Aging in Wyoming

Part III: Reviewing the Program of All-Inclusive Care for the Elderly, and alternatives

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Submitted

in accordance with

Footnote 18 to Section 048 of Chapter 94

of the

2023 Wyoming Session Laws

Wyoming Department of Health

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Executive Summary

The Program of All-Inclusive Care of the Elderly (PACE) program is an integrated model of medical and long-term care that aims to serve Medicare and Medicaid members in community settings for as long as possible.

Wyoming Medicaid funded a PACE program in Cheyenne from 2013 until 2020, when the program was cut as part of significant budget reductions.

This Legislatively-required study asks whether PACE could be cost-effectively re-established in the State.

We conclude that it cannot.

Instead, in the spirit of promoting home- and community-based alternatives to institutional long-term care, we propose three alternatives to re-establishing PACE. These options could be pursued together, separately, or not at all:

- Increase rates for selected home-based Medicaid services with low utilization, like non-emergency transportation or adult day care;
- Bundle core PACE services together into a rate that could be billed on a per-diem basis;
- Explore the development of a State-operated Medicare Advantage plan that could focus on serving Medicare and Medicaid members with preventive care early in their long-term care trajectories.

Section 1: Study objectives

1.1. Legislative requirements

Footnote 18 to Section 048 of House Enrolled Act 37 from the 2023 General Session reads:

> Of this general fund appropriation, twenty thousand dollars ($20,000.00) is appropriated for ~~an outside~~ study to review the program of all-inclusive care for the elderly (PACE) specified in W.S. 42-4-121. The study shall review the possibility of reinstituting the program throughout Wyoming, considering for-profit and nonprofit options and potential cost savings. The joint labor, health and social services interim committee shall also study the program for all-inclusive care for the elderly during the 2023 interim. (BRACKETED LANGUAGE SHOWN IN BOLD AND AS STRICKEN WAS VETOED BY GOVERNOR FEBRUARY 24, 2023.)

In the original language of the footnote, it was apparent that the Legislature intended this study to be done by an outside consultant. While this language was vetoed by the Governor to allow the study to be done in-house as well, the Department did attempt to honor the original Legislative intent by putting out a Request For Proposals (RFP) for this study in April, 2023.

Unfortunately, the two bids that we received did not meet technical quality standards as assessed by the review committee. The Department therefore made the decision to proceed with this study internally, and incorporate it as Part III of this "Aging in Wyoming" series.

1.2. Specified tasks

Parsing the language of the footnote, the Department is directed to study two questions:

- What for-profit and non-profit providers might be able to set up a PACE program in Wyoming?
- What would the potential cost-savings be from restarting the program?

These two questions —access and cost —are two sides of the same coin. In this case, a literal coin: a payment rate high enough to attract providers for PACE may or may not be a cost-effective way of delivering long-term care.

1.3. Implied tasks

Implied in this analysis are therefore two more questions:

- What PACE rate should the State be willing to pay in order to have cost-savings?
- What PACE rate would be required to attract providers throughout the State?

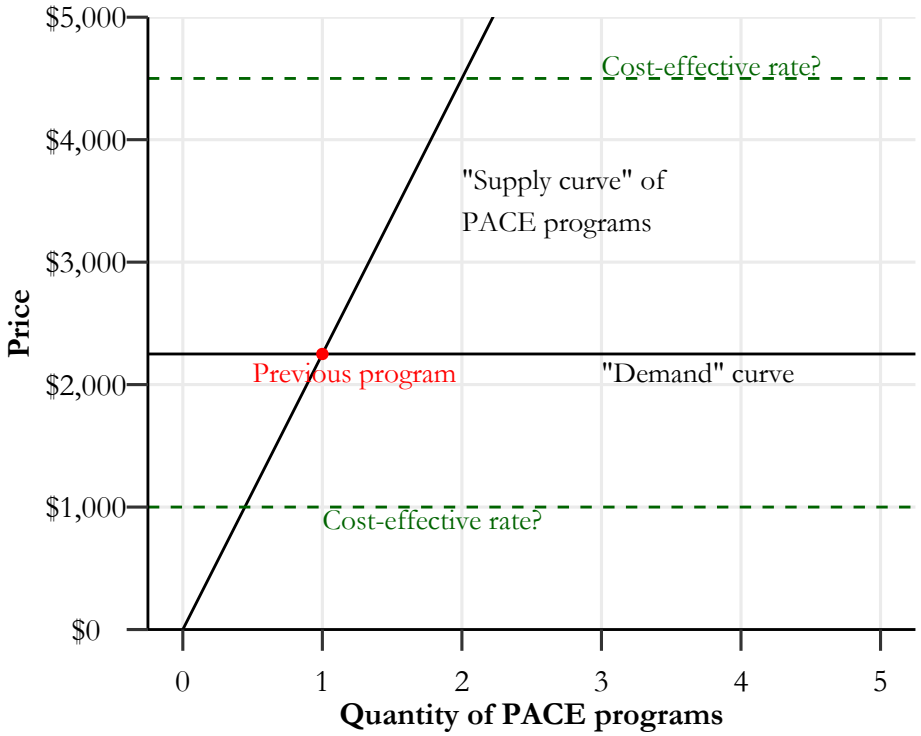
Figure 1 shows these implied questions graphically using an old friend from your introductory economics course: supply and demand.

On the figure, the flat 'demand curve' for PACE programs shows the per-member per-month rate the State was historically paying for PACE. The line is flat because we would have paid approximately the same rate to any PACE program in the State, even if there had been ten of them.

The upward sloping black line represents the historical 'supply curve' of PACE programs. It slopes upwards because there presumably would have been more provider interest in PACE if the State had offered a higher rate.

The exact slope of this supply curve, and how it may have changed since PACE was discontinued, is unknown, but we do know that the two curves once intersected at the red dot, which represents the status quo around 2020 —at a rate of approximately $2,250 PMPM, the one PACE program was being supplied.

Figure 1: 'Supply' vs. 'Demand' question



This study attempts to first ascertain what a 'cost-effective' PACE rate would be, given the statutory requirements and alternative care settings offered by Wyoming Medicaid. As shown by the dashed green lines on Figure 1, this rate could be higher or lower than the previous 'demand curve'.

We then look at how many for-profit and non-profit providers would be willing to set up a PACE program **at that cost effective rate**. As the figure indicates, if this new rate is higher than what we paid previously, there is a good chance PACE could be restarted.

Unfortunately, this study demonstrates that a cost-effective rate would actually be **lower** than what we paid previously. It is extremely unlikely, therefore, that any PACE programs could be restarted in Wyoming while demonstrating any cost savings.

Before we get there, however, Sections 2 and 3 provide some background on the PACE model generally, and the PACE program as it operated specifically in Cheyenne.[1]

[1] For these sections, we are indebted to Tyler Deines, James Hruby, Lee Grossman, Alice Zimmerman, Nicole Gabel, Jeff

Section 2: The PACE model

2.1. Purpose

The purpose of the Program of All-Inclusive Care of the Elderly (PACE) program is to provide integrated medical and long-term care to people over 55 who meet nursing home level-of-care criteria.

The goal is to keep members living in community settings for as long as possible.

PACE programs have strong incentives to do this through their unique funding model —a capitated (per-person) premium paid on behalf of members by Medicare and Medicaid. This fixed revenue source makes investments in preventive care attractive, if they can help the program avoid expensive institutional long-term care costs down the road.

2.2. History

PACE originated in 1971, when the On Lok organization[2] in San Francisco's Chinatown established one of the first adult day centers in the US. On Lok's goal was to provide community-based alternatives to nursing home care in an era when nursing homes were the default.

In its initial years, the program focused on providing adult day, in-home supportive services, meals, and senior housing. Funding was cobbled together from state, local and some federal (Administration on Aging) sources.

In the 1980s, the model grew in sophistication, with On Lok providing all-inclusive Medicare and Medicaid services to its members in exchange for a fixed per-person premium. By the early 1990s, the model had spread to four other states, and, through the Balanced Budget Act of 1997 it was made a permanent option in Medicare.

Today, there are 154 PACE organizations in 32 states, serving over 70,000 people in 300 different centers.[3]

2.3. Core components

The heart of the PACE model is a bundle of supportive services:

- Adult day care, usually provided in a community center a few times per week;
- Transportation for members to and from that center, as well as to all medical appointments;
- Congregate and home-delivered meals;
- In-home services (e.g., home health, personal care, chores);
- Primary care, medication management, and physical and occupational therapy conducted at the center; and,
- Care coordination conducted by an interdisciplinary team (IDT).

These services are complementary. Without the transportation, for example, many seniors wouldn't be able to get to the center to eat, socialize, and receive primary care. And without the adult day, PACE staff

Oliver, Tracy Brosius, Tim Ernst, Liz Parry, Shawn Bloom, Becky Carey, and Greg O'Barr for providing their perspectives from the State, the PACE provider, and the National PACE association.

[2] https://onlok.org/about/history/

[3] National Pace Organization, https://www.npaonline.org/find-a-pace-program

—from the medical director to the bus drivers —would lose a frequent opportunity to get 'eyes-on' their members, in order to better assess how they're doing and coordinate their care through the IDT.

2.4. Additional components

Most of the complexity of the PACE model, however, comes from the "All-Inclusive" part, which means what it says: providing **all** medical and long-term care services PACE members might require.

