timely care: Did people get care right away when they needed it?	**	*
Talking with doctors: Did the doctor spend enough time with people? Listen to them? Explain things well?	*	*
Main doctor: How did people rate their main doctor?	*	*
Getting needed care: Did people get general and specialist care?	**	*
Health plan: How did people rate this health plan?	*	*

Source: Texas Health and Human Services Commission. "STAR+PLUS Travis County Report 2015." Table. March 2016. Accessed February 3, 2016. https://www.hhsc.state.tx.us/quickanswers/report-cards/starplus/austin-area-starplus-report-card.pdf.

These report cards do not offer concrete measurement standards or necessarily give its participants very revealing information. Since the participants rated each category on a one to three star scale, it is also not clear exactly how great the differences are between the star levels. We can, however, draw some conclusions about the differences between the different MCO groups of Amerigroup and UnitedHealthcare. Since UnitedHealthcare only gets one star for every category, it seems it might be the weakest MCO. We can also draw some conclusions about the complete lack of three stars, or above average, reviews. Neither MCO receives an above-average rating—showing a clear need for some improvement.

Conclusion

Both STAR+PLUS HCBS and PACE conduct participant satisfaction surveys in order to gather feedback regarding the overall satisfaction of their consumers. This allows the respective programs to gauge how their services are affecting the everyday lives of participants.

Our research indicates that overall PACE enrollees are generally satisfied with the care they receive. The program's attention to care and teamwork impacts the participants profoundly—taking out the stress of self-coordinating all of their needed services and communicating among all their varying doctors. Given data limitations we can clearly see how STAR+PLUS compares to both Medicaid and Medicare national averages. The STAR+PLUS participants indicate that the services received do not necessarily match up to the national average. While we cannot unequivocally conclude that either PACE or STAR+PLUS participants are more satisfied than the other, we can conclude that PACE participants overall seem to be more satisfied with their quality and access to care.

4. Federal Perspective

Methodology

The first two perspectives have shown how the PACE programs, when compared to STAR+PLUS HCBS and STAR+PLUS Dual Demonstration, may save the state money when compared to Medicaid, while the third perspective shows overall how PACE participants tend to be more satisfied than Medicaid participants. The fourth and final perspective aimed to show what these different programs cost the federal government. When looking at the federal perspective, we will refer to the STAR+PLUS HCBS and STAR+PLUS Dual Demonstration options as simply STAR+PLUS.

Cost-savings for STAR+PLUS or PACE are difficult to determine on the federal level for several reasons. Since the average PACE population is more frail than the average STAR+PLUS population, PACE participants tend to be more expensive than the average Medicaid participant. On the other hand, the STAR+PLUS population does not have the same 55-plus age requirements as PACE, therefore making its population younger and less costly. Comparing the two averages becomes extremely difficult, since the Medicaid programs have less costly participants that balance out the more costly participants. PACE's average population, on the other hand, is more costly across the board.

Ideally we would want to compare identical populations—meaning we would only analyze dual-eligible STAR+PLUS HCBS/Dual Demonstration participants who are nursing-home-eligible and over 55 years old against the PACE population. If we could obtain this information comparing the same populations, determining which program is more cost-effective would be simple. This information, however, is not available. Our research has instead focused on what the literature says about PACE on the federal level.

Medicare Capitated Payments to PACE

The Center for Medicare & Medicaid Services pays a capitated payment per member to PACE programs based on the county rate of the area, a pre-determined frailty factor, and individual risk score. The county rate is determined from the PACE County's FFS rate for that payment year. This is determined based on the costs of other healthcare services within that county. Then PACE assigns each newly enrolled participant a risk adjustment factor that they adjust as the participants' conditions change throughout the years. This score simply measures just how frail or vulnerable they determine the participant to be. The frailty factor is then added to the final individual risk score in cases of emergency. The frailty factor is a means to compensate for cases that become far more costly than originally assessed. Based on these factors, CMS issues the capitated payment directly to the PACE provider. PACE providers can then use the payment as they see fit.[59]

[59] Center for Medicare & Medicaid Services. "Programs of All-Inclusive Care for the Elderly (PACE) Manual, Chapter 13."

Does PACE Save Money?

Based on the literature, we cannot conclude that PACE saves the federal government money in comparison to fee-for-service. Multiple studies have determined that PACE capitation rates are actually equivalent to what participants would have cost Medicare if they were FFS.[60] These results do not reflect the differences between PACE and FFS, in regards to how participants receive their care. For example, when a participant is prescribed physical therapy sessions and Medicare pays through FFS, that participant completes a set amount of physical therapy appointments based on the original prescription, and at the completion of these sessions the participant does not have the option to complete more unless he/she revisits a doctor and receives another referral. PACE participants, on the other hand, have the ability to continue receiving physical therapy until their doctors and physical therapists come to an agreement that the participant is ready to stop receiving physical therapy. The direct communication between the doctor and the physical therapist cuts out the need to revisit a doctor multiple times in order to receive more referrals for more therapy appointments. It simplifies the process. So while these two options cost similar amounts, the received services are slightly different.

Benefits of PACE

We found that of those participants who are nursing-home-eligible and enter the PACE program, nearly 20 to 30 percent will not be nursing-home-eligible after one year in the program.[61] This means that the PACE program takes very vulnerable and fragile aging adults and rehabilitates them to a point where they no longer can be considered frail enough to be in a nursing home. These results show a very proactive form of health care—solving potential issues before they become even worse. In addition, another study found that rates of hospitalization and hospital readmissions are lower for PACE enrollees than they are for other comparable populations.[62] These reduced hospitalizations, once again, point to a hands-on, proactive approach to health care. By engaging with their participants and communicating with their doctors, PACE programs help rehabilitate aging, nursing-home-eligible adults.

Conclusion

Our research shows that drawing conclusions about the cost-effectiveness of PACE on the state level can somewhat problematic. The data is not comparable and services become hard assign costs. We can also conclude the same from the federal perspective. While many studies cannot determine whether PACE actually saves the federal government money, they have determined that the health outcomes of PACE participants are superior to those participants not in PACE programs. What does this mean for our quantitative research? We can conclude that while PACE may cost the same as FFS in some cases, PACE also utilizes the money very efficiently.

[60] Ghosh, Schmitz, and Brown, " Effect of PACE on Costs, Nursing Home Admissions, and Mortality: 2006-2011."
[61] Karon and Robinson., "Modeling Medicare Costs of PACE Populations."
[62] Segelman et al, "Hospitalizations in the Program of All-Inclusive Care for the Elderly."

Chapter 4.
Challenges of Establishing and Sustaining PACE Sites: Issues of Collaboration, Cost, and Politics

Qualitative Approach

In the course of pursuing this study, it was determined that the incorporation of qualitative research would help provide the fullest picture of comprehensive, integrated long-term care and its feasibility for expansion in Austin. Broadly understood, qualitative research attempts to illuminate and integrate the nuances that may not be captured in quantitative analysis. Our quantitative research provides us with numbers, while the qualitative research helps us understand the human aspects behind those numbers. There are many approaches to qualitative research; for the purposes of this project we chose to focus on thematic analysis through key informant interviews. By using both a quantitative and qualitative approach, it is our hope that our research will provide a fuller picture and enable stakeholders to better move forward in the expansion of community-based care in Austin.

Research Questions

The overarching goal of our research is to examine comprehensive, community-based programs for the elderly such as PACE and determine the feasibility of bringing such a program to Austin. Our specific research questions are as follows:

- To what extent would comprehensive, community-based care for the elderly be beneficial in Austin?
- Is there a need for it? Why?
- Who would benefit from a program of this sort? Would it have a positive impact on families and reduce caregiver burden?
- How might the model be adapted to the local community of minority elders?
- What organizations are likely to consider the funding opportunity, and are they in a position to apply?

As our research proceeded, we determined the best approach would be in the form of a feasibility analysis incorporating both quantitative and qualitative analyses. In addition to conducting key informant interviews, we attended several question-and-answer sessions with academic researchers and experts in the field.

Question-and-Answer Sessions

We carefully considered the question of whether we should include the content of the question-and-answer sessions in our qualitative analysis. Ultimately we decided it would not be

academically rigorous to include information from these session in our key theme analysis, as these session were not originally conducted with the intent to be used in our qualitative analysis. The Q&A sessions were very distinct from the interviews—the interviews involved two researchers and one interviewee and were student-led, while the Q&A sessions occurred with the full group and were not led by our team. Additionally, the Q&A sessions generally covered topics beyond the scope of PACE establishment and expansion. We determined we would use information from the Q&A sessions when they provided further support for the key themes identified from the interviews.

Key Informant Interviews

For the purposes of our project, thematic analysis involved conducting interviews with key informants (such as program managers, the regulatory and compliance officer for a major integrated care provider in California, and experts in the field) and analyzing the data in order to pull out important themes. By themes, we mean recurrent topics or words that are convergent across all interviews and appear to be foundational to our research question. We identified one of the first PACE sites in the nation as the best site for conducting interviews; this site has been operating for over 40 years and has experienced all stages of development. The On Lok center is located in San Francisco, California, and has a similar demographic makeup to the city of Austin, serving primarily low-income, minority participants. The research team felt individuals there would be able to provide the best insight into what is needed to expand and run a similar program in Austin, Texas.

Seven key informant interviews were conducted in total— five with members of the PACE executive team, one with the director of a senior health center that falls under the site's wider operations umbrella, and one with an individual at a senior health research foundation that works closely with the PACE site. It should be noted the PACE executive team and senior health center director requested payment in order to be made available for interviews and a tour of the facilities. This was noted in the informed consent that was approved by the University of Texas Institutional Review Board (see Appendix B), and was considered during final analysis. All interviews were conducted in pairs and on-site in California, save for the interview with the individual at the research foundation, which was conducted via the Internet using Skype. The interviews were semi-structured, with the interviewer following an outline of key areas (e.g. startup, expansion, regulatory) previously determined by the team. The teams took audio recordings of the interviews as well as handwritten notes; the audio recordings were referenced during analysis only when questions arose about direct quotes.

Informed Consent and Confidentiality

Each interviewee was provided with a consent form that acknowledged participation was voluntary and that their contributions would be anonymized. Additionally, we included a section describing and disclosing the required payment made to the PACE site and adult day center.

Limitations

As mentioned above, the primary limitation to our research was the PACE program's requirement that our team pay a fee in order to have access to the executive team and senior

center director to conduct interviews, as well as take a tour of the facilities. This was the first time any member of the research team had encountered such a barrier. We determined that we would move forward with the interviews, but make special note of the payment.

Given that our interviewees were all located in California and the majority were from one company, there is some concern about generalizability. Additionally, with only seven interviewees, our sample is small. Finally, no PACE or senior center participants were included in the interviews. While we made the decision to focus our research on the startup and roll-out process for an insurer/provider-type LTSS program, including the input of program participants would undoubtedly provide an even fuller picture. As such, our research should be understood to address only the operational side of an insurer/provider-type LTSS program.

Refinement

The key informant interviews were designed to uncover critical themes in creating, running, and expanding a successful insurer/provider-type LTSS program. We felt that having access to high-level team members from different facets of the organization would give us the opportunity to define success in the most comprehensive, multi-faceted way possible. Given that the goal of qualitative research is to allow the subject (here, the leadership team for this particular PACE site) to reveal themes to the researcher, we decided to use a semi-structured interview approach; rather than have each interview team adhere to the same set of questions, we identified five broad areas we hoped to have the interviewee address. Our five areas are as follows:

- Startup and establishment;
- Obstacles to startup;
- State agency involvement;
- Challenges; and
- Financial constraints.

Each area contained guiding questions that were further developed by the team (see Appendix C). While the interviews were semi-structured, we felt it would benefit everyone to have a set of questions to act as a fail-safe in the event challenges arose with the interview.

Findings

Following is a detailed analysis of the themes that emerged from our key informant interviews. We identified five higher-level thematic categories, as well as multiple sub-themes that fall under those broader categories. The following sections explore the deeper meaning of each individual thematic category, culminating in an analysis of the implications of these categories for bringing an insurer/provider-type LTSS program to Austin.

Key Themes

Communication and Collaboration

When analyzing our interview results, ***communication and collaboration*** quickly emerged as an important theme. Every interviewee mentioned the importance of effective communication and collaboration in both establishing and expanding a PACE program. The meaning of collaboration in particular is multi-faceted.

