Texas PACE Rating Report

July 18, 2019

I. Purpose

This report is intended to demonstrate Texas Health and Human Services' (HHSC) compliance with Federal and State regulation on the development of the capitation rates for the Programs of All-Inclusive Care for the Elderly (PACE).

II. Background

PACE is a fully integrated Medicare program and Medicaid state plan option that provides community-based care and services to people aged 55 or older who meet a state's nursing home level of care criteria. 42 CFR 460.182 requires that states make a prospective monthly capitation payment to a PACE organization for a Medicaid participant enrolled in PACE which:

- Is less than what would otherwise have been paid under the state plan if not enrolled in PACE;
- Takes into account comparative frailty of participants; and,
- Is a fixed amount regardless of changes in a participant's health status.

There are specific requirements for PACE in the state of Texas which are outlined in the Texas Administrative Code at Title 1, Part 15, Chapter 355 Subchapter E, Rule §355.501.

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=355&rl=501

Additional requirements for Texas PACE Reimbursement rates can be found at the Texas Human Resources Code §32.0532(b).

http://www.statutes.legis.state.tx.us/Docs/HR/htm/HR.32.htm

STAR+PLUS is a Texas Medicaid managed care program for people who have disabilities or are age 65 or older.

III. Overview of the Rate Setting Methodology

PACE rates are determined coincident with the state's biennium as directed by 1 Tex. Admin. Code §355.501 (2016). This statute includes a prescribed

method of determining the upper payment limits (UPL) and reimbursement rates for each PACE contractor.

Specifically, 1 Tex. Admin. Code §355.501 (2016) directs HHSC to develop the capitation rates based upon the historical costs for clients age 55 and older receiving nursing facility services or HCBS services in the counties served by each PACE contract.

An average monthly historical cost for the counties served by each PACE contract is determined by dividing the total historical claims data for the counties served by each PACE contract by the number of member months for the counties served by each PACE contract.

An adjustment for administrative costs is added to the average monthly historical cost per client. The per member month amount is added for:

(A) processing claims, based on the state's cost to process claims under the managed care payment system; and

(B) case management, based on the state's cost to provide case management under the managed care payment system for HCBS clients.

The average monthly historical cost per client for each PACE contract is projected forward from the claims data base period to the rate period to account for anticipated changes in costs for each PACE contract. The methodology used for trending these historical costs is comparable to that used for trending costs in the managed care program.

HHSC calculates three reimbursement rates for each PACE contract: one for clients eligible for Medicaid services (Medicaid Only rate), one for clients eligible for both Medicare and Medicaid services (Dual Eligible rate), and one for clients eligible for only Medicare services as QMBs. The payment rates for the three client categories for each PACE contract are determined by multiplying the UPLs calculated for each PACE contract by a factor less than 1.0. HHSC may reduce the factor as necessary to establish a rate consistent with available funds.

The following are the PACE rates determined for the State Fiscal Year (SFY) 2020 – SFY 2021 biennium (September 1, 2019 – August 31, 2021). These rates are the result of a 7.3% reduction to the Upper Payment Limit (UPL) which is developed for each of the three PACE sites in Texas. This reduction is a combination of a 1% managed care savings factor to ensure that these rates are less than those that would have other been paid for state plan

services and 6.4% budget reduction factor to ensure that the total cost of the PACE program does not exceed amounts appropriated by the Texas Legislature in the 86th Legislative Session, 2019. The development of the UPL is shown in attachment 1.

See the rate development sheets in attachment 1 of this report.

1. El Paso County,
2. Lubbock County,
3. Potter and Randall Counties, and
4. Statewide Qualified Medicare Beneficiaries (QMB).