It's one thing to set up an adult day center, transportation, and care coordination in a community. It's another thing entirely to become a mini health insurer and develop a comprehensive network of providers who can care for your members.

This kind of broad outside network can be split into three main categories:

2.4.1. Higher-level medical services

This category encompasses medical services beyond primary care, to include:

- Emergency Department (ED) visits and any hospital inpatient stays;
- Hospital outpatient services; and,
- Specialist office visits and procedures.

Where one hospital might be able to provide most outpatient and inpatient services for a community PACE program, specialists (i.e., all the "ologists"), by definition, are diverse, and often have to be found elsewhere.

2.4.2. Pharmacy benefit

PACE programs are required to offer a generous Medicare Part D drug benefit. Since they tend to be small, most programs outsource drug benefits to larger insurers or Pharmacy Benefit Managers (PBMs). Because they cover so many people, these entities can use their significant market leverage to negotiate more effectively with drug manufacturers to keep costs down.

The downside to outsourcing Part D is usually less control over benefit design (e.g., what drugs are preferred). PBMs have also courted controversy with a lack of transparency on how much of the potential savings ("rebate") they negotiate are truly provided back to their clients.

2.4.3. Institutional long-term care

PACE programs are also required to pay for any long-term care their members may require outside of their home, including nursing home and hospice.

2.5. PACE revenue comes through fixed premiums

PACE is a full-risk managed-care product. This means that, instead of paying for services directly, Medicare and Medicaid provide PACE organizations with a flat monthly rate per person enrolled.

These premiums are intended to be set at an actuarially-fair level that includes **not just current care needs**, but also smooths over the entire trajectory of future care PACE members might require.

While their services are community-based, PACE programs are therefore generally liable for the cost of institutional levels of care, ranging from assisted living facility (ALF) services, to skilled nursing facility (SNF), memory care, and even lock-down units. All of these future expected costs are built, to some degree, into the total premium.

This makes the PACE concept similar to that of private Type A "Life Care" Continuing Care Retirement Community (CCRC), where individuals pay large entrance fees at an earlier age in exchange for provision of whatever care requirements they might need later. Because the risk of very expensive care is built-in to the initial contract, the facility has a very strong incentive to keep people at the lowest (and thus least expensive) level for as long as possible.

Since the rate builds in risk, its appropriateness depends on two strong economic assumptions:

- PACE organizations should not be able to "cherrypick" the people they enroll; in other words, they should not be able to selectively only admit the people that are healthier and thus less likely to require expensive long-term care.
- Once people are enrolled in PACE, they should be members of PACE for their remaining lives. PACE entities must not be able to "dump" or disenroll patients to other programs once they become expensive.

As we discuss in Section 4 of this report, there are problems with both of these assumptions.

2.6. Advantages

However, the PACE model also has several big advantages.

2.6.1. Care is well-coordinated

The complexities of navigating the medical system can be a challenge for people with many chronic health conditions, especially if they are poor or don't have family support. PACE makes this much easier, since a "one stop shop" assesses needs, coordinates all appointments with a multitude of medical providers, and provides transportation on the member's behalf.

This care coordination happens constantly. The entire PACE team —from the bus drivers, home health staff, and front desk, all the way to the medical director —usually will see every PACE member several times per week, and all staff participate in the Interdisciplinary Team (IDT). This frequent and close observation from all members of the IDT allows PACE programs to fine-tune patient's needs, which can be critical for those with chronic illnesses that can easily spiral out of control.

2.6.2. PACE organizations have a strong incentive to keep people in lower levels of care

Because they are paid on a premium basis, PACE revenue is fixed on a per-person level. Keeping costs down is therefore key to sustainability. Few things are more expensive to a health plan than an inpatient stay or nursing home spell triggered by an uncontrolled health condition.

This economic incentive cuts both ways (per the subsequent Disadvantages section), but the upside is the pressure to invest effectively in prevention, in order to keep people at home for as long as possible.

2.6.3. All-inclusive rates are flexible enough to allow for whole-person care

Unlike traditional fee-for-service medical payments, where rates are set for very specific and well-defined services, PACE programs have flexibility in providing the full spectrum of needs people may have. These might range from increased socialization opportunities, to emotional support, to covering rent and paying for home modifications (e.g. grab bars in the bathrooms).

This flexibility also applies within services. For transportation in a fee-for-service model, as an example, there is no incentive for a transportation provider to go the extra mile and provide anything other than what is specifically required in the fee. With PACE, the flexibility provided by the all-inclusive funding, combined with the economic incentive to keep people at the lowest level of care, leads to a transportation model that is far more responsive to the member —operating at odd hours, making unique accommodations, walking them to their door, etc. —and provides more value to the organization as a whole (i.e., by participating in the IDT).

2.6.4. PACE premiums provide predictable revenue

For organizations, this is helpful in eliminating financial uncertainty and adding a measure of stability.

2.7. Disadvantages

There are, of course, drawbacks. Many of these are the dark side of the same advantages listed previously.

2.7.1. Members have less choice in providers

Because PACE is a "one-stop shop" that also serves as a narrow-network health plan, members may not be able to pick their own doctors or otherwise go out of the network contracted with the PACE organization.

Within the care delivery structure of PACE itself, the flat rate can also create incentives that work against member choice, in favor of convenience or cost to the provider. Home visits, for example, can be limited, or transportation can operate on a reduced schedule.

2.7.2. All-inclusive rates create incentives to avoid high-cost clients

All managed care plans have this economic incentive. In the worst cases, this incentive manifests itself in practices that include:

- "Cherrypicking", which is when plans selectively recruit members by designing their benefit plan to attract healthy people and repel the sick;
- "Stinting", which is when plans ration or limit high-cost care; and,
- "Dumping", where organizations try to off-load difficult clients on other organizations. The classic example here is a nursing home discharging a patient to a hospital and refusing to take them back.

We do not want to imply that these practices are routine, or were ever practiced by the PACE program in Wyoming. But it would be naive to deny that the economic incentive exists under the full-risk premium structure.

Additionally, while PACE is subject to higher scrutiny by State and federal law than most managed care companies, it is difficult for government bureaucrats to *truly* know individual case specifics more than the providers themselves —much less micromanage care delivery.

2.7.3. Mandatory PACE Part D requirements drive away potential higher-income enrollees

The vast majority of enrollment in PACE programs nationally are low-income dual Medicare and Medicaid members. Generally speaking, few higher-income Medicare folks participate, even though PACE might benefit them as well.

The primary reason why is the required integration of highly-subsidized Part D pharmacy benefits into the PACE program. Because the average premium for these plans for non-duals can exceed $1,000 per month, this significantly discourages enrollment.[4]

Bipartisan federal legislation —the PACE Part D Choice Act[5] —has been introduced to address this problem by allowing non-duals to select their own standalone Part D benefit.

[4] https://www.fiercehealthcare.com/payers/new-senate-bill-seeks-add-part-d-options-pace-beneficiaries
[5] https://www.carper.senate.gov/wp-content/uploads/PACE-Part-D-Choice-Act-2023.pdf

Section 3: PACE in Cheyenne

3.1. History

3.1.1. PACE statute

In the 2010 Budget Session, the Wyoming Legislature laid the groundwork for PACE in Wyoming through the establishment of W.S. 42-4-121 (via HB86), which outlined how the program should operate. For the purposes of this study, we highlight some of the most relevant sections:

- Section (c), which defined the purpose of the PACE program in Wyoming as providing "prepaid, capitated, quality comprehensive health care services" designed to:
  - (i) Enhance the quality of life and autonomy for frail, older adults;
  - (ii) Maximize dignity of, and respect for, older adults;
  - (iii) Enable frail, older adults to live in the community as long as medically and socially feasible; and,
  - (iv) Preserve and support the older adult's family unit.
- Section (d)(ii), which set the capitation rate at "no less than ninety percent (90%) of the fee for service equivalent cost, including the department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all of those services were to be provided on a fee for service basis."
- Section (n), which forbids PACE organizations from withholding necessary services from PACE members; and,
- Section (m), which allows PACE members to "disenroll from the PACE program at any time."

3.1.2. Operations timeline

As directed by the Legislature, the Department applied for a State Plan Amendment (SPA) with the Centers for Medicare and Medicaid Services (CMS). This SPA was approved in September, 2011.

In February 2012, one provider —Cheyenne Regional Medical Center (CRMC) —submitted its PACE application. The governing three-way agreement between Wyoming Medicaid, CMS, and CRMC was signed in December 2012. At this point, CRMC had invested approximately $10 million in capital and staff to get its PACE program up and running.