Collaboration has emerged as a key theme in two respects—it is primarily understood to mean working with available resources and leaders in the community and state to push forward and make the expansion process easier. That being said, collaboration can also mean thinking outside the box; collaborating and co-mingling populations in order to deliver services to more people, as well as make the expansion process easier by lowering the economic burden on the program. Communication is multi-faceted as well; a detailed analysis of the data has shown communication to mean both communication with political figures (e.g. regulatory, state politicians, CMS) and communication with participants. Both forms of communication appear to be foundational for collaboration, but should be understood as being distinct—political communication entails being able to speak effectively with state officials in order to navigate the complex regulatory environment, while participant communication involves engaging with program participants on a level that encourages multi-cultural sensitivity and understanding.

When discussing housing, one key informant noted that they would not have been able to expand and include housing without partnering/collaborating with other programs, stating "[we] wanted to expand in Fremont and had a relationship with the housing developer, as well as city support." The feasibility of something like housing hinges on being able to collaborate with other members of the political, business, and social communities.

Barriers to Entry (Regulatory/Legal)

Communication and collaboration appear to be crucial to successfully starting a new PACE program. Interviewees noted that the regulatory and legal process for starting a new site can be daunting, and that "there is a lot of licensing and regulation, which takes a long time." One key informant discussed the importance of being able to communicate effectively with federal and state agencies who monitor PACE facilities, stating "there's always communication, never a lack of communication between regulators." He also emphasized the importance of being able to collaborate and build relationships with the people in the regulatory realm.

Political and Governmental Relationships

Similar to the issues with regulatory, collaboration via establishing political relationships emerged as important for a successful CBMLTSS program. The regulatory and compliance officer made it clear he believes it would not be possible to meet the many and various regulatory requirements for PACE without having a positive relationship with the agencies in charge. The regulations governing CBMLTSS programs can be varied and quite complicated, and it is important to have established (or the ability to establish) relationships with the people in government.

Quality of Care and Multicultural Awareness

Finally, communication and collaboration involve being able to provide a high quality of care. Specifically, communication and collaboration with the program participants themselves alerts staff to the need for multicultural awareness. Multiple interviewees spoke to the care that needs to be taken when working with a multicultural population—for example, the California site serves primarily Hispanic and Chinese populations. One person noted that these two groups take dramatically different approaches to death, certainly an important topic to address in a program that cares for the elderly, and stated that without appropriate communication with the program participants, staff would not have been aware of the cultural differences and would not be able to effectively and thoughtfully serve their populations.

Cost-Effectiveness

Getting PACE off the ground takes a lot of capital investment. As one interviewee noted, it's important for organizations to "not underestimate the capital=intensiveness of opening a PACE facility." For this California PACE site, it cost about $7-8 million to start. The informant stated it is important to consider how fast the program could grow, the rising price of property, and the ability to hire competent staff.

With startup costs being capital-heavy, one may wonder how this program is cost-effective, which is why there is a debate on this topic. When discussing this issue with key informants, sub-themes emerged to help provide insights to factors that could have a positive or negative impact on the bottom line.

Capitated Payments

The PACE model centers around capitated payments. This means that based upon the participant's health history and other criteria, a provider receives a set rate of money each month to pay for the care of the participant. It is in the best interest of the program to keep the participant healthy because if the cost of care provided exceeds the capitated payment, the money comes out of the provider's pocket. However, generally, if that happens for one participant, savings from another individual will help to cover the costs.

This makes rate-setting for the capitated program an important aspect. One key informant noted that rates differ across the state and approaches recommended may benefit regions or counties differently. These rates have to do with how much the state will pay for Medicaid reimbursement. When asked if there are savings for the state, the interviewee stated "the jury is still out." This is because the model produces overall cost savings, but some research shows that the state does not realize any of it because dollars saved go to Medicare, which saves money on the federal level. As the interviewee elaborated, "[we] know we're saving on Medicare side, but not 100 percent clear that there are state savings. Some states like Texas put caps [on the number of enrolled participants], because [they are] unsure of state savings. Others, like Pennsylvania, are convinced that this is a state savings [program by] providing citizens with needed care, so [they] are very open to PACE in the state." When asked where California stands on this issue, the interviewee stated it is still unclear due to changing players and other aspects. She believes the state isn't convinced and PACE has to keep fighting. "On Lok fights the legislature on rates

and has sued for better rates." On Lok felt it prevailed in the last legislative session because rates were flat over many years until a recent rate increase.

The capitated payment system also allows for programs to provide more for clients because of cost savings on the provider side. One key informant stated that the capitated system "is a perfect incubator for experimenting with new technologies providing effective long-term care" thanks to the leftover capitation money. On Lok has been able to invest in more technologies to provide care for the elderly. Innovations include personal care robots and video services to contact patients in their homes.

However, any key informant stated that the biggest barrier to PACE is being a permanent provider. "The combination of capitated payments and lifetime commitment does not provide any stability." Continuous care for an aging population with set monthly rates and whose health care costs can rise means an organization has to monitor and find creative ways to stay financially afloat. If an organization cannot do this, it can find itself struggling financially.

Number of Participants (Limitation on Enrollees)

The number of enrollees affects the capitated system. As one interviewee stated, the "economic efficiency is based on the congregation of care." This means that a provider will want to have diversity in the level of needs among the population served. This may seem contradictory to the program since it serves nursing-home-eligible clients, but the idea is to serve a range of individuals along the spectrum in order to have savings each month per client or money to cover participants whose costs may exceed their capitated payment.

One key informant provided another angle to the limitation on enrollees. When asked if it is common for PACE to have a wait list, this person said it depends on the organization. "PACE is a 'volume game' because administration is extensive, there is a lot overhead; therefore, you want to enroll as many [participants] as possible. Keep growth happening as you approach limits." It was felt that having caps on the number of individuals served is a big problem, because it hinders building the program or having ability to pay for itself when there are caps or low rates. This can causes the program to not be cost-effective.

Size: Larger Size is Costly, but may Produce Economies of Scale Savings

Starting a PACE program is expensive, difficult, and complex. Expanding it can be difficult if the capital is not present. However, if a provider becomes larger and can continue to grow, cost savings can be realized. This is because the size of the program means more people served. This can lead the provider to gain power and authority in conversations regarding rate-setting and regulations like number of enrollees. This theme will be explored further in the following section.

Political Relationships and Advocacy

Environment

Several key informants credited On Lok's initial success to the financial and political support the program received during its initial startup in the 1970s. They attribute the consistent and continual growth of PACE to a supportive political environment that promotes "collaboration and communication." Since the program's success requires a high amount of cross-agency communication, this highly coordinated collaboration is a necessity for growth. An On Lok key informant expressed concern for the potential success of future PACE sites outside the state of California. Because the relationship between CMS and On Lok must be cooperative, states that do not have the same amount of cooperation might face some challenges.

The regulatory audits of On Lok facilities that occur every two years display the supportive relationship between CMS and On Lok. On Lok spends months preparing for the biannual audits, but these audits are never adversarial. In fact, On Lok knows exactly what days the auditors will conduct the audit and they are informed beforehand precisely which sites and which participant files will be audited. Our key informant said they do this because of their good relationship.

Competition

MCOs and other options for community-based healthcare services have continued to grow over the past years since PACE's start in the 1970s, creating competition for the services that PACE provides. This competition from MCOs and other community-based healthcare services prompted On Lok to pursue a more rigorous marketing and outreach strategy. Recently, the State of California passed legislation that allows MCOs to develop a provider/insurer Community-based Managed Long-Term Services and Supports model, similar to PACE. PACE program directors and administrators share several concerns over the passage of this legislation.

Primarily, program directors and administrators anticipate increased competition for the same group of eligible participants. Despite being a non-profit, On Lok is still a business that needs to maintain a steady customer base. PACE has begun to work with MCOs in order to get references for potential clients. While some MCOs have shown interest in this cooperative solution, the majority of them have not. While the conversation of MCOs referring clients to PACE is happening with top executives, intake specialists for MCOs are either 1) not receiving the message from the top executives to refer these clients, 2) receiving the message and ignoring it, or 3) top executives could not be saying anything to their staff at all and only agreeing to the PACE providers during meetings, but not implementing this policy.

Secondly, PACE marketing and outreach strategies focus their attention on potential participants. On Lok administrators find that because many potential participants are not familiar with their program they opt for less suitable options. For example, one program manager explained that most seniors looking to select health insurance are familiar with BlueCross BlueShield, but have never heard of PACE. The informant explained further that even though it cost the potential participant the same, they often choose an MCO option that provides significantly fewer services than PACE. On Lok administrators want to ensure that potential participants are making fully informed decisions.

To combat these two issues, On Lok's marketing strategy has taken a new approach. They now embody the idea that it is "not about getting more people, [but it is] more about telling [their] story better." On Lok believes that complete communication with potential participants will ultimately give participants the best care. If potential participants know about every one of their healthcare options, then they will be fully equipped to make the best decision for their situations. By telling their story better, PACE is able to ensure that potential participants will understand not only the PACE program design, but also just how many more services they are able to provide. On Lok wants their potential participants to know that although MCOs are attempting to function as both a provider and an insurer, they are not able to provide all that the PACE program can.

Size Matters

PACE's small client base, relative to all other Medicaid healthcare options, makes it difficult to attract state resources. PACE cited their relatively smaller participant size and their access to state resources as two of their biggest challenges to the growth and expansion of PACE. Advocacy at the state and local levels remains critical for the expansion of future PACE sites. Because program size matters for success, PACE utilizes other resources to get the help they need to maintain adequate funding, consistent participant size, and statewide recognition. The state PACE association, CalPACE, helps PACE programs mitigate regulatory challenges by providing a "collective voice on policy issues" and a "focused strategy" for PACE expansion and advocacy.

Regulations Can be Flexible

While regulatory requirements represent a large barrier to starting a PACE program, regulations become more flexible for well-established programs. A regulatory affairs and compliance specialist described for us the informal process that they use to request waivers or flexibilities to certain state or local regulations. An example of a recent flexibility request centers around the federal PACE regulation that requires physicians to be direct employees of the PACE center. This requirement prevents PACE participants from competing for appointments, which promotes qualify of care. On Lok requested an exemption to this regulation in order to contract with community physicians instead of having them on the PACE payroll. The decision is currently pending, but a key informant seem hopeful that the flexibility would be approved. The key informant emphasized that this flexibility in the regulations would not be possible without the good relationship between the PACE program and CMS. There is constant communication and collaboration between PACE, CMS, and the California Department of Health Care Services.

In regards to the rigid regulations, another key informant said that during training the PACE partners suggested that PACE providers should consider the spirit of the regulation. "You should shape and mold your site to fit the population and staff you have on hand." For instance, the key informant told us that not every On Lok participant visits the center once a week as outlined in the PACE regulations. According to the key informant, some participants feel overwhelmed with the amount of attention they receive at the center, and so On Lok ensures they receive most of their care in-home. This shows that, at least in California, there is some flexibility to adapt the PACE program to the culture and needs of a provider or a specific site.

Population Served

Quality of Care and Participant Satisfaction

Our research team was unable to conduct interviews with participants, as it was outside the scope of our Institutional Review Board-approved interviews. However, a key informant was able to provide us with insight into participant satisfaction from leadership's point of view. It is implicit in the data that a higher quality of care will lead to higher levels of participant satisfaction.

While the PACE model is designed to take a lot of pressure off participants and their family members (especially in regards to medical decisions), it can still be overwhelming for some. An interviewee noted that some participants complain of feeling "micromanaged"—they constantly feel under the microscope, with a whole team of medical staff constantly checking on and assessing them. The interviewee stated, " it can be a bit much for some participants." Interdisciplinary team members take steps to address this issue by having social workers meet with participants and report back to the rest of the IDT. The social workers collaborate with the IDT to help illuminate for them how the participant is feeling about the process. This team approach ensures the participant still receives quality care, with the added bonus of feeling less overwhelmed by the amount of attention they are receiving. While indirect, it seems reasonable to assume the efforts taken by the IDT leads to higher levels of participant satisfaction.

The site we visited has made further efforts to improve participant satisfaction. One key informant highlighted their new Healthcare Hospitality Program. In the past, new enrollees would spend a month working exclusively with a recruiter. During this time, they would typically develop a strong rapport, but at the end of the month the participant and the recruiter's relationship would be terminated. The sudden end of this relationship sometimes left participants feeling confused and abandoned. With the new program, participants will meet with their recruiter after being enrolled for three months to conduct a check-up to see how they are feeling about the program.

Multicultural Awareness

Multi-cultural awareness emerged as another facet of quality of care. Several key informants noted the importance of being aware of participants' culturally based needs— that is, it is essential that site staff are aware of different practices surrounding things like death and mourning. This particular program has a high population of Chinese and Latino participants, two populations with very disparate beliefs surrounding mourning and the celebration of religious and cultural holidays.