PACE Rate	SFY 2020 - 2021 UPL	SFY 2020 - 2021 PACE Rates
El Paso County - Medicaid Only	$4,697.16	$4,352.58
El Paso County - Medicare/Medicaid	$3,092.39	$2,865.54
Potter & Randall Counties - Medicaid Only	$4,253.62	$3,941.57
Potter & Randall Counties - Medicare/Medicaid	$2,993.20	$2,773.61
Lubbock County - Medicaid Only	$5,003.65	$4,636.58
Lubbock County - Medicare/Medicaid	$3,392.90	$3,144.00
Statewide QMB Rate		$43.95

For each PACE service delivery area, a cohort of STAR+PLUS members who meet PACE eligibility is studied. These members must be 55 years of age or older and meet nursing facility level of care. These members may be in a nursing facility (NF) or getting services through Home and Community Based Services (HCBS) waiver. These members are also classified according to Medicare eligibility status, Dual Eligible, or Medicaid Only.

Those members who are part of the Dual Eligibles Integrated Care Demonstration Project (Dual Demo) or have a Medicare Advantage plan are not included in this analysis.

This study was performed using a combination of SFY2017 Managed Care and Fee-For-Service (FFS) claims data where appropriate. Managed care data sources are certified encounter data sets used in the rate development for other programs and include 3 months of runout. A provision for incurred but not reported claims (IBNR) has been added to the managed care experience. No provision for IBNR was added to the FFS claims as the

claims utilized for FFS are claims for SFY2017 paid through December 2018.

All Medicaid claims were gathered in certain key categories: Acute Care, Long Term Care, and Prescriptions. Per-member-per-month (pmpm) values were calculated by dividing the total claims cost by the total member months.

Finally, provision for Transportation services is included and is equal to the Transportation capitation rates paid to the managed transportation organizations (MTOs) operating in these geographic regions.

Frailty Adjustment

Statutory language in 1 Tex. Admin. Code §355.501 (2016) and Tex. Hum. Res. Code § 32.0532 (2015) directs HHSC to compare Medicaid costs of PACE and STAR+PLUS recipients. Specifically, HHSC is directed to ensure the program is cost-neutral or costs less when compared to the cost to serve a population in STAR+PLUS that is comparable in demographic and social characteristics and in health status.

To facilitate this comparison, HHSC used Medical Necessity and Level of Care (MN/LOC) and Minimum Data Set (MDS) assessments, which are used to determine whether individuals meet medical necessity criteria for long term care services, as well as impairment level over several areas of health care. Individuals who meet medical necessity may be served in the community through the HCBS waiver, in which case MN/LOC assessments are used, or in nursing facilities, in which case MDS assessments are used.

The PACE assessments were matched with enrollment and encounter data from STAR+PLUS for similar age and county and collected data on members characteristics such as county of residence, age, activities of daily living (ADL's) and health care status (e.g., presence of dementia and Pressure Ulcers). This combination of data provided all of the necessary elements for the calculation of LTSS risk adjustment factors.

The method used to predict the LTSS costs estimates for members based on their characteristics is Generalized Linear Model (GLM) regression. The cost estimates for STAR+PLUS members, were applied to the PACE case-mix using PACE MN/LOC and MDS assessments.

To model the LTSS costs, a cohort was defined based on PACE and STAR+PLUS members as of August 2017. The most recent assessment available for each of these members was used in the study. However, data available for the PACE population is collected on a different basis. A factor was employed in the rate calculations to cover this requirement, but because of the different collection basis involved, only 50 percent of the adjustment was applied.

Trends

Below are the trend factors applied in the PACE rate development. The trends used were historical and projected trend factors developed by HHSC for STAR+PLUS populations that closely match PACE-eligible members. The SFY2017 data is trended from 3/1/17 (mid-point of the data period) to 8/31/20 (the mid-point of the rating period). Additional detail on the development of trend assumptions is available in the corresponding STAR+PLUS program rate setting reports.