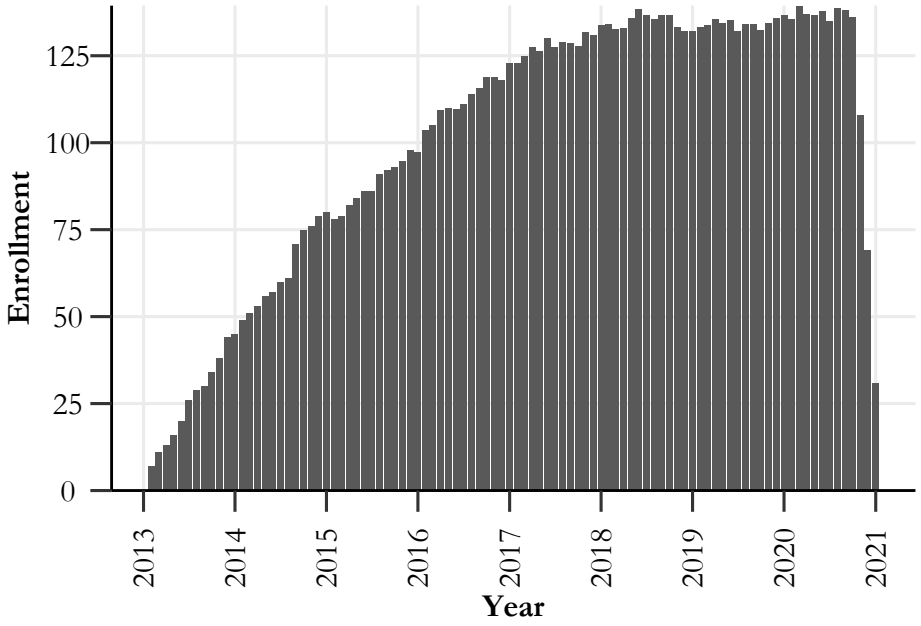
Operations began at the initial PACE site (800 E. 20th St.) on February 1st, 2013 with the first five participants.[6] The program steadily grew over the next five years, reaching a peak of ~ 140 people by 2018, as shown in Figure 2.

In that year, CRMC began the process of renovating a new PACE center down the street (1200 E. 20th St.), at a cost of an additional $4 million.[7] The program moved into its new building in July of 2019.

[6] Wyoming PBS featured PACE on its Wyoming Chronicle show in September 2015. This episode provides an excellent in-person look at the center: https://video.kqed.org/video/wyoming-chronicle-wyoming-pace/

[7] https://www.wyomingnews.com/news/local_news/wyoming-pace-program-to-be-eliminated-as-result-of-state-budget-cuts/article_535fc4eb-73ef-5ae3-a927-2b8a4bbb25f1.html

Figure 2: PACE enrollment history



3.2. Care delivery

3.2.1. Facilities

The core of the PACE program in Cheyenne was this adult day center. Both incarnations included everything necessary for the PACE mission: a dining area (food was prepared at the hospital and brought over), shower/bathing facilities, a pharmacy, laundry, physical therapy area, crafting and puzzle rooms, a quiet room, and provider spaces.

Transportation to and from the center was provided by a fleet of five (5) buses, all equipped with wheelchair lifts. These buses also drove people to outside medical appointments, as well as any field trips to restaurants or other activities during the day.

3.2.2. Staff

PACE employed around 45 people, including:

- Therapies staff, to include speech, physical, respiratory and occupational specialists;
- Social workers, case managers, and activities staff;
- 5 drivers;
- 2 full-time primary care providers (MD and NP);
- 5 administrative staff;
- 5 nurses, who were on call; and,
- 8 to 10 Certified Nursing Assistants (CNAs).

3.2.3. Organizational providers

In addition to staff directly employed by PACE, the organization leveraged hospital resources, to include use of the Emergency Department, inpatient beds, CRMC home health agency, and the network of hospital-affiliated physicians and other providers in Cheyenne.

3.2.4. Outside providers

Because PACE was all-inclusive, any resources not at the center or its hospital parent organization needed to be contracted.

Results here were mixed. The organization had success in working with CRMC affiliated specialists (e.g., the UC Health system, as well as University of Colorado hospital in Denver). As will be noted in the next section, however, PACE struggled in contracting for institutional long-term care, assisted living facility beds, dialysis, vision, and dental services.

3.3. Payment and rate setting

3.3.1. Medicaid premiums

As with the national model described previously, PACE rates in Wyoming Medicaid were designed around a single, all-inclusive rate. This rate, per statute, was intended to cover between 90% and 100% of the 'fee-for-service' equivalent cost that PACE members would have cost Medicaid if they hadn't been served in PACE.

To estimate this counterfactual cost, actuaries contracted with the Department used the average experience of the Medicaid long-term care population in Laramie County. This key assumption would prove problematic, as will be described in later sections.

The PACE rate became more complex in each annual update, incorporating things like pharmacy rebate and Upper Payment Limit (UPL) supplementary payment programs.

3.3.2. Medicare premiums

In addition to the (long-term care focused) premiums received from Wyoming Medicaid, PACE also received premiums from Medicare, intended to cover most of the medical costs. Since, as noted previously, PACE functioned as a Medicare Advantage provider, the premiums they received were set based on a complex bidding process and risk-adjusted based on the diagnoses coded on members' charts.

3.4. Discontinuation and transition

3.4.1. Decision to cut PACE

The Department of Health made the decision to discontinue the PACE program during the significant budget cuts of 2020. PACE was cut for two primary reasons:

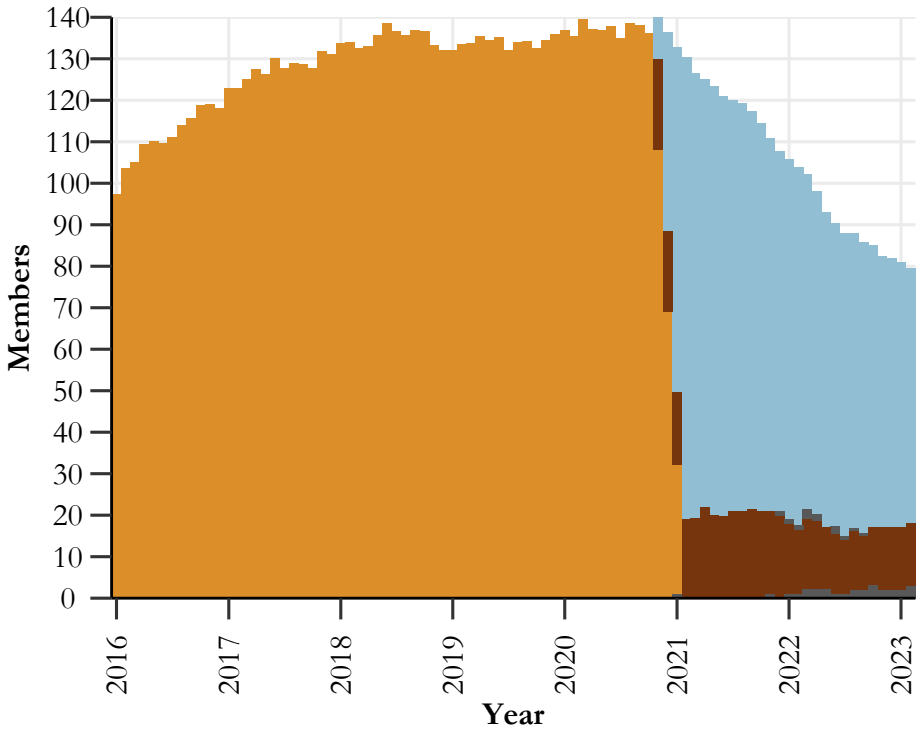
- We believed that the PACE premiums were higher than the costs we would incur for those same members outside of PACE; i.e., that there would be net budget savings.

- The PACE program only served members in Laramie County, so impact of cutting the program would not be felt statewide.

3.4.3. Most members transitioned to the Community Choices Waiver

Throughout 2020, the Department worked with CRMC to develop transition plans for each member. Figure 3 shows where members went after the transition began, with blue being the Community Choices Waiver and dark brown being nursing home. Note on the figure (which shows total counts of people) that the overall *percentage* of members in nursing homes began at ~15%, and —while the overall count of people in nursing homes has remained flat —the *percentage* has since increased to 25% today. This percentage will continue to increase as the former PACE cohort ages and requires more care.

Figure 3: PACE members after it was discontinued (orange is PACE, blue is CCW and brown is nursing home)

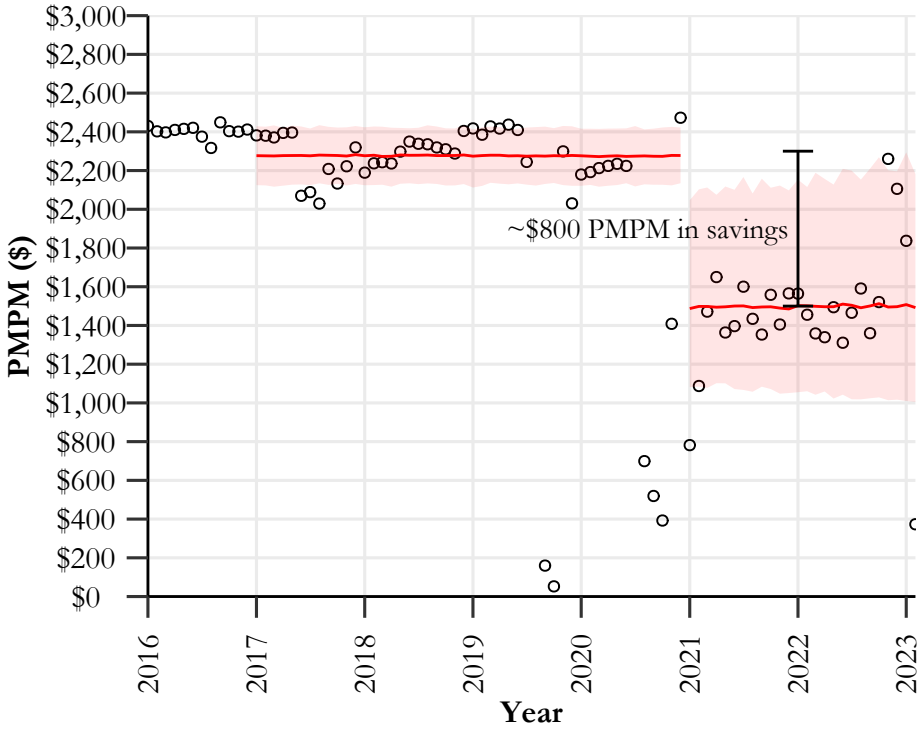


3.4.4 Cutting PACE saved $1.6 million State General Funds per biennium

Figure 4 shows the cost to the State before and after transition; from this,we estimate that cutting PACE saved approximately $800 on a per-member per-month basis. Assuming a steady-state of 140 clients, this translates into biennial savings of ~$2.7 million, half of which is to the General Fund. Adding in half of the ~$500,000 in biennial administrative savings gives us the total estimated $1.6 million figure.