For example, a key informant explained the need for Chinese participants to schedule medical procedures after the Chinese New Year, because it is considered bad luck to go into the New Year recovering. She also explained that those in the Latino culture are very open and comfortable with comforting each other when a participant passes away, but Chinese participants prefer to mourn silently and alone. For this reason, the interviewee recommended that PACE staff not only be well versed in the languages of participants, but also be intimately familiar with religious and cultural norms of participants.

Community Engagement and Integration

While PACE sites can lead to increased community engagement, it also appears there can be difficulties in making these sites known to the wider community. One interviewee noted, "make sure the community knows who you are and what you do—PACE is so different."

PACE builds coalitions within the immediate neighborhood in order to build legitimacy and recognition among the wider community. One interviewee recalled how the neighborhood banded together when the local government wanted to require parking permits. Residents of the community were concerned that such a program would severely limit PACE employees' ability to work and provide services in their neighborhood. This stands out as an example of how a successful CBMLTSS program can be integrated into the community, enriching the lives of not only participants in the program but people in the wider community as well.

The program was able to overcome a potentially large challenge, despite the fact they only serve a small percentage of the community. In doing so, they were also able to build political support that enabled the program to accomplish its mission.

Demographics

CBMLTSS programs serve very vulnerable populations. As a key informant noted, "long-term care is compensating for functional deficit," meaning providers are contending not only with physical decline but mental decline as well. The needs of the population served by this particular program are very complex.

Following from this, a high-risk participant pool leads to potentially higher costs. One interviewee noted managed care organizations may be cautious about serving this population in a similar way—they may get more money, they noted, but the participant also incurs higher costs. "If the MCO does a poor job they will almost certainly lose money on the client, but if they do a good job they'll definitely make money." The demographics of a CBMLTSS program are complicated and any MCO who attempts to roll out a new program may not know if it is financially advantageous to them for quite some time.

Impact on Family

The impact of this program on families appears varied; interviewees noted that the level of family involvement varies by proximity and family dynamics. Some participants do not have families involved, while others (particularly those diagnosed with dementia or other cognitive decline) have designated a family member to make decisions on their behalf. The IDT serves to mitigate the stress of decision-making that family members would otherwise experience on their own; by having the participant's entire medical team in one place, it enables the decision-maker to confer with the experts and lower their decision burdens. During IDT meetings, trained staff are present to ensure that family members do not drive the treatment plans for PACE participants.

Co-location of Services

Day Center

Though an adult day center is mandated with the operation of a PACE program, when a PACE program partners with an outside community adult day center, a continuum of care can be established. Key informants were able to describe several benefits for both the participants and the provider.

As one interviewee described, benefits for the patients are both physical and emotional. Patients are able to strength-train and attend cardio exercise classes as well as participate in a variety of activity classes. This gives the participant personal satisfaction and purpose through the "mastery of creative things." Family members also benefit because they know their loved one in is a place that cares for them, lifting a burden for family members. This person stated that partnering with senior centers is good because they have a captive audience and a diverse group that can be referred to a PACE program.

As a participant ages and becomes more cognitively impaired, the senior center cannot provide the needed care. Once a participant is no longer cognitively able to participate at a senior center, the center can refer him or her to PACE. This is an easy process if the two sites are co-located. This helps to provide a great combination because it can offer a full continuum of care from food and medical to social and recreational.

However, there are some challenges for co-locating the service providers. As one key informant stated, there is no mechanism for the senior center and a PACE provider to share costs. However, in this case, the senior center is a program that was later folded into the PACE provider, which allowed for the PACE provider to subsidize the operating deficit. This may not be the case for all partnerships. One of the last challenges stated is that "the system is only set up for people who are really, really poor or really, really rich." The senior center serves older adults of every socioeconomic status; however, it can only serve those who have the cognitive ability to make their own decisions and understand the center rules. Once people have declined past that point, the Medicaid-eligible have the choice to enroll in PACE and the wealthy have their own means, but the middle class are often left out in the cold when it comes to finding the care they need because there are fewer support systems in place.

Housing

As people age, they retire from jobs and start to live on fixed incomes. As housing costs tend to rise in major cities, this can negatively impact older adults by displacing them from their homes. This can affect older adults by moving them farther away from medical services, which can make transportation more difficult. Several PACE providers have started to partner with affordable housing developers to construct housing near or at same location as a PACE provider. This benefits the provider and participant by having access to 24/7 care, lower transportation costs, and affordability.

Whether the PACE provider has its own housing or partners with another housing developer, not all residents are enrolled in PACE and the non-PACE residents get their health care elsewhere.

This mixed population can cause some challenges. As one key informant stated, it can cause frustration for non-PACE residents at times because they do not have access to the health care, food, and other social activities taking place on-site. Shared used of space can be a possibility, but is tricky. Another interviewee stated that in California, there isn't a license for PACE, but there is a license required for activities like running a day center. This allows non-PACE participants to receive services in an adult day center. A lot of clients utilize both services. One key aspect was co-locating these services to fund a collective of partnerships that can offer services outside their PACE capabilities.

Benefits of partnership include that housing and PACE clients tend to be a very similar demographic, making it easier to serve both of them with available resources, and it creates better uses of time and space. It also creates the need for more extensive regulations, however, and since PACE centers are primarily for PACE enrollees, it may create some unwanted strife between differing client bases. The intensity of needs for PACE enrollees and responsibilities of PACE employees require high focus and many times serving the non-PACE population creates a barrier to care, as it is difficult for the staff to switch between two client bases.

Age-Friendly Communities

There is a growing civic objective to build age-friendly communities so they successfully integrate with the broader community and maintain positive feedback loops. As key informants explained, San Francisco is moving toward designing and implementing policies and programs to build an age-friendly community. From building community choirs to establishing task forces that include individuals of all ages, these efforts help people address problems with aging in place. This allows for forward-thinking efforts to design policies that will help people over their life span, as noted by a Ph.D. student researching efforts of creating an age-friendly community in San Francisco. She said that age-friendly initiatives must be characterized by a systematic coordination of municipal planning, housing, social services, transportation, and intergenerational engagement in order to sustain large demographic shifts. Alternatively, these same components must be cross-functional to provide for the needs of groups of all ages so they do not overburden or alienate other segments of the population. "There has to be an emphasis on adopting an age-in-everything lens," thus making it work for all ages.

Continuum of Care

There is a lack of a continuum-of-care access to all older adults. As mentioned previously, the system is only set up for people who are very poor or very wealthy. At the same time the system itself is "highly fragmented, [with] a lot of different funding streams, administrative oversight, and patchwork of services," as stated by a key informant from the SCAN Foundation. This makes it difficult for consumers to access and navigate services.

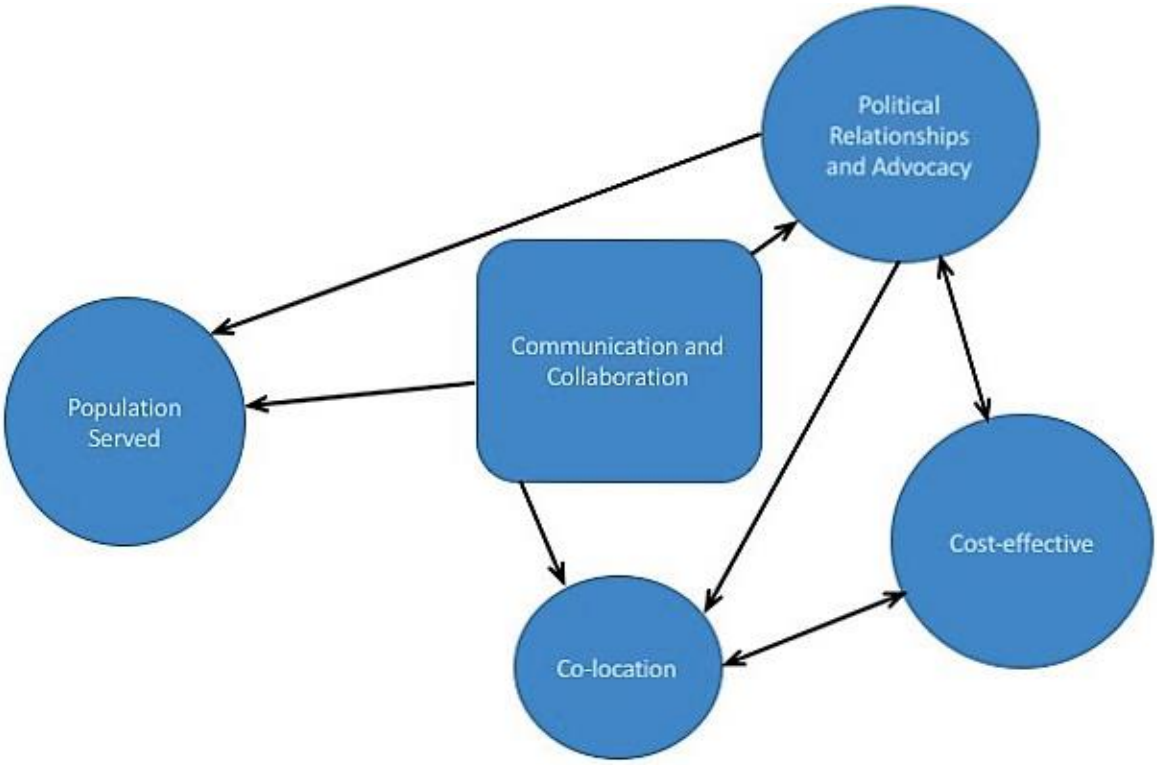
In California, there is a state-level coordinated care initiative that is starting to integrate service delivery and financing, thus breaking down the siloes. Along with age-friendly communities, these continuum-of-care initiatives are helping people age with dignity, as stated by the key informant.

Conclusion

Thematic Map

The purpose of the thematic map is to orient the reader to the overall structure of the themes that emerged as important in the key informant interviews. We decided against providing verbatim transcripts of the interviews as we did not use a standardized set of questions and the interviews are all quite lengthy; instead, we wanted to provide a visual guide to our key themes and the ways in which they are interconnected. Five high-level themes emerged from our analysis, with multiple sub-themes falling under these broader categories. Communication and collaboration emerged as the central theme, necessitating its position at the center of the map. It became clear during analysis that communication and collaboration heavily underpinned the structure of the other identified key themes. The interrelated nature of these themes becomes more clear in the following detailed analysis.

Figure 4.1. The PACE Cycle



Source: PRP project analysis.

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Chapter 5.
Applying Qualitative and Quantitative Research Findings to Austin's Dual-Eligible Population

A Review of Community Care Programs for Dual-Eligible Beneficiaries

As detailed in Chapter 2, Texas currently offers three programs that provide community-based, managed, long-term supportive services for its poor, frail, and dual-eligible population: the Program for All-Inclusive Care for the Elderly (PACE), the STAR+PLUS Home and Community Based Services (HCBS) waiver, and the STAR+PLUS Dual Demonstration Project. This chapter will examine the history of PACE in Texas and discuss the feasibility, challenges, and potential opportunities of bringing a PACE or PACE-like comprehensive care model to Austin. (Much of the Texas PACE research was performed by PRP student Lucas Asher and written in his undergraduate thesis published partway through this project, as cited.)

A comparison of the three programs analyzed in this report is provided in Table 2.1 in Chapter 2. PACE, originating in the Chinatown district of San Francisco, is a comprehensive care model for nursing-home-eligible older adults who qualify for both Medicaid and Medicare. A PACE site serves as beneficiaries' insurer and provider, allowing them to remain living in the community while also receiving all the acute and preventative care they need at the PACE site. The STAR+PLUS HCBS waiver serves a comparable population as PACE with similar medical and LTSS benefits through a capitated Medicaid payment model. Unlike the PACE program, however, the HCBS waiver functions solely as the insurer and contracts out needed services. Additionally, STAR+PLUS HCBS does not pay for non-medical transportation, while PACE does, and is currently offered throughout the state of Texas, while PACE is only offered in four counties. Finally, the STAR+PLUS Dual Demonstration Project is similar in its structure to STAR+PLUS HCBS, but is much newer and available in only six demonstration counties. In this plan, both Medicare and Medicaid pay capitation payments to managed care organizations with service coordinators similar to the STAR+PLUS HCBS program.

History of PACE in Texas

With the cost of government rising and tax revenues stable, Texas wrestles with the critical issue of how to offer and pay for an array of health and social services that balance client preferences with the real-world necessities of cost containment. Most people who need long-term care services prefer to receive those services in their own homes and communities. In addition to improving an older person's quality of life, community alternatives may be less expensive than high-level nursing homes. Medicaid is the funder of last resort for both acute and long-term care for poor Texans, but increasingly the state is using interest lists for Medicaid waivers to experiment with alternative community-based services as an alternative to institutional care and as a way to control costs.[63] Later in this chapter, we explore the implications of these state

[63] Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer."

policies for the city of Austin, and address the question of what the qualitative and cost analysis findings mean for taking care of low-income frail and disabled older adults.