	Nursing Facility		HCBS	
	Medicaid Only	Dual Eligible	Medicaid Only	Dual Eligible
Acute Care - FY2018	2.0%	1.6%	2.0%	1.6%
Acute Care - FY2019	1.2%	1.6%	1.2%	1.6%
Acute Care - FY2020	1.2%	1.6%	1.2%	1.6%
Long Term Care - FY2018	0.8%	1.1%	2.4%	3.7%
Long Term Care - FY2019	1.4%	1.6%	1.4%	3.3%
Long Term Care - FY2020	1.4%	1.6%	1.4%	3.3%
Prescription - FY2018	-0.4%	3.0%	6.9%	3.0%
Prescription - FY2019	-0.4%	3.0%	6.9%	3.0%
Prescription - FY2020	-0.4%	3.0%	6.9%	3.0%

The trends applied to the medical transportation component of the claims cost is the historical and projected trend factors developed by HHSC for SFY2019 Medical Transportation Program. The SFY2019 capitation rate for the corresponding service area is trended forward from 3/1/2019 (mid-point of the data period) to 8/31/20 (the mid-point of the rating period). Additional detail on the development of trend assumptions for the medical transportation component is available in the corresponding Medical Transportation Program rate setting report.

Medical Transportation - FY2020	3.0%	3.0%	3.0%	3.0%

Non-benefit Costs

As required by statute, non-benefit costs should only represent claims processing and case management costs based on the state's costs. PACE administrative expenses are not directly considered in this rating process.

Included were provisions for Service Coordination and Claims Processing. The Service Coordination costs were those developed for the STAR+PLUS program for SFY2019. No updates have been made to the claims processing costs from the last biennium.

Projected Member Months for Each Rate Cell:

PACE Rates	Caseload	SFY 20-21	Change	Annual Spend
El Paso County - Medicaid Only	28	$4,352.58	9.7%	$ 1,482,314
El Paso County - Medicare/Medicaid	918	$2,865.54	-2.5%	31,553,677
Potter & Randall Counties - Medicaid Only	2	$3,941.57	-7.8%	112,808
Potter & Randall Counties - Medicare/Medicaid	148	$2,773.61	6.1%	4,913,120
Lubbock County - Medicaid Only	12	$4,636.58	13.5%	681,577
Lubbock County - Medicare/Medicaid	163	$3,144.00	7.9%	6,140,224
Statewide QMB Rate	0	$43.95	-10.0%	-
	1271			$ 44,883,719

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Texas HHSC – Actuary III

July 18, 2019

FY2020-FY2021 PACE Rating Summary
El Paso - Rating Summary

Attachment 1 - Exh A

	Medicaid Only - NF		Dual Eligible - NF		Medicaid Only - HCBS		Dual Eligible - HCBS	
	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm
FY2017 Experience Period								
Member Months	479		4,261		3,121		5,218	
Estimated Incurred Claims - Acute Care								
Inpatient Facility	617,821	1,289.81	52,175	12.24	1,535,646	492.04	59,687	11.44
Outpatient Facility	36,932	77.10	133,300	31.28	542,650	173.87	288,129	55.22
Professional	232,974	486.38	213,938	50.21	2,264,745	725.65	972,380	186.35
Other Institutional	92,769	193.67	197,843	46.43	392,886	125.88	10,854	2.08
Acute Care Total	**980,496**	**2,046.96**	**597,257**	**140.17**	**4,735,928**	**1,517.44**	**1,331,049**	**255.09**
Estimated Incurred Claims - Long Term Care								
CBA	19,643	41.01	38,767	9.10	4,015,257	1,286.53	8,684,291	1,664.29
Nursing Facility and Hospice	1,823,939	3,807.81	15,826,081	3,714.17	127,838	40.96	233,189	44.69
Long Term Care Total	**1,843,582**	**3,848.81**	**15,864,848**	**3,723.27**	**4,143,095**	**1,327.49**	**8,917,480**	**1,708.98**
Estimate Incurred Claims - Prescriptions	**271,471**	**566.74**	**7,012**	**1.65**	**3,322,041**	**1,064.42**	**27,508**	**5.27**
Estimated Incurred Claims - Medical Transportation		**9.43**		**9.43**		**9.43**		**9.43**
Total - All Claims		6,471.95		3,874.51		3,918.77		1,978.77
Provider Reimbursement Adjustment								
Acute Care - Non Inpatient	1.0000		1.0000		1.0000		1.0000	
Acute Care - Inpatient	1.0000		1.0000		1.0000		1.0000	
Long Term Care	1.0000		1.0000		1.0000		1.0000	
Annual Trends								
Acute Care	1.43%		1.60%		1.43%		1.60%	
LTC	1.23%		1.46%		1.68%		3.41%	
Prescriptions	-0.40%		3.00%		6.90%		3.00%	
Medical Transportation	3.00%		3.00%		3.00%		3.00%	
Projected FY2020 Incurred Claims								
Acute Care		2,151.10		148.18		1,594.64		269.66
LTC		4,016.82		3,916.61		1,407.43		1,922.06
Prescriptions		558.85		1.82		1,344.41		5.85
Medical Transportation		9.86		9.86		9.86		9.86
Total		6,736.63		4,076.46		4,356.34		2,207.43
LTC Risk Adjustment (HB 3823)	1.04	82.99	1.04	80.28	0.89	(76.23)	0.89	(98.14)
Administrative Expenses								
Claims Processing		6.00		6.00		6.00		6.00
Service Coordination		45.21		45.35		77.45		66.02
Total		6,870.83		4,208.10		4,363.56		2,181.31
Upper Payment Limit								
Medicaid Only	4,697.16							
Medicaid/Medicare	3,092.39							
Fully Funded Rate								
Medicaid Only	4,650.19							
Medicaid/Medicare	3,061.47							