As with Figure 3, the actual PMPM costs of the "former PACE" cohort will continue to increase as it ages. This is natural, because the cohort is now closed. The program cost savings, however, are real, because PACE would have continued to enroll new people if it hadn't been cut. The best time to observe the cost difference for the average PACE case mix was therefore immediately after transition.

Figure 4: PMPM for PACE members before and after transition



3.5. Strengths of the Cheyenne PACE program

3.5.1. The program was well-liked by its previous members

As part of this study, the Department conducted an in-depth telephonic survey[8] of former PACE members regarding their experience in the program and since the transition.

Of the 78 former PACE members identified as still being on Medicaid in the summer of 2023, we managed to cold-call and survey 35, a response rate of 45%. We were unable to contact the remainder largely due to disconnected phone numbers and full voicemail boxes.

The survey contained 23 questions. Most questions asked respondents to rate various aspects of the PACE program on a Likert scale of 1-5, similar to a standard Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

The overall picture the survey paints is very positive, with an average overall quality rating by respondents of 4.7 out of 5. Figure 5 shows the frequency of 1-5 responses for multiple aspects of the program, with meals being rated the lowest (just over 4 out of 5) and transportation rated the highest.

When former PACE members were asked to compare their experience with PACE with their current experience, either on the Community Choices Waiver (CCW) in a nursing home, most responded that their current experience was the same or worse as PACE, per Figure 6. While most participants rated their current quality of care relatively highly (an average of 4.2/5), most also reported a lower current quality

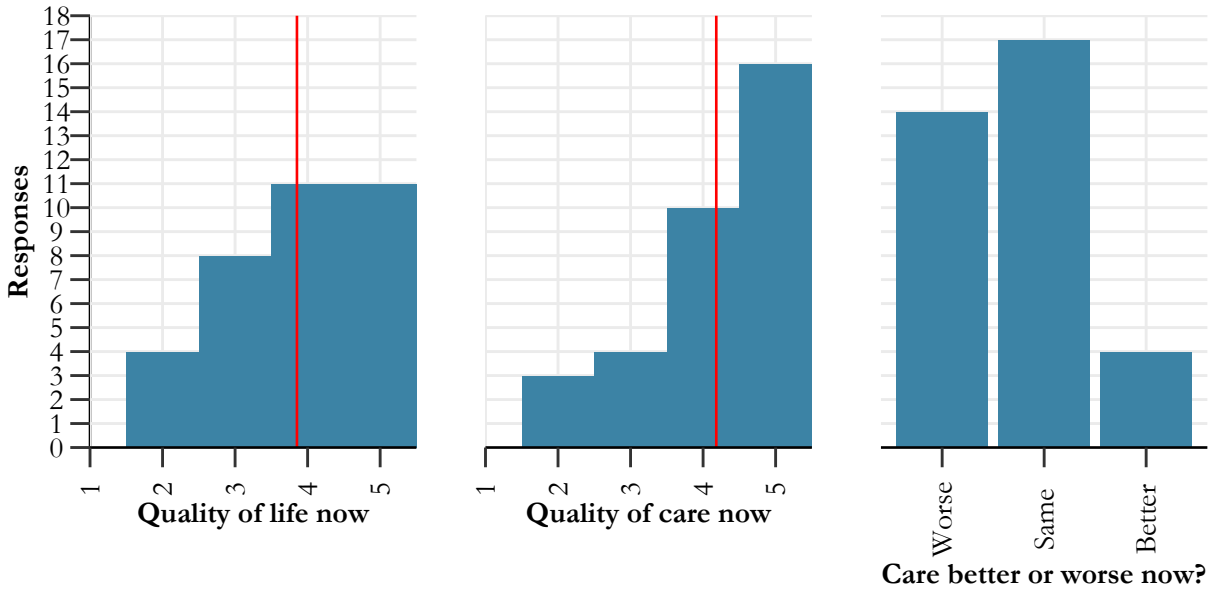
[8] Here, we deeply appreciate the work of our two University of Wyoming summer interns, Amelia Horst and Katie Carter.

Figure 5: Quality survey results

of life.

While these perceptions are colored by the distance of memory and the increasing infirmities of age (over two years have passed since PACE was discontinued), it's clear that the PACE program was deeply missed by the folks we talked to.

Figure 6: Quality survey results



3.5.1. The program successfully executed the PACE model of high-quality integrated and coordinated care

Even though there were some complaints of the program from time to time, the Department had few concerns about the quality of care delivered. Most PACE members who were interviewed in on-site surveys by the Department expressed satisfaction with the services they received.

More importantly, it's clear that the integration of transportation, socialization, and care coordination described in previous sections was successfully executed by the program —and has not been replicated in the community since the program's discontinuation.

3.5.1. The program creatively used available community resources

As will be discussed in the next section, Cheyenne's PACE program was significantly limited by the number of available providers in the community.

Where they could, however, the program demonstrated creativity in using non-traditional resources. PACE formed a partnership with Laramie County Community College (LCCC), for example, in having cosmetology and dental hygienist trainees provide free haircuts and tooth cleanings for its members.

3.6. Weaknesses of the Cheyenne PACE program

Along with its significant strengths, there were some specific weaknesses in how PACE was executed in Wyoming.

3.6.1. PACE administrative overhead was disproportionately high for the State

Wyoming Medicaid had to employ two (2) full time equivalent (FTE) employees to manage a program that only served ~130 people in one county. Two main factors drove this disproportionate burden:

- PACE was governed by a complex three-way agreement between the State, the provider, and the federal government.
- Since the program was paid on a capitated basis, rate development was a significant undertaking involving both state staff and contracted actuarial consultants.

The overhead also grew over time. CMS, for example, used to take the lead in a comprehensive survey of PACE records, contracts, and on-the-ground quality surveys. Within a few years, however, the federal agency handed over this process to the State with little notice or support.

Additionally, CMS also required adjustments to PACE rates on a regular basis, which increased the cost of contracted actuarial work.

3.6.2. Administration was also heavy for the PACE provider

As discussed in the previous section, each PACE program not only has to manage the complexity of its own staff in an integrated community-based model, but they also have to serve as mini insurance plan for all their outside providers.

This entails managing contracts, negotiating rates, paying individual claims, and dealing with CMS to receive risk-adjusted premium revenue on the Medicare side. Initially, because the program lacked experience, it also had to contract with its own actuaries to develop its initial premium bids to CMS.

On top of all this, PACE had to provide a full Part D drug benefit to its members, which, as noted previously, required contracting with a larger insurer or PBM, managing rebate and formulary options, and operating an in-house pharmacy.

Few of these requirements scale down with size. In other words, a program for 140 people likely has the same fixed administrative costs as a program for many thousands.

3.6.3. PACE had difficulty arranging local contracts for specialists and long-term care

The provider network developed by the program outside of the hospital and its physician groups was limited, which effectively reduced patient choice, but also limited the program's ability to serve higher-needs clients.

Dialysis providers, dental, nephrology, and nursing home care were particular pain points.

Most of this was simply due to lack of competition due to Wyoming's rural and frontier geography. Even in its capital city, when you have to contract with the only game in town, it's difficult to secure favorable terms.

There were also complications with Wyoming Medicaid being able to make side payments (i.e., via Upper Payment Limit programs) to nursing homes directly that effectively raised the price bar for CRMC.

Finally, there was also the issue of care responsibility. When a PACE client had to enter nursing home care, questions on who would be managing that care —the PACE program or the nursing home —anecdotally created friction in potential contracts.

3.6.4. The State struggled to get standardized utilization and quality data from the program

Likely because of the significant administrative burden on a relatively small PACE program, Wyoming Medicaid was never able to obtain the standardized (e.g., per our usual fee-for-service claims) and comparable medical encounter and utilization data from CRMC.

This data was required to evaluate quality indicators like emergency department visits, inpatient hospitalizations, and overall diagnosed acuity. Its absence made it difficult to compare PACE member experience with other long-term care programs in our internal performance management system, and thus for program staff to justify the value of the premiums that we were paying.

Had PACE continued, this deficit would have been exacerbated by the increasing emphasis of CMS on quality metric reporting for managed care plans.

Section 4: "Demand"

This section concludes that the previously-paid premium was not cost-effective. If PACE is restarted, premiums would need to be adjusted based on factors that affect long-term care demand, like acuity and age.