Currently there are three PACE sites in Texas. The PACE model began in 1987 with the establishment of Bienvivir All-Inclusive Senior Health in El Paso. Bienvivir began as a federal demonstration project and was one of the first organizations in the country to replicate the On Lok Model. It became a PACE provider in 1992 when it entered into a contract with the State of Texas. As the largest and oldest PACE site in the state, it has a staff of 560 employees and serves 855 participants at three centers throughout its service area. It has 881 slots for Medicaid clients and maintains a monthly roster of 848 filled Medicaid slots. As the first PACE site in Texas, Bienvivir was an important resource for the other two sites when they began their application process to become PACE providers.

The second PACE site, The Basics at Jan Werner, which serves Potter and Randall Counties in the Texas panhandle, started as a community-based center in the late 1970s that provided care for elderly individuals who would otherwise need nursing home care. After visiting Beinvivir and realizing that it provided similar services, the developers of the new site began their application process to become a PACE site.[64] The organization entered into a contract with the state in 2004. Today it is allotted 150 Medicaid slots and maintains a monthly roster of 139 filled Medicaid slots.

In 2010, the third PACE site located in Lubbock started its contract with the state. The Silver Star Health Network's PACE program is a division of the parent health system, which is a community health care network. This provider is unique from other PACE providers because it is the only site in the county that is operated by a community health center.[65] Today it is allocated 115 Medicaid slots and keeps a monthly average of 87 filled Medicaid slots.

The demographics of PACE participants in Texas differ greatly from national averages. The majority of participants in Texas are Hispanic females 65 or older.[66] In addition, the state's PACE participants are more medically fragile than their national counterparts. According to the Texas PACE Association, PACE participants in the state have a higher average risk score compared to PACE sites nationally. The number of diagnoses is 23 compared to an average of 13 at other PACE sites. Fifty-five percent of Texas participants have a dementia diagnosis compared to 50 percent nationally.[67] These data suggest that the State's PACE providers are caring for a more vulnerable population than providers in other states.

History of Legislation to Expand Number of Sites in Texas

In 2001, the Texas Legislature directed HHSC to develop and implement the PACE program statewide in Texas.[68] In the legislation, the state administering agency, Texas Department of Aging and Disability Services, was directed to use its best efforts to establish six new PACE

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[64] Asher, "The Program of All-Inclusive Care for the Elderly," 27.
[65] Ibid., 28.
[66] Legislative Budget Board, "State Government Effectiveness and Efficiency Report."
[67] Ibid.
[68] Texas Legislature, Acts of the 77th Legislature, Senate Bill 908.

program sites in operation by 2002, 11 sites in 2003, and 16 in 2004. However, more than ten years later, there are still only three PACE sites in operation.

The 2014-15 General Appropriations Act authorized the SAA to raise the enrollment cap and allow 96 additional participants across all existing PACE sites.[69] However, only 49 slots were allocated and divided among the current three providers because the funding for the other 47 slots financed the difference between the amounts appropriated for slots in fiscal 2014 and 2015 and the number enrolled in PACE at the end of fiscal year 2013.[70] The same legislation also authorized the SAA to add three additional PACE sites with 150 participants each, which would tentatively begin enrolling participants in August or October of 2015.[71] The SAA has completed its Request for Proposal and has three contracts pending.

Importantly, the Texas Legislature did not authorize additional funds for the SAA to serve more participants. Instead, if allocated funds are insufficient to serve PACE participants, HHSC is authorized to "transfer up to $369,839 in General Revenue Funds (GRF) in fiscal year 2014 and $3.4 million in GRF in fiscal year 2015 from Medicaid to PACE."[72]

Though three new sites have been authorized, they are still not established PACE providers because of ongoing negotiations with the state over Medicaid reimbursement rates. In Texas, Medicaid rates are set by HHSC, the parent agency of the SAA. The SAA estimates that establishing a new PACE site takes 18-36 months and requires around $3 million to $5 million in startup costs. The newly authorized PACE providers are still in the early part of the process because of the stalled rate negotiations. The new sites cannot submit their application to CMS for approval until HHSC and the sites agree on the Medicaid rates. Only after CMS approval, which can take three to six months, can the PACE providers enter a three-way agreement with CMS and the SAA, and provide services.[73,74]

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[69] Legislative Budget Board, "State Government Effectiveness and Efficiency Report."

[70] Ibid.

[71] Ibid.

[72] Ibid.

[73] Asher, "The Program of All-Inclusive Care for the Elderly," 54.

[74] Code of Federal Regulations (CFR) 460.182 Medicaid payment:

(a) Under a PACE program agreement, the State administering agency makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid participant.

(b) The monthly capitation payment amount is negotiated between the PACE organization and the State administering agency, and specified in the PACE program agreement. The amount represents the following:

(1) Is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program.

(2) Takes into account the comparative frailty of PACE participants.

(3) Is a fixed amount regardless of changes in the participant's health status.

(4) Can be renegotiated on an annual basis.

(c) The PACE organization must accept the capitation payment amount as payment in full for Medicaid participants and may not bill, charge, collect, or receive any other form of payment from the State administering agency or from, or on behalf of, the participant, except as follows:

(d) State procedures for the enrollment and disenrollment of participants in the State's system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month, are included in the PACE program agreement.

The Texas State Legislature and PACE Authorization

Over the course of the team's project, one of the pending PACE sites withdrew its application and decided not to proceed with implementation of its proposed PACE site. As a result of the rate negotiations, the provider did not believe the proposed rates would make the project feasible. This was calculated using the feasibility study submitted to the SAA in its application. The provider projected a major decrease in Medicaid revenues over the first five years of operation and continued decreases in operating income after year three and end of year five.[75]

Though one provider withdrew its newly authorized site for approval from the state, the question still lingers as to why the legislature has not appropriated funds to develop and implement additional PACE sites given the potential cost savings. The lack of expansion of PACE in the state is partly because the state lacks cost and quality outcome data compared to other Medicaid programs that serve a comparable population. The team became aware of this from the quantitative results. The state's Medicaid program, which has transitioned to a managed care model, is similar to PACE as it integrates acute care and long-term services. However, without comparable data, the state has not been able to determine whether PACE is a cost-effective alternative to managed care. The General Appropriations Act allows the SAA to transfer funds from managed care to PACE to serve more participants but without evidence that PACE costs less than managed care, the state will be reluctant to transfer funds.[76]

However, House Bill 3823 from the 2015 legislative session will enable the state to compare PACE outcomes with its managed care program. The legislation will "link the reimbursement rates of PACE to those of the Medicaid program, modify the methods for collecting PACE and Medicaid program data, and require an evaluation of the PACE program to compare PACE costs and care outcomes to Medicaid program outcomes."[77] Supporters of the legislation believe it will yield important data that will provide evidence to the state that PACE should be expanded to serve more participants.[78] Supporters are also satisfied that the legislation "contains provisions that ensure that the Medicaid reimbursement rates for PACE are sufficient to sustain the program, but also would not be enough to exceed what is necessary and reasonable to operate the program."[79]

PACE Provider Benefits and Challenges

In addition to examining the legislative history of PACE in Texas and the role of its advocates, the team reviewed a research colleague's interviews with staff at each of the Texas PACE sites and the SAA in order expand on some of the benefits and challenges PACE providers face in Texas. This helped inform the team of any nuances regarding PACE expansion in Texas and to better understand the reasons for slow expansion.

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[75] Castillo, Letter to Texas Department of Aging and Disability Services.

[76] Asher, "The Program of All-Inclusive Care for the Elderly."

[77] House Research Organization, "Bill Analysis of HB 3823: Rate-setting and evaluation of PACE program compared to STAR+PLUS."

[78] Ibid.

[79] Ibid.

Benefits of PACE from the Provider Perspective

The most common benefits of PACE expressed by staff from the various PACE sites were health outcomes and participant satisfaction. One staff member stated that PACE is "managed care in the truest sense of form" because before enrolling in PACE, participants had no central authority managing their care. She noted how difficult it is to manage the health care system as a "competent young adult" so for frail, low-income adults, navigating the system is nearly impossible.[80] A PACE Center acts as a "wheel hub" that refers participants to specialists when necessary. As the hub of operations, the PACE center staff can coordinate and manage all participant care as the program's nurse, managers, and physicians are in constant communication with specialists. All aspects of the participant's visit with the specialists are related back to the program staff without requiring the participant to do anything. For instance, if a cardiologist wrote a prescription for the participant, he or she would fax the prescription to the program staff instead of giving it to the participant. This enables the participant to receive the medication faster and enables coordination and communication between the specialist and PACE program staff. The participant's care is managed without the participant providing information about the specialist visit to PACE staff and filling the prescription on his or her own. This aspect of PACE that manages the participant's care in a coordinated way is what the staff member most appreciates about the model.[81]

One of the site's directors agreed with the previous staff member that the program acts as a managed care program because of the coordination across all medical disciplines. The PACE model allows staff to address all participant needs and reduces barriers for patients to access medical care. She stated it is a holistic approach that includes home care, medication, and physical therapy. "You get to treat the whole person and know everything about them." Because PACE coordinates all participant care and provides all medical and social services, staff members are able to learn much about their participants, which can lead to providing higher-quality care. Another director added that program participants and staff become like family and the she is "happy to be a part of it" because they are able to make a difference in people's lives. For instance, participants have gone up to her and told her that they would not know what to do without the program. In the first few days at the center, the director heard a couple of participants laughing when one participant expressed bewilderment at her daughter, who thought she "dumped" her mother at PACE; however she is actually "having the time of [her] life."[82]

A medical officer described a hypothetical scenario to elaborate on the coordination and integration that a PACE model can provide. He can see a patient with a painful knee in the morning, evaluate it, inject it with a steroid, send the participant to the physical therapist for heat treatment and then to the occupational therapist to be evaluated for lifestyle changes. A treatment plan that would normally take weeks to accomplish can be done in a few hours because all the participant's health care providers are under one roof.[83]

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[80] Asher, "The Program of All-Inclusive Care for the Elderly."
[81] Ibid.
[82] Ibid.
[83] Ibid.

The medical officer also described the typical participant when he or she is first enrolled. The participant is usually taking several medications prescribed from various physicians with no designated person overseeing their care. When the Interdisciplinary Team with the integration of various disciplines comes in, the patient can receive more consistent care and consecutive lab work. This keeps participants out of the hospital and in their homes. "We had patients going to the ER every three weeks. Now, patients haven't been in hospitals in over a year or two. They can call a nurse 24/7, who then can go to their house and call me. I can make a decision at 11 p.m. instead of participants taking a trip to the ER."[84] With this system of care, PACE is able to not only contain costs for the overall health system but also save patients the burden and time that comes with prolonged illnesses.