FY2020-FY2021 PACE Rating Summary
Lubbock - Rating Summary

Attachment 1 - Exh B

	Medicaid Only - NF		Dual Eligible - NF		Medicaid Only - HCBS		Dual Eligible - HCBS	
	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm
FY2017 Experience Period								
Member Months	744		6,031		693		1,717	
Estimated Incurred Claims - Acute Care								
Inpatient Facility	731,919	983.76	97,539	16.17	290,228	418.80	35,512	20.68
Outpatient Facility	110,068	147.94	124,593	20.66	116,148	167.60	111,854	65.15
Professional	343,306	461.43	337,487	55.96	390,773	563.89	253,071	147.39
Other Institutional	139,684	187.75	96,979	16.08	49,393	71.27	51	0.03
Acute Care Total	**1,324,977**	**1,780.88**	**656,598**	**108.87**	**846,542**	**1,221.56**	**400,488**	**233.25**
Estimated Incurred Claims - Long Term Care								
CBA	8,132	10.93	1,698	0.28	625,293	902.30	2,062,689	1,201.33
Nursing Facility and Hospice	2,726,800	3,665.05	21,396,490	3,547.75	20,576	29.69	95,956	55.89
Long Term Care Total	**2,734,932**	**3,675.98**	**21,398,188**	**3,548.03**	**645,869**	**931.99**	**2,158,645**	**1,257.22**
Estimate Incurred Claims - Prescriptions	**509,395**	**684.67**	**14,757**	**2.45**	**684,098**	**987.15**	**11,705**	**6.82**
Estimated Incurred Claims - Medical Transportation		**11.54**		**11.54**		**11.54**		**11.54**
Total - All Claims		6,153.08		3,670.89		3,152.25		1,508.82
Provider Reimbursement Adjustment								
Acute Care - Non Inpatient	1.0000		1.0000		1.0000		1.0000	
Acute Care - Inpatient	1.0000		1.0000		1.0000		1.0000	
Long Term Care	1.0000		1.0000		1.0000		1.0000	
Annual Trends								
Acute Care	1.43%		1.60%		1.43%		1.60%	
LTC	1.23%		1.46%		1.68%		3.41%	
Prescriptions	-0.40%		3.00%		6.90%		3.00%	
Medical Transportation	3.00%		3.00%		3.00%		3.00%	
Projected FY2020 Incurred Claims								
Acute Care		1,871.49		115.09		1,283.71		246.57
LTC		3,836.44		3,732.27		988.11		1,413.97
Prescriptions		675.13		2.71		1,246.83		7.56
Medical Transportation		12.06		12.06		12.06		12.06
Total		6,395.13		3,862.14		3,530.71		1,680.17
LTC Risk Adjustment (HB 3823)	1.00	4.58	1.00	4.42	0.72	(129.86)	0.72	(175.18)
Administrative Expenses								
Claims Processing		6.00		6.00		6.00		6.00
Service Coordination		43.92		43.12		44.41		45.64
Total		6,449.63		3,915.68		3,451.26		1,556.63
Upper Payment Limit								
Medicaid Only	5,003.65							
Medicaid/Medicare	3,392.90							
Fully Funded Rate								
Medicaid Only	4,953.61							
Medicaid/Medicare	3,358.97							