4.1. A cost-effective PACE rate depends on where members would have been served without PACE

As noted in the background section, per statute and CMS rules, PACE rates must be set between 90% and 100% of "the fee for service equivalent cost, including the department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all of those services were to be provided on a fee for service basis."

The million-dollar question is: if the same people had been served outside of PACE, what would their costs have been?

Because most PACE members were also eligible for Medicare, Medicaid costs are essentially related to long-term care. So, from the State's perspective, the question simplifies to: what percent of PACE members would have been served in nursing homes vs. alternative home- and community-based settings like the Community Choices Waiver (CCW)?

This question is obviously difficult to answer without a time-travel machine. However, we can make some inferences based on what we observed shortly after the program was discontinued, as well as some statistical modeling.

4.2. Most PACE members would not have otherwise been served in nursing homes

While PACE is designed to keep people in community-based settings for as long as possible, it's clear that, at least in Wyoming, the effect on offsetting nursing home enrollment was minimal.

In estimating the possible cost savings of cutting the program, the Department drew on two observations:

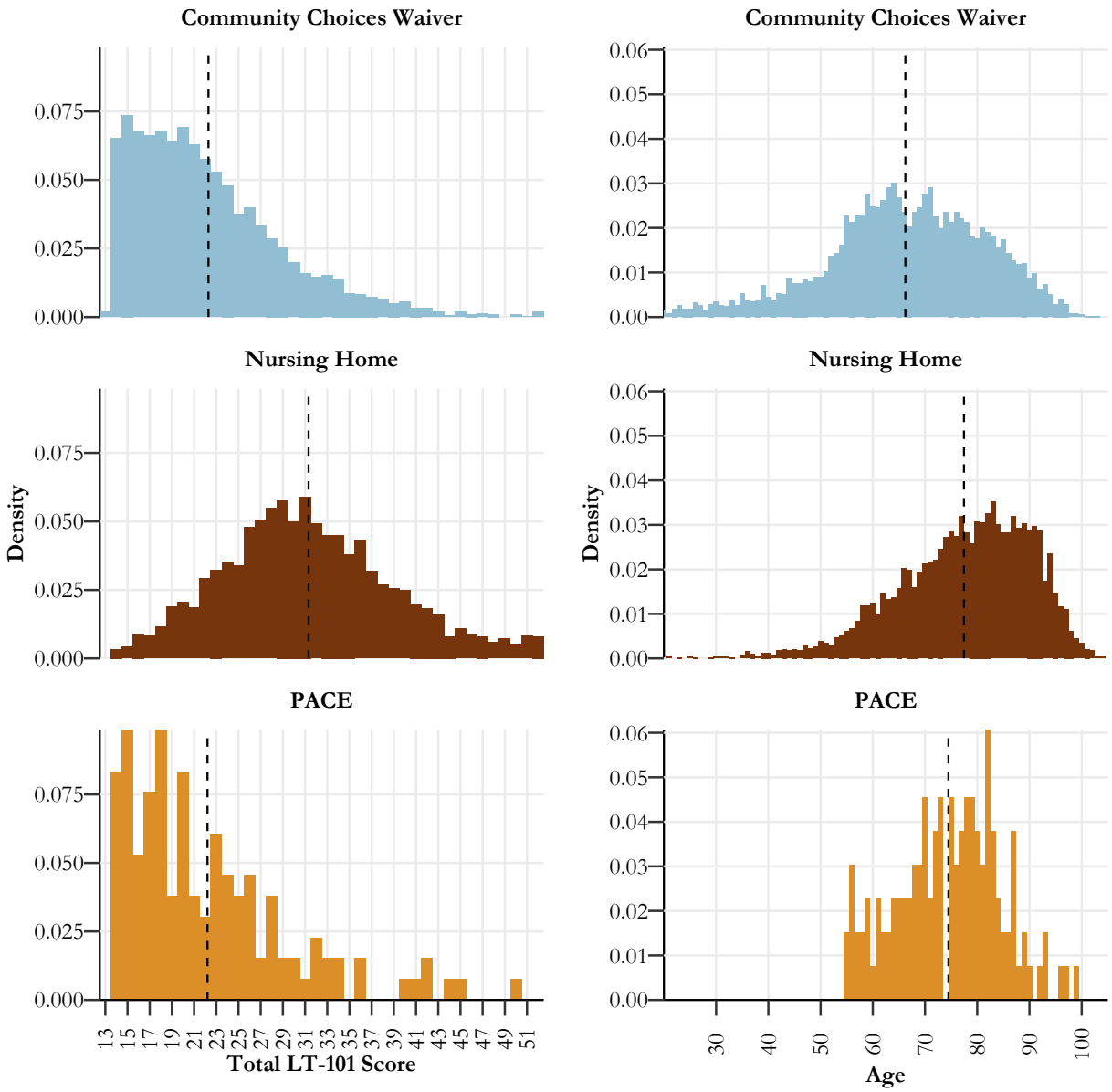
- The age and acuity of PACE enrollees looked a lot more that of people on the Waiver than that of people in nursing homes, and;
- PACE enrollment appeared to come at the expense of Waiver —not nursing home —enrollment.

4.2.1. The PACE enrollment profile mirrored that of the Community Choices Waiver

Figure 7 shows the distributions of LT-101 scores (left) and ages (right) for the Community Choices Waiver (top), nursing home (middle) and PACE (bottom).

While the PACE age distribution is in-between that of the CCW and nursing home (largely because of its 55 minimum age), the LT score distribution clearly reflects the CCW.

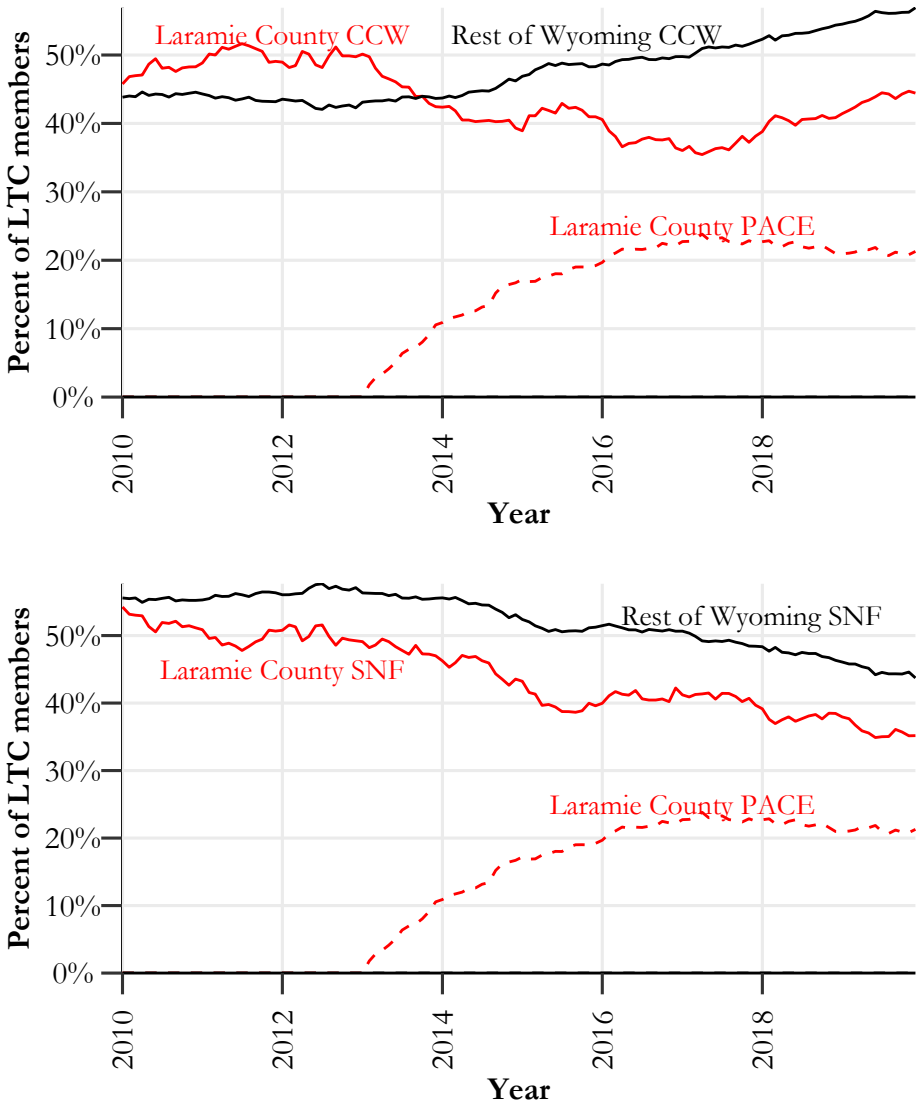
Figure 7: Observed distribution of age and LT-101 scores



4.2.2. PACE enrollment came at the cost of CCW enrollment, not nursing home

Figure 8 shows trends in Medicaid long-term care enrollment over time as a percent. The top graph shows the correlation between the growth in PACE enrollment and the relative decline in CCW enrollment for Laramie County (in red), especially contrasted with the relative growth of CCW in the rest of the State (black).

Figure 8: PACE growth came at expense of Community Choices Waiver



The bottom panel compares PACE growth with the relative share of Medicaid members in nursing home settings. Here, there is little apparent change in the Laramie County (red) trajectory compared with the rest-of-Wyoming average —both are more or less parallel after PACE was introduced in 2013.