PACE is a cost-effective model because the program takes individuals who would normally be in nursing homes and enables them to stay in their homes with their families. The medical officer cited statistics to justify his opinion that because most Medicare costs are spent on the last three to four years of an older adult's life, it is cost-effective for the government to put the risk on PACE. Thus, PACE staff have to develop very good managerial skills to prevent unnecessary hospitalizations and emergency room visits.[85]

Another staff member noted the important task is to identify cost efficiencies (such as administrative) within the organization, understand and project program costs, and build reserves over time. Through their experience, they learned how to manage their population better and keep them out of the hospital. Even as a non-profit, in order to be successful PACE programs have to manage their organization like any other business in order to reinvest any realized surplus for future growth.[86] These management strategies mirror national PACE trends

Challenges of PACE from the Provider Perspective and SAA

As noted earlier in the current status of PACE expansion, one of the biggest challenges faced by providers are the rates and caps on enrollment, which can lead to tension in the relationship between the PACE provider and the SAA. As with Medicare rate rules, the Medicaid rate that the state pays the PACE provider must be less than what the state would pay a provider serving a similar population. This aligns the program's objective of delivering similar services as other care providers but at lower costs to the federal and state governments. Since the state has control over the Medicaid rate process, there are differences among PACE providers across the states because of factors like a state's spending, regulatory, and political environments. Since each state operates their respective Medicaid programs differently within approved federal guidelines, PACE provider's relationship with their state administering agency varies from state to state.[87]

One executive director of a PACE program explained the biggest challenge for her site was getting the SAA to follow mandates of the legislature, which she feels has been supportive of PACE. She believes that the SAA has not been supportive of expanding PACE and in setting reasonable reimbursement rates for newly authorized sites. While current rates for providers are

[84] Ibid.
[85] Ibid.
[86] Ibid.
[87] Ibid.

adequate reimbursement, she is concerned that newly authorized sites will not be successful if the rates are not higher than currently proposed.[88]

Another challenge experiences by a PACE provider was the application process to become a PACE site. As the key informant stated, "PACE is highly regulated by CMS as the applicant process to become a site takes well over a year." She stated the application process is so arduous that she would not apply to become a PACE provider from scratch. During the interview she would ask, given the difficult regulatory environment, why an organization would want to operate a PACE site? In order to overcome this, operating a PACE program requires passion and a determination to deliver high-quality care to frail older adults. Every staff member, from the executive director to the van driver, has to be invested in the PACE model in order for the organization to succeed.[89]

In addition to the regulatory environment, one staff member noted her greatest challenge was the state's unfamiliarity with PACE. This hampers the program's operation. One reason is due to the SAA auditor turnover. She stated that "once a contact develops an understanding of the PACE program, a new liaison lacking program knowledge is brought on to replace the former contact." In addition, the federal regulations are inconsistent and up to the interpretation of the auditor. With a different auditor from one year to the next, different interpretations are applied, which makes it difficult for the PACE provider to manage.[90]

Lastly, the state regulatory climate is a barrier to growth. Due to the state's role in dispensing Medicaid funds, the state must be willing to invest time and money in regulating PACE providers. "States must determine whether new legislation is required, the licensure or certification that providers will need, and whether any financial requirements beyond those stipulated by the federal government will be necessary in view of the state's regulations."[91] Because states play a significant role in the operation of PACE programs, the growth of programs nationwide is highly dependent on the state's interest in seeing the program succeed.

The commissioner of the SAA stated his view on the challenges. He believes that these challenges are not uncommon for regulatory agencies. The role of a regulator is to enforce rules, which means regulators visit and inspect sites unannounced at times. This can be done collaboratively, but he stated the relationship would never be as collaborative as a provider would want. He did admit that the SAA could do a better job at communicating with providers about the rules and the agency could improve its knowledge base regarding the PACE program. However, when asked about providers' concerns with reimbursement rates, he said that HHSC couldn't raise the reimbursement rate without more funding from the Legislature. In the meantime, they are trying to calculate as generous a rate as possible with the appropriations HHSC currently has. Ultimately, the commissioner believes the reason for sluggish PACE

[88] Ibid.
[89] Ibid.
[90] Ibid.
[91] Ibid.

expansion in the state lies with the program's significant administrative and regulatory costs and competing priorities for legislative appropriations.[92]

Qualitative and Quantitative Research Implications for Austin

The history of PACE's authorization and funding in Texas, coupled with providers' perceived heavy regulatory burdens and rocky relationships with state regulators, may initially paint a negative picture of PACE's feasibility in Austin. However, Austin's diverse client population and initial community support may provide opportunities for a program like PACE to flourish in the city. This section will analyze what our qualitative and quantitative findings about PACE and other managed care programs indicate about how local policymakers can best serve Austin's frail, elderly, low-income community.

Benefits and Opportunities of bringing PACE to Austin

Our research found that a PACE model may provide unique benefits that could not be obtained from STAR+PLUS CBMLTSS programs. Primarily, our quantitative analysis of client surveys indicated that PACE beneficiaries are uniquely satisfied with their quality of care. Survey responses from STAR+PLUS participants suggested that they are less satisfied with the quality of care and information they receive than national averages for both Medicaid and Medicare recipients. In contrast, PACE participants expressed significantly higher satisfaction with the access and quality of their care than non-PACE participants. If we are looking for the most beneficial model for participants, PACE seems like it leads to greater client satisfaction than STAR+PLUS.

Furthermore, cultural competency is ingrained in PACE's history, potentially making it better suited to diverse Austin populations. Interviewees in San Francisco expressed their belief that PACE's combination of individualized care and community-building activities creates an environment in which unique cultural differences can be respected while the overall group is served. In Austin, where by 2040 nearly half of all residents 65 years and older will be non-white, such a culturally competent model may be well-received. Furthermore, because PACE entirely removed the burden of scheduling and coordinating with administrators (since this is all handled internally), potential problems induced by language barriers are diminished. In short, PACE's history and programmatic design seems particularly well-suited for the elderly population of the future.

Additionally, during this time of skyrocketing housing costs, our findings indicate that PACE is an ideal model for linking housing and health care services for the dual-eligible population. In San Francisco, several PACE providers have partnered with affordable housing developers to construct housing alongside PACE providers. There are definite benefits to this arrangement. Our informants stated that the housing and PACE clients tend to be a very similar demographic, so it is easier to serve both of them at once, thereby saving time, space, and money. The participants have 24/7 access to care, and the provider has to spend less money on transportation. At the same time, the arrangement necessitates more extensive regulations, as well as some friction between those who live in the complexes but aren't in the PACE program, and those who

[92] Ibid.

are. Nevertheless, providers in San Francisco indicated this co-location is ideal and especially suited to the PACE model.

This is positive news in Austin since those organizing the renovation of the RBJ Center, which is on track to double its affordable rental unit portfolio for seniors and build a plethora of new retail spaces, have expressed enthusiasm at the prospect of bringing a PACE model to the new complex. The fact that the care community in Austin is expressing such emphatic support suggests this model might be replicable in Austin.

Potential Challenges of Bringing PACE to Austin

Our qualitative research indicated that many of the aspects required for a successful CBMLTSS program are simply not evident in the current regulatory environment in Texas. First, as detailed in Chapter 4, PACE providers in San Francisco emphasized that a strong, friendly, and communicative relationship between PACE providers and state regulatory agencies is necessary for a sustainable PACE program. Indeed, a regulatory compliance officer at On Lok emphasized that he thought it would be impossible to meet their regulatory requirements without a positive relationship with the agencies in charge. As stated in the previous section, interviews with PACE sites in Texas indicate that this type of warm relationship between PACE sites and regulators is simply non-existent in Texas. Although many providers feel that the legislature views the PACE program positively, they believe that regulators have an ambivalent or negative perception of the program. Regardless of the objective validity of these claims, the fact that providers perceive a negative relationship is important. Numerous informants at On Lok stated that continued success is dependent on a supportive political environment and coordinated collaboration, and the fact that Texas providers do not think that this environment is present here calls into question how the program can function smoothly in the current environment.

Interviews in California also indicated that in order to attract state resources and remain viable in the long-term, PACE must be able to grow in size. Our qualitative research indicated that this is because with larger beneficiary populations, PACE sites can obtain savings due to economies of scale and can advocate more effectively for their needs at the state and local levels. In Texas, legislators and regulators place a strict cap on the number of enrollees at each PACE site as well as on the number of sites statewide. At the same time, our quantitative analysis indicates that the state does not always set its capitated rates high enough to compensate for the diminished client base. Overall, the caps on enrollment therefore prevent sites from obtaining more significant savings reductions and may also diminish their ability to advocate for their needs with regulators and legislators.

At the same time, however, the new research into PACE's costs authorized in HB 3823 shows promise for potentially increasing the client base. If the state analysis reveals that PACE is indeed a cost-effective model compared to STAR+PLUS, supporters are optimistic that lawmakers will loosen the caps on enrollment, enabling Texas sites to become more cost-effective and advocate more effectively for their needs. At the federal level, the 2015 PACE Innovation Act (S. 1362) approved by the U.S. House of Representatives allows the Centers for Medicare & Medicaid Services to develop pilot projects based on the successful PACE Model of

Care.[93] The new Act will create a unique opportunity for Texas to rebalance the state's long-term care system and bring the model to more non-elderly individuals with multiple chronic conditions and disabilities in addition to older adults who are not nursing-home-eligible.[94]

Our research also indicated that there can often be large startup costs for PACE providers that may be prohibitive: the quantitative results reveal that in the first two to three years a PACE site can run operational losses ranging from $500,000 to over $800,000. [95] Interviews with PACE administrators in San Francisco also emphasized that starting a PACE program is expensive, difficult, and complex. These cost and administrative barriers may make it difficult to attract investors into a PACE site in Austin. On the other hand, reception towards bringing a CBMLTSS program like PACE to Austin is strong among local stakeholders and care providers, such as the RBJ Center. Support this early on from a potential site suggests the logistical barriers to entry may not be as enormous as initially postulated, and the fact that the building, infrastructure, and client base at RBJ is already established indicates that perhaps the startup costs for this or a similar arrangement would be manageable.

Local Organizations Best Suited to PACE in Austin

Our research identified that it is much easier to sustain a PACE site in the long term if there is strong support and buy-in from local nonprofits and providers. In Austin our research has shown this to be the case. On April 12, 2016, for example, during an Eldercare Summit we hosted for stakeholders and care providers in Austin, a poll showed that 83 percent strongly supported expanding CBMLTSS programs in Texas and 69 percent disagreed that Austin has sufficient options for aging in place (see Appendix D). Support for bringing PACE to Austin is therefore clearly present.

It is also clear that the organizations that would provide support must be culturally competent, flexible, and amenable to resource co-location: this is evident in the organizations that exist in Austin, such as the RBJ Center, Family Eldercare, and AustinUP. The fact that these organizations are supportive of this research project and of PACE's mission, and that their current service administration reflects PACE's goals, indicate that nonprofit support necessary for PACE in Austin is present.

Future Outlook

With a growing aging population and significant budget constraints, Texas faces real challenges in providing high-quality care for medically and financially vulnerable older adults. The PACE program offers the state a unique alternative to save costs by providing integrated community-based care using capitated Medicare and Medicaid funds. However, unlike in other states such as California, PACE faces an uphill climb in expanding in the state. This is due to many factors, from the legislature's tight control over the RFP process to the adversarial relationship between the SAA and PACE providers and an overall regulatory and political environment that has not expressed the support needed to expand PACE in the state. Though PACE participants

[93] Cortes and Sullivan-Marx, "A Case Exemplar for National Policy Leadership."
[94] Banach and Gong, "PACE Innovation Act Creates Opportunities."
[95] National PACE Association, "PACE Program Development Considerations," 8.

experience better health outcomes than in traditional fee-for-service programs and participant care costs less to federal and state governments, the prospect of expansion in Texas is bleak. The "silver-haired tsunami" is quickly approaching and PACE could help fill the gap in services for a vulnerable older population. However, enrollment caps and insufficient support from the state make it exceedingly difficult for the program to provide care for the millions in the state who will need supportive health and social services in order to maintain their independence and live safely in their communities.

Nevertheless, hope remains in the impending state comparison of rates and cost-effectiveness between STAR+PLUS and PACE. Besides providing needed apples-to-apples comparisons in figures, the new information will hopefully impel state leaders to place PACE expansion higher on their legislative priorities.

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Chapter 6.
Final Discussion, Next Steps, and Recommendations

What's Next?

After conducting thorough qualitative and quantitative research about the differences between STAR+PLUS HCBS, STAR+PLUS Dual Demonstration, and PACE, the question becomes—what's next? Based on our qualitative research, we know there is a growing population of older adults who will require specific and unique healthcare options in the city of Austin. More specifically we also know there is a subset of that population who are low-income, ethnically diverse older adults who will live longer than average with more diseases, disabilities, and specialized healthcare needs. With this knowledge, we can predict a potential shortcoming in both healthcare options and affordable housing options in the city of Austin. Will our current healthcare options adapt to fulfill those impending needs? Or must we seek more alternatives to do so? When asking questions about the future, we must do our best to anticipate problems knowing that today's ideas may result in tomorrow's solutions. While investing more money in current healthcare infrastructure and options in the present may not cause immediate results, we can trust those actions will prevent future problems.

Since the Texas Legislature directed the SAA to have 16 PACE sites in operation by 2004 and Texas currently only has three, we can deduce there is a clear disconnect between having the idea for a PACE site and actually creating a PACE site. As we move forward with our research, we understand the push from the state to invest in and expand STAR+PLUS options. With this understanding, we note the major challenges to starting a PACE program in the state of Texas. Not only are PACE sites not currently growing in number, despite authorization, but the government continues seeking more options through STAR+PLUS. The future implementation of the two PACE sites currently in rate negotiations will give real insight into the future of PACE in Texas. Based on the success or failure of these two sites, PACE in Texas might begin to grow or stay stagnant.