FY2020-FY2021 PACE Rating Summary
Potter-Randall - Rating Summary

Attachment 1 - Exh C

	Medicaid Only - NF		Dual Eligible - NF		Medicaid Only - HCBS		Dual Eligible - HCBS	
	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm
FY2017 Experience Period								
Member Months	358		4,476		461		1,210	
Estimated Incurred Claims - Acute Care								
Inpatient Facility	154,547	431.70	64,568	14.43	262,894	570.27	29,839	24.66
Outpatient Facility	30,139	84.19	41,527	9.28	100,930	218.94	21,694	17.93
Professional	118,172	330.09	161,181	36.01	271,438	588.80	179,673	148.49
Other Institutional	4,350	12.15	-	-	39,189	85.01	-	-
Acute Care Total	**307,208**	**858.12**	**267,276**	**59.71**	**674,450**	**1,463.02**	**231,207**	**191.08**
Estimated Incurred Claims - Long Term Care								
CBA	183	0.51	4,413	0.99	370,659	804.03	1,261,872	1,042.87
Nursing Facility and Hospice	1,256,642	3,510.17	14,484,455	3,236.03	3,054	6.62	17,220	14.23
Long Term Care Total	**1,256,825**	**3,510.69**	**14,488,868**	**3,237.01**	**373,713**	**810.66**	**1,279,092**	**1,057.10**
Estimate Incurred Claims - Prescriptions	**264,967**	**740.13**	**1,557**	**0.35**	**415,202**	**900.65**	**1,544**	**1.28**
Estimated Incurred Claims - Medical Transportation		**11.54**		**11.54**		**11.54**		**11.54**
Total - All Claims		5,120.48		3,308.61		3,185.87		1,261.00
Provider Reimbursement Adjustment								
Acute Care - Non Inpatient	1.0000		1.0000		1.0000		1.0000	
Acute Care - Inpatient	1.0000		1.0000		1.0000		1.0000	
Long Term Care	1.0000		1.0000		1.0000		1.0000	
Annual Trends								
Acute Care	1.43%		1.60%		1.43%		1.60%	
LTC	1.23%		1.46%		1.68%		3.41%	
Prescriptions	-0.40%		3.00%		6.90%		3.00%	
Medical Transportation	3.00%		3.00%		3.00%		3.00%	
Projected FY2020 Incurred Claims								
Acute Care		901.78		63.12		1,537.45		202.00
LTC		3,663.93		3,405.10		859.47		1,188.90
Prescriptions		729.82		0.39		1,137.58		1.42
Medical Transportation		12.06		12.06		12.06		12.06
Total		5,307.60		3,480.67		3,546.56		1,404.38
LTC Risk Adjustment (HB 3823)	0.96	(77.64)	0.96	(71.59)	0.65	(140.31)	0.65	(182.97)
Administrative Expenses								
Claims Processing		6.00		6.00		6.00		6.00
Service Coordination		43.92		43.12		44.41		45.64
Total		5,279.87		3,458.20		3,456.65		1,273.04
Upper Payment Limit								
Medicaid Only	4,253.62							
Medicaid/Medicare	2,993.20							
Fully Funded Rate								
Medicaid Only	4,211.08							
Medicaid/Medicare	2,963.26							

Calculation of SFY20 - SFY21 statewide QMB Rate for Texas PACE Program

$	**86,968,426.50**	**= Total Incurred Claims (201609 to 201708) Estimated**
	1,860,282	**= Total Estimated Member Months (201609 to 201708)**
$	**46.75**	**= QMB Statewide rate**
$	**49.42**	**= QMB rate trended from 9/1/2017 to 8/31/2020**
$	**46.95**	**= Final QMB rate for SFY 20 and SFY 21 with 5% reduction**