4.2.3. Statistically-modeled estimates of Medicaid member long-term care trajectories confirm these observations

Because the PACE rate needs to smooth over the risk for *lifetime* care needs, we need to build a model of these counterfactual trajectories —in the absence of the PACE program —to more rigorously evaluate what a cost-effective rate would have been.

Such a model is described in Section 7 (the technical appendix). It's very similar to the one we proposed in Part II of this series to evaluate the effectiveness of intercepting "pre-Medicaid eligible" people with limited home-based services.

The results of the model show that the actual average lifetime percentage of people in nursing homes for PACE was approximately 20% —not the ~ 40% community-wide average that was assumed in the rate development process.

4.3. Any future PACE rate needs to adjust for individual acuity

This analysis shows how important it is not to assume that PACE members' long-term care experience merely follow community averages.

If Wyoming Medicaid were to reconstitute the program, we would strongly recommend adjusting PACE premiums on an individual basis by acuity.

As a toy example, the transition model just described could be used to adjust premiums by age, sex, and initial LT-101 assessment score. Figure 9 shows the results of this exercise, with a "lifetime percent nursing home" measure that could be used to adjust the premium up (for higher values) or down.

4.3. Remaining problem: is PACE for life —or not?

Adjusting for acuity only solves part of the problem posed by the managed-care aspects of PACE. There still remains a fundamental contradiction between the design of the PACE premiums, which assume a lifetime long-term care trajectory, and existing State and federal laws[9], which guarantee the ability of individuals to voluntarily disenroll from PACE and move on to conventional Medicaid eligibility programs —like the standard nursing home group.

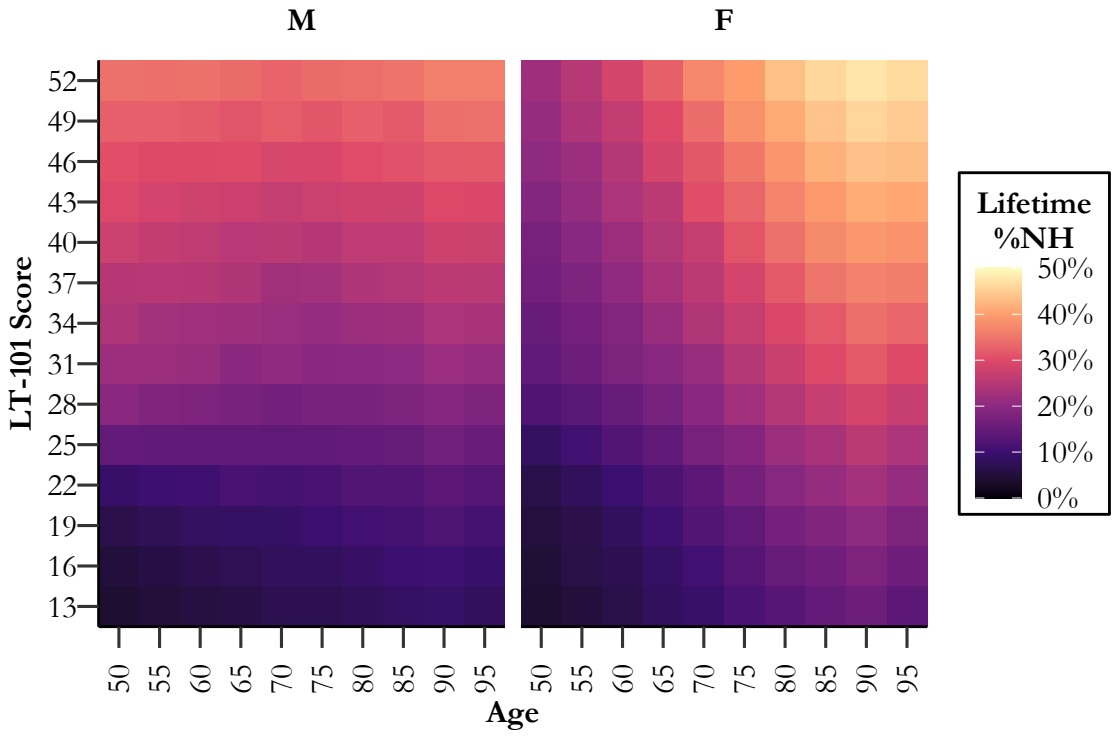
This creates a not-insignificant degree of moral hazard that potentially benefits both PACE providers and nursing homes at the expense of the State.

Specifically, if PACE members who need to be in a nursing home could be persuaded to drop out of PACE, this would both lighten the financial burden on the program (who would otherwise be on the hook for those costs), as well as potentially increase payments to nursing homes (since the rate paid by PACE was often lower than the Medicaid + UPL rate).

Over the course of the PACE program, these PACE-to-Nursing Home transfers happened nine (9) times, beginning in 2017 and accelerating in 2020. While this number seems small, it needs to be considered in the context of overall enrollment (~140 people) and the share who likely needed nursing home care (~20%, or 28 people) at any given time.

[9] W.S. 42-4-121(m) and 42 CFR §469.162

Figure 9: Example rate cells from rate adjusted by age and LT-101 score



We do not assume any nefarious intent here, and many of these transfers may well have been appropriate (e.g., perhaps members moved to a nursing home outside Laramie County in order to be closer to family). However, just the existence of this contradiction allows risk to 'leak' out of the all-inclusive premium, no matter how fancy the rate model is.

Section 5: "Supply"

The previous section established that a cost-effective PACE rate would likely be lower than what the State previously paid. This section concludes that no providers capable of building a PACE program would accept this new rate. The prospects of re-establishing PACE in Wyoming are therefore nil.

5.1. Very few providers in Wyoming would be capable of bringing PACE back, regardless of the rate paid

Of all the providers who serve our older residents —to include senior centers, nursing homes, hospitals, home health agencies, adult-day centers, Assisted Living Facilities, Federally-Qualified Health Centers, and Rural Health Clinics —we estimate that only a handful of the larger and well-capitalized hospitals in Wyoming would be capable of establishing and operating a PACE program. These include:

- Cheyenne Regional Medical Center;
- Wyoming Medical Center (Casper);
- St. John's Health (Jackson);
- Campbell County Memorial Hospital (Gillette);
- Sheridan Memorial Hospital; and,
- Cody Regional Health.

There are two primary reasons here:

- As well documented in previous sections, PACE programs are extraordinarily complex, not only in their initial investment and care delivery model, but also in the administrative overhead required to operate a Medicare Advantage plan; and,
- Wyoming's geography limits the number of outside providers that can be contracted to provide all-inclusive services.

5.1.2. There are high barriers to entry, in terms of capital, staffing, and expertise

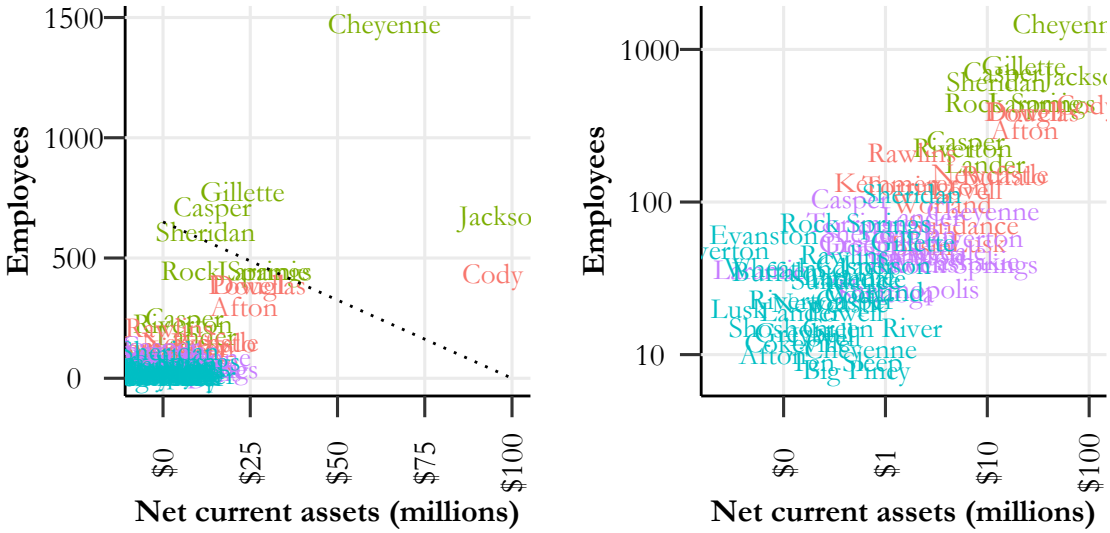
Recall that the Cheyenne PACE program took an initial local investment of at least $10 million to build. That was ten years ago. We have already described the ~45 staff members from multiple disciplines, the requirement to provide all-inclusive care, and the administrative complexities involved in building a provider network, paying claims, and managing risk-adjusted premiums from Medicare.

To estimate which providers might be able to tackle these kind of requirements, we looked at two dimensions:

- Total number of employees, which measures roughly the total organizational and staffing capacity entities might have to leverage, as well as a proxy for the total enrollment (people served) over which an entity might be able to spread costs;
- Net current assets, calculated by subtracting current liabilities from current assets. This roughly measures how much money is "sitting around" (i.e., relatively liquid) that could be used to invest in a new PACE program.

Figure 10 shows Wyoming providers —for whom we have public financial data —graphed along these two dimensions.