The Waiting Game

Since both STAR+PLUS HCBS and STAR+PLUS Dual Demonstration do not have current data that reflects the new aspects of the programs, we must await new data that accurately reflects the services offered by each respective program and the costs of those services. For example, as a newly rolled-out program, STAR+PLUS Dual Demonstration is only offered in six counties. Future expansion of the program ultimately depends on the success of these six counties, which we will not know for at least another year. The dual demonstration program, structured similarly to PACE, does show a slight shift for healthcare provision within the state of Texas. The new program acts more like a fully integrated managed care program—different than anything else offered through Medicaid. This gradual change shows promise for healthcare reform in the future for Texas. Through this implementation, we can see how health care has begun changing to reflect the changing and growing population of older adults.

In addition, since STAR+PLUS HCBS recently began covering nursing home care and services, the current financial data does not reflect the costs of these new changes. But similarly to STAR+PLUS Dual Demonstration, these changes reflect a shift in Medicaid healthcare options.

Furthermore with PACE, we must wait for the Texas House Bill to see how the program compares with STAR+PLUS options in terms of cost-effectiveness. The results of this study will determine whether or not the cost of PACE's all-inclusive approach to healthcare is worth the price.

What's Lacking?

By conducting comprehensive qualitative and quantitative research on available data, we were able to get clear picture of how programs like these are evaluated. We have developed further understanding about what aspects and qualities these evaluations value. For example, when evaluating the merits of PACE programs, the State of Texas focuses mainly on the cost-effectiveness of the program. Policymakers want to know if the program saves money when compared to the already existing Medicaid options.

Through our research we have also identified certain qualities these evaluations should be taking into consideration. For example, we determined the importance of evaluating the quality of life for participants in various healthcare programs. By measuring the number of non-medical related outings or number of opportunities for older adults to hang out with their peers, evaluations can reflect the importance of the mental health side of health care. Evaluating items like these differ from measuring health outcomes such as the number of hospital visits or physical therapy visits. More opportunities for individuals to participate in non-medical interactive activities make for a better quality of life.

Advocacy

While we wait for the data needed to make decisions about the effectiveness of the current healthcare options in Texas, we can still advocate for the expansion of these options for older adults in the present. It is important to equip individuals with knowledge about the current system. We can create an easier-to-navigate website outlining all of the local non-profits that provide affordable healthcare options in Austin along with information about statewide options.

It is important for organizations with power to continue advocating for those who need their support. Organizations like the St. David's Foundation can continue to fund short-term solutions in the present. For example, they can support non-profit organizations that provide valuable services to the community. They can also advocate specifically for programs like PACE to be expanded in the state of Texas. If PACE does not turn out to be a viable option, they can help fund a PACE-like center that offers various healthcare services through STAR+PLUS HCBS.

For local Austinites, we recommend writing your legislators to inform them of support for expanding healthcare options in the state of Texas. It is also important to stay knowledgeable about the current shift in STAR+PLUS healthcare. As these new programs expand, staying educated about the results of the new healthcare options will make for better advocating for more efficient options.

Affordable Housing

We were able to identify two main affordable housing communities in Austin for low-income older adults—Lyons Gardens and the Rebekah Baines Johnson (RBJ) Center. We visited each location, interacting with the staff, touring the facilities, and evaluating the quality of services. By interacting with the housing options we were able to get a clearer picture about the affordable house situation in Austin. These two places, while fulfilling a vital need in the community, can only serve a finite amount of individuals. The need for affordable housing well outnumbers the amount of housing units within these two locations.

Based on our qualitative research conducted in San Francisco, California, we believe the process to link affordable housing with affordable healthcare for the low-income, aging community to be a natural one. When talking to the On Lok staff members about how they linked affordable housing to PACE, they spoke about the gradual process in doing so. As their PACE programs became more successful, they were able to locate and fund housing options for their participants.

Eldercare Summit

In April 2016 during our second semester of research, our team had the opportunity to host an Eldercare Summit—an opportunity to share our research with the community, reach out to health care activists and policymakers, and gather local opinions regarding healthcare for the low-income, aging population.

As a group, we were able to present our key findings followed by a time of questions and answers from the audience. Following the presentation, we hosted a panel discussion of local community and political leaders, including Texas House Representative Larry Gonzalez, former House Representative Carl Isett, Paul Saldaña, Austin ISD Board of Trustees District 6 and Vice Chair of the Board of Directors for the Austin Geriatrics RBJ Senior Housing Center in Austin, and Professor Shirley Franklin, former Mayor of the City of Atlanta—moderated by Mandy De Mayo, Executive Director of Housing Works. The panel offered opinions based on their vast experience working in public policy and advocating for the aging population. Following the panel discussion, we hosted an interactive polling session from the audience in order to gauge the public opinion about both the viability of the recommended long-term service and support options and comments from a panel discussion of local political and community leaders to evaluate the viability of the proposals.

In the summit's closing, participants could sign up to serve on a steering committee. The committee would work with St. David's Foundation and Central Health on resource mobilization to implement the proposed solutions for affordable assisted living at RBJ Senior Independent Living Center. Four women signed up on the Google form, including two officials from the Capital Area Council of Government, a Director of Gerontology Education Programs, and a retired teacher advocate, to potentially address this objective. The names of these participants are available upon request from Shadhi Mansoori (Shadhi.mansoori@gmail.com).

Final Thoughts

Our research reveals two important issues that merit attention: 1) the immediate need for healthcare options for the low-income older population and, 2) the more options for this special population, the better. Once Texas legislators conduct sufficient research comparing PACE to STAR+PLUS, future PACE sites might become part of the solution. In addition, STAR+PLUS Dual Demonstration might expand based on potential success in the six counties that it is offered.

PACE appears to be cost-effective and less expensive than fee-for-service, but cost-effectiveness as compared to STAR+PLUS programs remains unclear. And since the current political climate does not lend itself to expanding something that maybe viewed as an entitlement program, PACE may not have a future. Expanding comprehensive care, however, may actually serve to lower overall costs. Even though PACE *does* have many documented benefits, the question remains as to whether the program is economically and politically superior to the other options. Based on our qualitative research conducted in San Francisco, however, we believe they can coexist. They do not have to be mutually exclusive. On Lok employees mentioned several times over the course of our visits that other healthcare programs simply made for more competition for potential participants. Older adults had the option to choose a program they believed would be most beneficial for them. This increased competition does not create any major problems, only gave more options for a diverse population.

As we look towards the future, we have identified a few possibilities with implementation in mind. A mentioned, the RBJ Center in East Austin is in the midst of a major expansion project, presenting an opportunity to align health care with affordable housing. As they expand, retail space will become available to rent. If the space could be used to house doctors or therapists, residents of RBJ would have the opportunity to make doctor or physical therapy visits without traveling far from their homes. This will make access to health care more feasible and practical for their everyday lives. In addition, we believe it would be most beneficial to collaborate with organizations like AustinUP or GRACE, or other local aging organizations in order to create programs that help educate low-income seniors to be more effective in influencing their living arrangements and healthcare options. This collaboration has the potential to become a new coalition that aims to advocate for human rights and the dignity of the most vulnerable seniors in Austin. Although waiting for the right information or funding of programs like PACE or STAR+PLUS Dual Demonstration may become discouraging, we can always continue to seek other options and advocate for those who may not be able to do so for themselves.

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Appendix A.
CMS PACE Manual Chapter 13 on Capitated Payments

Programs of All-Inclusive Care for the Elderly (PACE)

Chapter 13 – Payments to PACE Organizations

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(Rev. 2, Issued: 06-09-11)

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10 - Introduction

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

This chapter gives an overview of the policies and methods CMS follows in determining the amount of payment a PACE organization will receive for coverage of benefits for PACE participants who are enrolled in their plan as provided by 42 CFR § 460.180 of the PACE Regulations. In addition, this chapter outlines PACE organization responsibilities, payers, premiums, and Medicare Part D.

10.1 - General Payment Principles

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The following basic principles distinguish the PACE financing model:

- Obligation for payments is shared by Medicare, Medicaid, and individuals who do not participate in Medicare and Medicaid;
- Medicare, Medicaid, and private payments for acute, long-term care, and other services are pooled;
- The capitation rates paid by Medicaid are designed to result in cost savings relative to expenditures that would otherwise be paid for a comparable nursing facility-eligible population not enrolled under the PACE program;
- Medicare rates are pre-Affordable Care Act (ACA) rates, unadjusted for Indirect Medical Education (IME), and adjusted for risk and frailty;
- The PACE organization accepts the capitation payment amounts as payment in full from Medicare and Medicaid.

[71 FR 71318 (Dec. 8, 2006)]

20 - PACE Organization Responsibilities

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

PACE organizations are paid monthly prospective payments for each eligible enrolled PACE program participant in accordance with Sections 1853 and 1894(d)(1) of the Act. For Medicare Part A-only participants who are also eligible for Medicaid, the State is obligated to pay some Medicare Part B premiums under Section 1902(a)(10) of the ACT.

The PACE organization is required to do the following:

- Verify at time of enrollment whether the participant is dually eligible for Medicare and Medicaid and whether the participant has Medicare Part A and/or Part B;
- Remind participants that unless they are dually eligible, they will need to continue to pay their Medicare Part A premium, if not free, Part B (if not eligible for State coverage) and/or Part D premiums, if applicable;
- Submit risk adjustment/encounter data (when applicable) to CMS;
- Identify payers that are primary to Medicare;
- Determine the amounts payable by those payers;
- Coordinate benefits to Medicare participants with the benefits of primary payers.

[42 CFR §§ 460.150, 460.152(a), 460.180; 71 FR 71309, 71318; (Dec. 8, 2006)]

30 - Payment Methodology

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

30.1 - Part A and Part B of Medicare

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

CMS makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicare participant in the payment area. Prospective payments are made up of the pre-ACA county rate, unadjusted for Indirect Medical Education (IME), and multiplied by the sum of the individual risk score and the organization frailty score. This payment methodology is described in the PACE program agreement. The following three sections provide a brief description of PACE payment and the differences between PACE payment and payment for other Medicare Advantage plans.

30.2 – County Rates

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The prospective payment rates for PACE are based on the applicable amount under section 1853(k)(1) of the Act, unadjusted for IME. The applicable amount is the pre-Affordable Care Act rate, which will be phased-out under the Affordable Care Act for other Medicare Advantage plans. The applicable amount will not be phased out for PACE. In rebasing years, this rate is the greater of: 1) the county's FFS rate for the payment year or 2) the prior year's applicable amount increased by the payment year's National Per Capita Medicare Advantage Growth Percentage. In non-rebasing years, this rate is the prior year's applicable amount increased by the payment year's National Per Capita Medicare Advantage Growth Percentage.

Section 1853 (k)(4) of the Act requires CMS to phase out Indirect Medical Education (IME) amounts from MA capitation rates. PACE programs are excluded from the IME payment phase- out under that section.

Effective CY 2006 and subsequent years, CMS makes advance monthly per capita payments for aged and disabled enrollees based on the bidding methodology established by the MMA. PACE plans are not required to bid, however.

30.3 – Risk Adjustment

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

For the final payment rate, the county rate for the PACE organization is multiplied by the individual participant risk score. Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries. The individual participant risk score for Medicare Advantage and PACE is calculated using the CMS–HCC model (community, long-term institutionalized, End-Stage Renal Disease (ESRD) or new enrollee) published in the Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (Rate Announcement).

A frailty factor is added to each individual's risk score for PACE plan payment. Risk adjustment predicts (or explains) the future Medicare expenditures of individuals based on diagnoses and demographics. But risk adjustment may not explain all of the variation in expenditures for frail community populations. The purpose of frailty adjustment is to predict the Medicare expenditures of community populations with functional impairments that are unexplained by risk adjustment. The frailty score added to the beneficiary's risk score is calculated at the contract-level, using the aggregate counts of ADLs among HOS-M survey respondents enrolled in a specific organization. More information regarding the HOS-M can be found in Chapter 10, Section 30.7. Because the

CMS-HCC model has been designed to pay appropriately for the long-term institutionalized population, frailty adjustments are added to the risk scores only for community-based and short-term institutionalized enrollees (i.e., the frailty adjustment for long-term institutionalized enrollees is zero). Updated frailty factors are published in the Rate Announcement for the payment year in which they are first used.

30.4 – Additional Payment Information

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

For additional, more detailed information about PACE Medicare payment, see the following documents:

- Risk Adjustment, Chapter 7, Medicare Managed Care Manual. http://www.cms.gov/manuals/iom/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326&intNumPerPage=10
- Payments to Medicare Advantage Organizations, Chapter 8, Medicare Managed Care Manual. http://www.cms.gov/manuals/iom/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326&intNumPerPage=10
- CMS publishes changes to the Medicare Advantage payment methodologies in the Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Advance Notice) in mid-February at http://www.cms.gov/MedicareAdvtgSpecRateStats/ for public comment. The final payment methodologies are published in the Announcement of Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (Rate Announcement) on the first Monday in April at the same website.

[42 CFR § 460.180(a) through (c); 71 FR 71318 through 71319 (Dec. 8, 2006)]

30.5 - Medicare Part D Payment

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

In order for PACE organizations to continue to meet the statutory requirement of providing prescription drug coverage to their enrollees, and to ensure that they receive adequate payment for the provision of Part D drugs, beginning January 1, 2006, PACE organizations began to offer qualified prescription drug coverage to their enrollees who are Part D eligible individuals. The MMA did not impact the manner in which PACE organizations are paid for the provision of outpatient prescription drugs to non-part D eligible PACE participants.

PACE organizations are required to annually submit two Part D bids: one for a Plan Benefit Package (PBP) for dually eligible enrollees and one for a PBP for Medicare-only enrollees. The Part D payment to PACE organizations comprises several pieces, including the direct subsidy, reinsurance payments, and risk sharing. Payments for eligible enrollees of either PBP will include a low-income premium subsidy and a low-income cost-sharing subsidy for basic Part D benefits. Payments for dually eligible enrollees will also include an additional amount to cover nominal cost sharing amounts (“2% capitation”), and an additional premium payment in situations where the PACE plan’s basic Part D beneficiary premium is greater than the regional low-income premium subsidy amount.

[PACE Program Agreement Appendix M: Medicare and Medicaid Payment Amounts]

30.6 - Medicaid

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

Each State that elects PACE as a Medicaid State Plan option must develop a payment amount based on the cost of comparable services for the State's nursing-facility-eligible population. Generally, the amounts are based on a blend of the cost of nursing home and community-based care for the frail elderly.

Under a PACE Program Agreement, the State Administering Agency makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid participant.

The monthly capitation payment amount is negotiated between the PACE organization and the State Administering Agency, and specified in the PACE Program Agreement. The amount represents the following:

- Is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program;
- Takes into account the comparative frailty of PACE participants;
- Is a fixed amount regardless of changes in the participant's health status;
- Can be renegotiated on an annual basis.

Under Sections 1894(f)(2)(B)(v) and 1934(f)(2)(B)(v) of the Act, the PACE organization must be at full financial risk. The State may not share risk with the PACE organization. The PACE organization must accept the capitation payment amount as payment in full for Medicaid participants and may not bill, charge, collect or receive any other form of payment from the State Administering Agency or from, or on behalf of the participant, except as follows:

- Payment with respect to any applicable spenddown liability under 42 CFR §§ 435.21 and 435.831 and any amounts due under the post-eligibility treatment of income process under 42 CFR § 460.184;
- Medicare payment received from CMS or from other payers in accordance with 42 CFR § 460.180(d).

State procedures for the enrollment and disenrollment of participants in the State's system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in the month, is included in the PACE Program Agreement.

[42 CFR §§ 460.180; 460.182; 460.184; 42 CFR §§ 435.21; 435.831; 71 FR 71321 (Dec. 8, 2006)]

30.7 - Post-Eligibility Treatment of Income

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

Section 1934(b)(1)(A)(i) of the Act states that a PACE organization shall provide to eligible individuals, all covered items and services without application of deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid. States are permitted to use post-eligibility treatment of income in the same manner as it is applied for individuals receiving services under a home and community-based services waiver program under Section 1915(c) of the Act.

An argument could be made that Sections 1934(b) and (i) of the Act are in conflict since under 1934(i) of the Act, PACE participants may incur limited liability for part of the cost of their services. However, the type of Medicaid participant liability permitted by Section 1934(i) of the act is not cost sharing prohibited by Section 1934(b)(1)(A)(i) of the Act.

Section 1902(a)(17) of the Act permits an individual (or family) who has more income than allowed for Medicaid eligibility to reduce excess income by incurring expenses for medical or remedial care to establish Medicaid eligibility. However, this spenddown process is used in establishing Medicaid eligibility rather than being the type of cost sharing prohibited by Section 1934(b)(1)(A)(i) of the Act which refers to deductibles, copayments, coinsurance or other cost sharing beyond participant liabilities related to Medicaid eligibility.

[42 CFR § 460.184; 71 FR 71322 (Dec. 8, 2006)]

40 - PACE Premiums

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

40.1 - Definition of Premiums

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The term "premiums" as used in this section does not include spenddown liability under 42 CFR § 435.121 and 42 CFR § 435.831, or post-eligibility treatment of income under 42 CFR § 460.184. A participant's "share of cost" responsibility under Medicaid is not considered a premium. PACE organizations may continue to collect any liability due to them under Medicaid spenddown and post-eligibility processes, but that liability is not a premium.

[71 FR 71322 (Dec. 8, 2006)]

40.2 - Categories

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

Based on Sections 1894(i) and 1934(j) of the Act, CMS believes the Congress intended to permit individuals with Medicare Part A, Medicare Part B, Medicaid, any combination of the above, or none of the above mentioned benefits, to participate in PACE. 42 CFR § 460.150(d) states that a potential participant is not required to be Medicare enrolled or Medicaid eligible.

A participant's monthly premium responsibility depends upon his or her eligibility under Medicare and Medicaid.

[42 CFR § 460.150(d); 71 FR 71309 (Dec. 8, 2006)]

40.3 - Premiums for Persons who are Medicare Eligible

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

Nearly all Medicare participants have both Part A and Part B, and the capitation amount that Medicare pays is the sum of the Part A and Part B capitation rates. However, Section 1894(a)(1) of the Act permits a PACE program eligible individual who is entitled to Medicare benefits under Part A or enrolled under Part B to enroll in the PACE program.

For persons who are eligible under only one part of Medicare, the Medicare capitation amount will be only the portion for that part. Such a participant is required to make up the difference through

payment of an additional premium amount equal to the missing piece of the Medicare capitation amount. The premiums for Medicare-only participants are as follows:

- For a participant who is entitled to Medicare Part A and enrolled under Medicare Part B, but is not eligible for Medicaid, the premium equals the Medicaid capitation amount;
- For a participant who is entitled to Medicare Part A, but is not enrolled under Part B and is not eligible for Medicaid, the premium equals the Medicaid capitation amount plus the Medicare Part B capitation rate;
- For a participant who is enrolled only under Medicare Part B and is not eligible for Medicaid, the premium equals the Medicaid capitation amount plus the Medicare Part A capitation rate.

No premium may be charged to a participant who is dually eligible for both Medicare and Medicaid or who is only eligible for Medicaid.

[42 CFR § 460.186; 71 FR 71322 (Dec. 8, 2006)]

40.4 - Participant Part B Premiums

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

Unless a PACE participant is Medicaid eligible, he or she is responsible for paying the Part B premium. CMS regulations specifically prohibit PACE organizations from offering gifts or payments to induce enrollment. Thus, the payment of Part B premiums by a PACE organization would essentially constitute an inducement for certain individuals (those who pay Part B premiums out of pocket) to enroll in PACE.

Such payment may also violate Section 231(h) of the Health Insurance Portability and Accountability Act of 1996 [Section 1128(A)(5) of the Social Security Act, codified at 42 U.S.C. Section 1320a7a(a)(5)]. That provision imposes civil money penalties on parties who provide inducements to Medicare or Medicaid beneficiaries that they know or should know are likely to influence a beneficiary's choice of a provider, practitioner, or supplier of Medicare or Medicaid items or services. Although the Office of the Inspector General has not issued an advisory opinion on this topic with respect to PACE, the OIG has reviewed similar proposals from Medicare fee-for-service providers and managed care organizations and has found them to be inappropriate.

[42 CFR § 460.82(e)(3)]

40.5 - Part D

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

As specified in Sections 1894 and 1934 of the Act, PACE organizations shall provide all medically necessary services including prescription drugs, without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid.

PACE program participants who have Medicare only will receive their qualified prescription drug coverage through Medicare Part D and will be responsible for a monthly premium. PACE program participants who have Medicare and also qualify for the State Medicaid program will be deemed eligible for the Part D Limited-Income Subsidy which will cover their monthly premium for Medicare Part D. As part of the PACE Program Agreement, the PACE organization agrees to calculate and collect beneficiary Part D premiums, to the extent applicable, in accordance with 42

CFR §§ 423.286 and 423.293.

40.6 - Premiums for Persons who are Medicaid Only

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

No premium may be charged to a participant who is only eligible for Medicaid. For Medicare Part A-only participants who are also eligible for Medicaid, the State is obligated to pay Medicare Part B premiums under Section 1902(a)(10) of the Act.

[71 FR 71318 (Dec. 8, 2006)]

40.7 - Premiums for Persons who are Private Pay (without Medicare or Medicaid)

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The statute does not specify the premium that may be charged to non-Medicare and non-Medicaid PACE participants. As CMS has indicated in the preamble to the final rule, it is acceptable for a PACE organization to charge the combined Medicare and Medicaid capitation rates as the premium for these individuals.

[71 FR 71309 (Dec. 8, 2006)]

Appendix source: Center for Medicare & Medicaid Services. “Programs of All-Inclusive Care for the Elderly (PACE) Manual, Chapter 13.” 2011. Accessed March 21, 2016. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019036.html.

Appendix B.
Institutional Review Board Approval of Qualitative Research Methods

Research Proposal
The PACE Model in
Texas and California

1. Principal Investigator

2. Purpose

This study examines the Program of All-Inclusive Care for the Elderly (PACE) and specifically, PACE sites in Texas and California. As a unique model of care for low-income seniors, studies show that PACE does improve the quality of care of its enrollees. Yet, the program's growth is sluggish as there are more available sites that can be established under federal and state laws. The research explores this dichotomy to learn about some of the existing headwinds in establishing more PACE sites in Texas and California. The project goal is to understand the extent to which PACE is an ideal model of care for low-income seniors given both states' rapid aging population growth.

From our interviews with administrators of the two PACE sites in California, we intend to learn how their sites were established, how they measure the quality of care provided and satisfaction among families and enrollees of the program. We would also like to learn what the state and federal regulatory environment are like and given that PACE is not a high profit- margin model of care, how the sites are financially sustainable.

From our interviews with the participants at the California Department of State Health Services we want to learn how the state regulates the PACE sites and what can be done to enable faster growth. Also, we would like to understand the state's view on PACE as a sustainable model for the future of senior care in California.

From our interviews with National Pace Association employees, we want to understand what ways the association supports PACE sites, what can be done to promote growth and how the association advocates for PACE at the state and federal levels.

3. Procedures

First, participants will receive e-mails explaining the aims of the research and asking if they would be interested in participating. Then, we will send them consent forms to fill out and send back to me. Next, we will ask them if we could travel to their sites to meet them in person or if they would prefer a phone interview. If they approve of me traveling to their site, we will send them the Site Letter Approval letter that they must fill out before we travel to the site and provide the letters to IRB. We will then arrange mutually agreeable dates that allow me to travel and conduct our research. Our research only consists of a structured interview guide and is based on

prepared questions. After traveling to the sites we will analyze the qualitative data and report the results.

a. Location

On Lok Senior Health Services
1333 Bush Street San Francisco, CA 94109 Phone: (888)
886-6565
www.onlok.org/Services.aspx
St. Paul's PACE
111 Elm Street San Diego, CA 92101 Phone: (619) 677-3800
www.stpaulspace.org

b. Resources

Secured research travel funds from St. David's Foundation and Central Health.

c. Study Timeline

Data collection will occur as soon as IRB is approved. Travel will occur in January-May 2016. Results will disseminated at the Eldercare Summit on April 12 from 2-5 pm a the LBJ School, Bass Lecture Hall. A final report is due to Central Health and St. David's Foundation.

4. Measures

Question items and measures are designed specifically for this project. No focus group interviews. See attached interview guide in IRBaccess. Participants will be interviewed for approximately 30 minutes. Participants are 21 and older.

5. Participants

a. Target Population

Administrators of PACE Sites, employee of the California Health Cares Commission and National Pace Association (advocacy group) employees. Anticipated sample size is 25.

b. Inclusion/Exclusion

N/A

c. Benefits

There are no direct benefits for participating in the study.

d. Risks

No risks for participants in our study.

e. Recruitment

We will e-mail potential participants for recruitment in our study.

f. Obtaining Informed Consent

We are applying for a waiver of signed consent, as there is no risk to participants in our study. We will not ask participants to divulge sensitive or confidential information since our research does not concern study of particular subjects. Instead, our research questions are informative and intended for me to learn more about the PACE program and our participants' involvement in the program. Our research participants are not taking risks in answering our research questions. Thus, an e-mail containing a brief overview of our study seeking their participation is appropriate.