Figure 10: Larger hospitals are likely only providers with resources



The panel on the left shows both dimensions on a nominal scale, and the panel on the right shows the dimensions on a log scale, to visually expand the cluster of smaller providers in bottom left. On the figure:

- Blue represents senior centers;
- Purple represents nursing homes;
- Red shows Critical Access Hospitals; and,
- Green shows Prospective Payment System (PPS) hospitals.

Our list of hospitals under Section 5.1. comes from drawing the dotted diagonal line on the left panel of Figure 10. This is an unscientific guess, but if none of the biggest providers are interested, it's difficult to believe that smaller providers could pull it off.

5.1.3. Post-COVID staffing shortages make things more difficult now

All providers in the long-term care business have been struggling with recruitment of nurse and nursing-adjacent staff. This makes implementing a new program even more of a challenge.

In a survey of potential PACE providers, we received 30 responses specifying primary and secondary barriers to establishing a program. Staffing was the single largest barrier (12/30), followed by capital requirements (8), administrative burden (4), low rates (4) and regulatory burden (2). Staffing, admin, and capital —in that order —were also the top secondary barriers.

5.1.4. "All-inclusive" services require a robust provider network

Wyoming's geography —a network of small towns sparsely connected over a vast and rugged landscape —makes building any kind of contracted provider network difficult. It's even harder to build the kind

of robust network that offers members significant choice and gives you market leverage in negotiating provider rates.[10]

Our "long streets" also make it difficult to efficiently share limited, specialized and low-volume resources (e.g. physical therapists) across sites —much less of an issue for larger hospital systems operating in a dense urban environment.

5.2. No capable providers have expressed interest

This is akin to the economic concept of 'revealed preference'.[11] When PACE was operating in Cheyenne, both CRMC and the State would receive periodic inquiries from some of these larger hospitals (e.g. Casper, Sheridan, Jackson) on the potential for expanding the program. Once we responded with details on what the program requires, however, we never heard anything back.

Similarly, for this study we reached out to select hospital administrators to get their perspectives. None indicated any interest.

A new PACE rate —one that would have to be **lower** than the previous rate for it to be cost-effective for the State —is not likely to stimulate further interest.

[10] Effective negotiation requires the ability to walk away (the "BATNA").

[11] Per the old joke: two economists walk past a new Porsche. The first economist turns to the second economist and says, "I'd give anything to own that car." The second economist says, "Clearly not."

Section 6: Findings and recommendations

6.1. Unbundled waiver services have not replaced PACE in Laramie County

When PACE was cut, the Department believed that its members would be well-served by waiver services in the community. It's clear from our member survey that this hasn't happened to the degree we hoped, and that something special in Cheyenne was truly lost.

The lack of transportation is the most obvious problem. Medicaid fee-for-service rates for non-emergency transportation are just too low to attract meaningful provider participation, and many former PACE members now on the waiver noted difficulty with getting trips to appointments.

While more difficult to observe, care coordination has also likely degraded. As we noted in the background sections, the "special sauce" of PACE is the synergy between the adult day, the meals, the socialization, the transportation, the care coordination and the in-home services happening every day.

6.2. The State should not attempt to restart PACE

While the PACE model has undeniable advantages, its managed care aspects —specifically, loading medical and long-term care risk into an all-inclusive premium —are difficult to execute well in a rural and frontier State.

The conclusion is well-supported throughout this study, but it is not particularly helpful for policymakers.

A more useful question we hope to answer is: how can the State reconstitute some of that "special sauce" without going full managed care?

6.3. Instead, it should consider three alternative options:

We propose these in order of potential cost and complexity, denoted by 'mild', 'medium' and 'spicy' levels. All could be pursued, either simultaneously or sequentially. They are not mutually-exclusive.

6.3.1. Mild: Increase select home- and community-based service rates

This would help to increase utilization of two helpful, but woefully-underutilized Medicaid services that represent two components of PACE:

- **Adult day care**, similar to the core of PACE, where people spend a half-day a few times a week at a center. In addition to offering respite to caregivers, getting out of the house provides socialization and the chance to check-in with how people are doing. Unfortunately, very few providers offer this service. Staffing, capital requirements, and rates were the primary barriers in our survey. Higher rates might offset the first two problems. It also may be important to take a hard look at regulatory requirements for licensure.
- **Non-emergency medical transportation (NEMT)**. This service helps get people to appointments, which can be particularly difficult with Wyoming's geography. As with adult day, low rates make it barely utilized.

The advantages and disadvantages of this option are two sides of the same coin: cost. We would anticipate cost to the State to increase, both from the rate increases themselves, but also due to the anticipated (and desired) increase in utilization.

6.3.1. Medium: Implement bundled "PACE light" service

This option would explore bundling **core** PACE services together in an flat **per-day** fee-for-service rate, similar to how day habilitative services are provided on the waivers for people with intellectual or developmental disabilities.

This would avoid the 'all-inclusive' PACE risk of open-ended long-term care, pharmacy, specialist, inpatient, and other costs, but could include things like:

- 1 × adult day;
- 1 × congregate meal;
- 2 - 3 × transportation trips;
- 0.3 × care coordination and medication reconciliation encounter.

Advantages include:

- Bundling these services together streamlines the administrative work of billing for everything separately, allows greater revenue predictability for providers, and supports some cross-subsidization in service lines.
- The overall rate could also be higher than the sum of its components because of the value provided by the synergy across all of them.

Disadvantages include:

- Likely higher costs to the State. As with the first option, this would effectively increase rates and utilization. There would also be administrative costs to implement this option. While "PACE light" would likely increase members' quality of life, we cannot determine what potential savings their might be from avoided institutional stays at this time.

6.3.2. Spicy: Study establishment of State-operated Medicare Advantage plan

Wyoming has around 12,000 people who are eligible for both Medicare and Medicaid, based on their age, disability, or low income. These individuals are known as "dual eligibles", or "duals" for short.

When it comes to medical care for duals, Medicare is the primary payer. Wyoming Medicaid ends up playing the role of a supplemental insurer, or "Medigap" plan, in covering coinsurance and other patient cost-sharing to providers after the primary payment is made. Whenever a dual-eligible person is treated, providers typically receive two checks:

- One from Medicare, paid by the fee-for-service administrative contractor (Noridian).
- Several weeks later, a check from Wyoming Medicaid, which is only cut after the Medicare claim information is received and processed.

There are three main problems with this current arrangement, all centering on perverse institutional incentives:

- Traditional fee-for-service Medicare has *no ability* to manage the medical care that duals receive. The system is built to pay virtually all claims it receives, with few questions asked.
- Wyoming Medicaid has *little incentive* to manage the medical care of dual-eligibles. Care management is administratively intense, costs money, and any savings this management could achieve would just accrue to the federal Medicare program, not the State.
- However, because duals are, by definition, aged or disabled and low-income, they end up being a significant feeder population for Medicaid long-term care. This means that chronic conditions that go unmanaged or are exacerbated when on Medicare can spiral into a liability for Medicaid in the long-run.

To address the problem of institutional incentives, we propose exploring the possibility of Wyoming Medicaid establishing and operating a Medicare Part C (or Medicare Advantage) plan focused on dual-eligibles (know as a Dual Eligible Special Needs Plan, or D-SNP) —though the same infrastructure could potentially be expanded later for a general Medicare Advantage plan in which any Medicare members could voluntarily enroll.

Unlike fee-for-service Medicare, in Medicare Advantage the federal government pays private insurers a risk-adjusted premium for each of their Medicare enrollees. And just like with any private insurance product, those insurers are then responsible for managing their enrollees' care, building provider networks, and making payments for services. Because their premium revenue is fixed[12], these insurers have strong incentives to control spending.[13]

In this proposal, Wyoming Medicaid would submit bids for Medicare Advantage D-SNP business through the same process as the private insurers, and play by the same rules.

The advantages include:

- Because all the financial risk would be on the State, we would have a strong interest to invest in the prevention and care management efforts that could decrease both Medicare medical costs and future Medicaid long-term care costs of dual-eligibles.
- Part C plans can offer a wide range of supplemental benefits, so the State would have significant latitude to experiment with what might work to bend down costs. Some Medicaid waiver services (e.g. home health, personal care, transportation) might be able to be supplanted or expanded here by Medicare benefits.
- Unlike the net cost of the first two options, Medicare premium revenue could make operations budget neutral, and even potentially supplant State General Funds. Most Medicare Advantage plans operate at profit margins around 4-5%. D-SNP plans are usually higher, in the 8-10% range.[14]

[12] This is only in theory; in practice, many Medicare Advantage plans are infamous for *'upcoding'* diagnoses, inflating the perceived risk of their enrollees and thus increasing their premium revenue. The GAO has done a series of reports on these overpayments, e.g., https://www.gao.gov/assets/gao-22-106026.pdf

[13] As this study notes with PACE, this can be done in wholesome ways, like investing in effective preventive care, or less-salubrious ways, like *stinting* through onerous prior authorization hurdles or *cherry-picking* through restrictive networks and formularies.

[14] https://aspe.hhs.gov/sites/default/files/documents/9b42ffbf2341726d5b63a9647b0aad15/medicare-advantage-overview.pdf

While some of these high margins are likely driven by some of the unsavory practices noted in the footnotes, there's a good chance the State could still come out ahead in the long run.