6. Privacy and Confidentiality

We will ask participants if we can use their first and last names in our study as it would add credibility to our thesis. Also, it would be beneficial for readers to know exactly who we interviewed. However, our study will not be negatively impacted if participants choose to remain anonymous. If they choose so, we will ensure their names are not revealed in our thesis and de-identify any other relevant information. we do not foresee confidentiality being requested as we are not seeking personal or sensitive information.

Confidentiality of the Data or Samples

a. We will be taking notes by hand if we are able to meet with participants in person and by computer for participants who we speak to via telephone.

b. Data will be securely stored on the research assistants and Principal investigators personal computers.

c. Data will be kept until completion of project December 31, 2016.

d. Data will only be kept confidential if participants request confidentiality. We do not foresee confidentiality being requested as I am not seeking personal or sensitive information.

7. Compensation

N/A*

**Note that individuals were not compensated but the organization was compensated with a modest consulting fee.*

Amendment Summary Form
Institutional Review Board

Note: This form is not required if the only change proposed is the addition or removal of research personnel. Submit the Research Personnel Form and online amendment application only.

IRB Protocol Number: 2015040087
Protocol Title: PACE Model in Texas and California
Principal Investigator: Jacqueline L. Angel, Ph.D.
Date: November 5, 2015

Provide a summary of the proposed modification(s). In the table below, describe the proposed change, the reason for the change, and where in the study document(s) they are located. Submit the affected documents in Microsoft Word (.doc) format and highlight the revised areas in yellow.

SUMMARY: [Example – A questionnaire was added and the study title was changed.]

Proposed Modification(s)	Reason for Change	Document/Section/Page #
Add 8 student investigators.	The eight graduate student investigators are responsible for collecting the interview data of administrators and public officials: Four in San Diego and four in San Francisco.	• See modification in amended application.
Change the study title to read, "PACE Model in Texas and California"	The study title was revised to align with the research objectives involving a comparison of Texas PACE programs to include two PACE sites in California: San Diego and San Francisco to understand best practices models in states with a large older Latino population.	• Title, page 1
Change in the study consent form and interview guide to focus on California	The consent form and interview guide were adapted for two cities with PACE sites in California: San Diego and San Francisco.	• Consent Form, pp. 1-3 • Interview guide, pp. 1-2 • Phone script, p. 1

Subject: IRB Study Number 2015-04-0087 Amendment Determination
Date: Thu, Jan 7, 2016 12:33 PM

Re: PACE Model in Texas and California

Dear Jacqueline L. Angel,

Thank you for your notification of the changes to the protocol study listed above. The proposed changes to the protocol have been acknowledged as not increasing the risk toward study participants and still fall under exempt status. I will place a copy of this communication in the folder for this protocol to keep the study up to date. The amendment status will show withdrawn. You can continue with your research.

Best wishes,

Meghan Hammock
IRB Program Coordinator
Office of Research Support

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Appendix C.
Project Interview Protocol

Option I: Hi I'm _______ and this is _______. We're students at the LBJ School of Public Affairs in Austin, Texas, working on a policy research project on community based long term care for the elderly. We are comparing models like PACE and similar programs to explore the opportunities and challenges of providing community care for the most vulnerable in Austin, Texas, and to identify how experiments in community based long term care can be introduced to the city of Austin. We're here to interview you to gather information on your program's systems and operations. This will take approximately an hour and we look forward to learning from you! All your answers will remain confidential unless you choose to give us permission to share at the end of the interview.

Option II: Hello! I'm ________ and this is _____ and _____. Thank you so much for giving us an hour of your time, we know your time is very valuable. We're students at the LBJ School of Public Affairs in Austin, Texas. We're working on a project exploring community based long term care for the elderly. We're looking at models like PACE and similar programs in an effort to identify the opportunities and challenges that surround providing community care for the elderly in our city and see how we might introduce such a program to the city of Austin.

This interview will provide us with the opportunity to use your insight and expertise to gain insight into the operation of PACE. *Your background in …. will be beneficial for our research*…. (*Mention interviewee background/experience here.*) And lastly, your answers will remain confidential, but on the record for our report; however, if at any time you would like to go off the record, we can go back and forth.

<u>Survey Instrument</u>

YOUR MISSION

→ Self-described mission
→ Drawbacks/challenges for families/patients
→ Self-described community contributions/involvement

1. How would you describe your mission at On Lok Senior Health Services and St. Paul's PACE? (executive director and administrative staff)
2. What are the benefits for patients and their families? [PROBE: physical/ emotional/ mental]
3. What are the drawbacks for patients and their families? [PROBE: physical/ emotional/ mental]
4. Generally, how involved are family members?
5. What do you see as your main contributions to your community?
6. How involved is the local community?

START-UP

→ Process [PROBE: timeline, barriers to entry]
→ Acquiring funds for start-up
→ Where would you get funds for further expansion
→ Support from California Department of State Health Services/other stakeholders?
→ What could CDHS do to make roll-out easier?

1. What did the startup process look like for your site? [PROBE: timeline for roll-out, barriers to entry]
2. How did you acquire the necessary capital to establish your program?
3. If you were to expand and open another PACE center, where would your source your capital?
4. Did you receive any support from California Department of State Health Services (San Diego and San Francisco) or other stakeholder groups?
5. What could CDHS do to make it easier for organizations to get their sites off the ground?

ONGOING OPERATIONS AND FINANCIAL MODEL

→ What's needed for expansion? [PROBE: adding more sites, not clients]
→ Primary operational challenges
→ Metrics for quality of care/client satisfaction?
→ Hiring practices/challenges in attracting professional staff?
→ Managing financial risk associated with client base
→ Capitated payments and sustaining operations

1. What would you need in order to expand your site to accept more enrollees?
2. What are the primary operational challenges you face at this site?
3. Outside of reporting requirements, do you have any metrics for measuring quality of care? What about client satisfaction?
4. What are your hiring practices? Do you have any difficulties attracting professional staff, like doctors?
5. Given the financial challenges inherent in providing long-term care to this population, how do you maintain an operating profit?
6. How do you manage the financial risk associated with your client base?
7. How do you feel about the capitated payments? Are they sufficient for sustaining operations or do you need supplementary income? PROBE: where does that come from?

PLANNING FOR THE FUTURE

→ What could state/federal government do to make operations easier
→ Do you need more sites in California? [PROBE: what would make expansion easier? is regulatory a challenge?]
→ Alternatives with similar services? [PROBE: Medi-cal, others]
→ Advice

1. What could the state or federal government do to make your operations easier and more effective?

2. Do you feel like the existing PACE and PACE-like sites are enough to serve the population in California?
3. If not, what can be done to improve the process to enable more growth? Does the regulatory process present a challenge for expansion?
4. Are there alternative models for long-term care in California you feel provide similar services? [PROBE: Medi-cal competition?]
5. What advice would you have for other organizations who are interested in establishing a PACE site?

WRAP UP
→ Self-described motivation to keep PACE site going
→ What does future of PACE look like for you?

1. At the end of the day, what motivates you to keep your PACE site going?
2. What does the future of PACE look like for you and your organization?

Government-specific questions:
Because PACE is financed by capitated payments from Medicare and Medicaid, some studies show PACE is less expensive for states than more traditional forms of medical care. In California, is PACE CDHS saving money and how do you measure "cost-effectiveness" compared to other forms of care?

California's age 65+ population is projected to double from 4.3 million in 2010 to 8.4 million in 2030. The Senate created the Select Committee on Aging and Long Term Care, (http://senate.ca.gov/agingandlongtermcare), chaired by Senator Carol Liu, to articulate a vision and develop a strategy for creating an effective and efficient Aging and Long Term Care support and services delivery system. The Committee intends to reframe the conversation about what aging is, how different people age, how they can and do contribute to society, and how the state can create a continuum of preventative and medical health care system that provides services and supports as individual needs dictate over time.

For research: Is there a cap to enrollees at California PACE sites?

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Appendix D.
Eldercare Summit Interactive Poll

Methodology

In order to gauge audience member's initial problem awareness, reception to research findings, and willingness to engage in next steps, the policy research group facilitated interactive question-and-answer polling among attendees of the April 12, 2016, Eldercare Summit. To accomplish the objective, we used 100 i-clicker 2 remotes, a response device on loan from the University of Texas Education Technology Center. The remotes were given to Summit participants as they were seated, and there were a total of three polling sessions. The sample size for the polling sessions consisted of approximately 46 participants, representing governmental, for-profit and non-profit organizations, political leaders, University of Texas student body, community advocates, and others. The total number of respondents fluctuated during the course of polling as participants entered and left the Summit. Each session, with the exception of the Survey Summit Evaluation, included a discussion of results moderated by Haley Chambers.

The first pre-polling session began immediately after the conference introduction. Participants were asked six questions that measured 1) knowledge and awareness of Travis County demographic trends, and 2) attitudes about aging in place, specifically options in care and living arrangements, and the cost of long-term care financing. During the polling, participants were prompted with a series of multiple-choice questions and a graph displayed the results. The moderator then briefly discussed the results with the audience. In the second polling phase we presented our research findings and moderated a discussion among political leaders, and followed that discussion with post-presentation polling. This post-presentation polling sought to identify attendees' perceptions of the feasibility of policy options based on research findings. Finally, after the post-presentation polling, the audience was asked some Summit evaluation questions, the results for which were not displayed.

Polling Results

Pre-Presentation Polling

1. By what percent is Travis County expected to grow from 2015 to 2030?

Answer choices	**5%**	**10%**	**15%**	**20%**	**30%**
Poll results	0%	9%	14%	33%	44%

2. By what percent is Travis County's 65+ population expected to grow from 2015 to 2030?

Answer choices	**5%**	**25%**	**50%**	**75%**	**100%**
Poll results	2%	40%	44%	9%	4%

3. Do you agree or disagree with the following statement: I think Austin is an age-friendly city.

Answer choices	Strongly agree	Somewhat agree	Neutral	Somewhat disagree	Strongly disagree
Poll results	4%	11%	11%	57%	17%

4. Do you agree or disagree with the following statement: If I couldn't care for myself, I would prefer to receive care in my home.

Answer choices	Strongly agree	Somewhat agree	Neutral	Somewhat disagree	Strongly disagree
Poll results	44%%	38%	4%	9%	4%

5. Do you agree or disagree with the following statement: I would be content aging in a nursing home.

Answer choices	Strongly agree	Somewhat agree	Neutral	Somewhat disagree	Strongly disagree
Poll results	0%	11%	13%	24%	51%

6. Do you agree or disagree with the following statement: I am concerned about the cost of health care and housing as I age.

Answer choices	Strongly agree	Somewhat agree	Neutral	Somewhat disagree	Strongly disagree
Poll results	87%%	11%	0%	0%	2%

Post-Presentation Polling

7. Keeping in mind current budgetary constraints, do you support or oppose expanding state funding for community-based long term care services?

Answer choices	Strongly Support	Somewhat support	Neutral	Somewhat oppose	Strongly oppose
Poll results	83%	14%	3%	0%	0%

8. Do you agree or disagree with the following statement: I or someone I know would likely participate in community-based long term care programs like PACE.

Answer choices	Strongly agree	Somewhat agree	Neutral	Somewhat disagree	Strongly disagree
Poll results	65%	22%	11%	3%	0%

9. Do you agree or disagree with the following statement: I feel Austin has sufficient options for aging in place.

Answer choices	Strongly agree	Somewhat agree	Neutral	Somewhat disagree	Strongly disagree
Poll results	0%	14%	17%	23%	46%

10. Do you agree or disagree with the following statement: Political leaders give enough attention to the needs of Travis County's low-income, frail elderly population.

Answer choices	Strongly agree	Somewhat agree	Neutral	Somewhat disagree	Strongly disagree
Poll results	3%	0%	16%	39%	42%

11. What is the most important factor the state should consider when evaluating Medicaid options for the low-income, frail elderly population?

Answer choices	Cost to taxpayers	Cost to beneficiaries	Health outcomes	Something else
Poll results	2%	2%	50%	28%

Post-Conference Evaluation Polling

12. How would you rate today's conference on senior health and housing services?

Answer choices	Excellent	Very good	Good	Fair	Poor
Poll results	43%	33%	19%	5%	0%

13. Do you agree or disagree with the following statement: I learned a lot of new information about senior healthcare options or affordable housing.

Answer choices	Strongly agree	Somewhat agree	Neutral	Somewhat disagree	Strongly disagree
Poll results	19%	57%	19%	5%	0%

14. Do you agree or disagree with the following statement: I feel more passionate about improving healthcare and housing options for older Austinites after attending this conference.

Answer choices	Strongly agree	Somewhat agree	Neutral	Somewhat disagree	Strongly disagree
Poll results	57%	33%	10%	0%	0%