- Wyoming Medicaid already has most of the insurance infrastructure in place, and paid for; i.e., provider enrollment, eligibility, claims processing. There would significant economies of scale in adding more members and providers to this existing baseline, without needing to reinvent the wheel.

Disadvantages include:

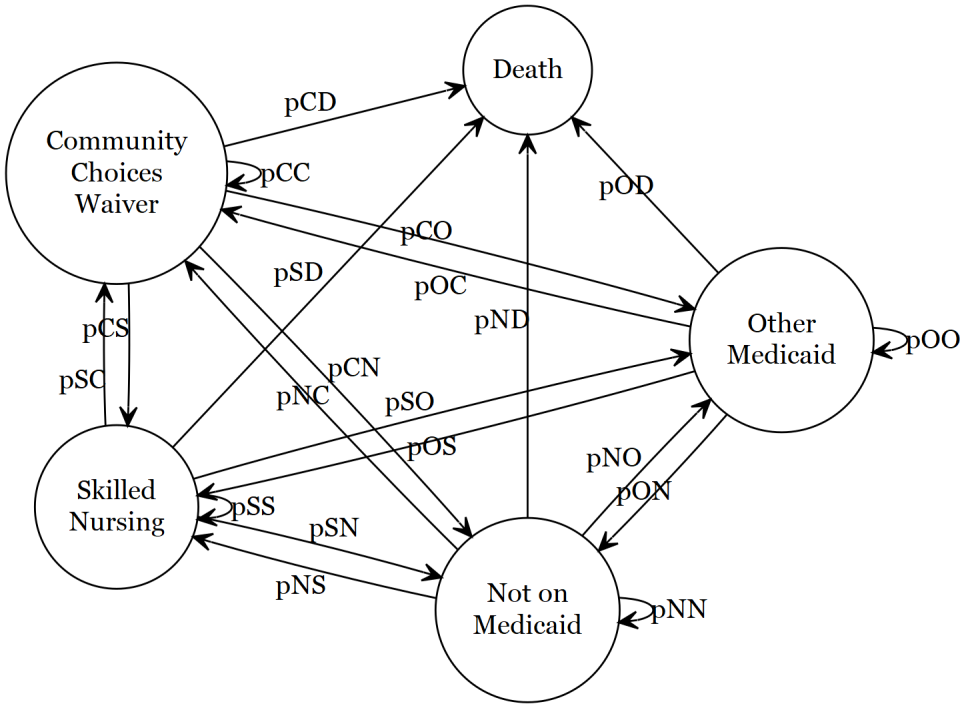
- While legally possible, this option is entirely in uncharted waters. No State has attempted to enter the Part C market. The closest analogs are county entities in California that operate both Medicare and Medicaid managed care plans.
- While both are public payers that sound the same, Medicare and Medicaid do have different rules and regulations, so the State would be faced with a not-insignificant learning curve. The State would need a significant number of additional positions to manage the Medicare side of the house.
- Additional administrative infrastructure would need to be built (e.g., marketing, enrollment, supplemental benefits, managing or outsourcing Part D benefits). These cost would likely need to be front-loaded, since premiums are only paid once the plan is operating.

Section 7: Technical appendix

This section formally describes the statistical model we used to illustrate the cost-effectiveness of the former PACE program.

We noted previously that the model is a version of the transition probability model previously described in Section 1.5.3 of Part II of this report series —modified by adding age and LT-101 score as predictors for annual transition probabilities between five states, as diagrammed in Figure 11.

Figure 11: Medicaid long-term care transition model



As with the previous model, this also predicts a series of time-varying (non-homogeneous) individualized transition matrices for an individual i.

We put the annual transition probabilities between the states for person i in year j into the matrix $\mathbf{T}_{ij}$, below. Note that we only need to model transitions from the four origins; death is an absorbing state where probabilities are known.

$$\mathbf{T}_{ij} = \begin{bmatrix} \textbf{Not Medicaid}_{ij}^{k} \\ \textbf{Other Medicaid}_{ij}^{k} \\ \textbf{Community Choices Waiver}_{ij}^{k} \\ \textbf{Skilled Nursing}_{ij}^{k} \\ \textbf{Death}_{ij}^{k} \end{bmatrix} = \begin{bmatrix} n_{ij}^{n} & n_{ij}^{o} & n_{ij}^{c} & n_{ij}^{s} & n_{ij}^{d} \\ o_{ij}^{n} & o_{ij}^{o} & o_{ij}^{c} & o_{ij}^{s} & o_{ij}^{d} \\ c_{ij}^{n} & c_{ij}^{o} & c_{ij}^{c} & c_{ij}^{s} & c_{ij}^{d} \\ s_{ij}^{n} & s_{ij}^{o} & s_{ij}^{c} & s_{ij}^{s} & s_{ij}^{d} \\ 0 & 0 & 0 & 0 & 1 \end{bmatrix}$$

We estimate the transitions **from** the four origins **to** the five destinations separately, modeling each row

using a categorical distribution:

$$\begin{aligned}
\text{Transition from Not Medicaid}_{ij} &\sim \text{Categorical}(\mathbf{n}_{ij}^{k}) \\
\text{Transition from Other Medicaid}_{ij} &\sim \text{Categorical}(\mathbf{o}_{ij}^{k}) \\
\text{Transition from CCW}_{ij} &\sim \text{Categorical}(\mathbf{c}_{ij}^{k}) \\
\text{Transition from Skilled Nursing}_{ij} &\sim \text{Categorical}(\mathbf{s}_{ij}^{k}) \\
k \in \{&\text{Not Medicaid (n), Other Medicaid (o), CCW (c),Skilled Nursing (s), Death (d)}\}
\end{aligned}$$

The categorical distribution uses a softmax link to derive a simplex (i.e., transition probabilities that add up to 100%) from five linear "scores," denoted by $s_{ij}^{1}, s_{ij}^{2}, \ldots, s_{ij}^{5}$ below:

$$\begin{aligned}
\Pr(k \mid s_{ij}^{1}, s_{ij}^{2}, s_{ij}^{3}, s_{ij}^{4}, s_{ij}^{5}) &= \frac{\exp(s_{ij}^{k})}{\sum_{n \in k} \exp(s_{ij}^{n})} \\
s_{ij}^{1} &= 0
\end{aligned}$$

Because the model sets one of these scores to zero in order to identify the others, we now have sixteen (16) score equations to estimate statistically —four equations for each of the four settings. Each person-month score is the linear combination of an overall intercept (α_x), their beginning LT-101 score ($\beta_x \times \text{LT-101}_i$), a tensor product smooth incorporating age and sex ($t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_x)$) and a person-level varying intercept ($\alpha_{\text{Person[i]}}$).

Importantly, this person-level effect allows us to estimate correlations between the four relevant rows of the transition matrix, which are otherwise modeled separately. The idea is that, after adjusting for age, sex, and LT-101, for example, someone who is less likely to die in any given year may also be less likely to go to a nursing home at any point.

$$
\begin{aligned}
s_{ij}^{no} &= \alpha_1 + \beta_1 \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_1) + \alpha_{\text{Person[i]}}^{no} \\
s_{ij}^{nc} &= \alpha_2 + \beta_2 \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_2) + \alpha_{\text{Person[i]}}^{nc} \\
s_{ij}^{ns} &= \alpha_3 + \beta_3 \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_3) + \alpha_{\text{Person[i]}}^{ns} \\
s_{ij}^{nd} &= \alpha_4 + \beta_4 \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_4) + \alpha_{\text{Person[i]}}^{nd} \\
s_{ij}^{on} &= \alpha_5 + \beta_5 \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_5) + \alpha_{\text{Person[i]}}^{on} \\
s_{ij}^{oc} &= \alpha_6 + \beta_6 \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_6) + \alpha_{\text{Person[i]}}^{oc} \\
s_{ij}^{os} &= \alpha_7 + \beta_7 \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_7) + \alpha_{\text{Person[i]}}^{os} \\
s_{ij}^{od} &= \alpha_8 + \beta_8 \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_8) + \alpha_{\text{Person[i]}}^{od} \\
s_{ij}^{cn} &= \alpha_9 + \beta_9 \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_9) + \alpha_{\text{Person[i]}}^{cn} \\
s_{ij}^{co} &= \alpha_{10} + \beta_{10} \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_{10}) + \alpha_{\text{Person[i]}}^{co} \\
s_{ij}^{cs} &= \alpha_{11} + \beta_{11} \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_{11}) + \alpha_{\text{Person[i]}}^{cs} \\
s_{ij}^{cd} &= \alpha_{12} + \beta_{12} \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_{12}) + \alpha_{\text{Person[i]}}^{cd} \\
s_{ij}^{sn} &= \alpha_{13} + \beta_{13} \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_{13}) + \alpha_{\text{Person[i]}}^{sn} \\
s_{ij}^{so} &= \alpha_{14} + \beta_{14} \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_{14}) + \alpha_{\text{Person[i]}}^{so} \\
s_{ij}^{sc} &= \alpha_{15} + \beta_{15} \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_{15}) + \alpha_{\text{Person[i]}}^{sc} \\
s_{ij}^{sd} &= \alpha_{16} + \beta_{16} \times \text{LT-101}_j + t2_{re}^{cs}(\text{Age}_{ij}, \text{Sex}_i, \tau_{16}) + \alpha_{\text{Person[i]}}^{sd}
\end{aligned}
$$

Priors used for the intercepts, fixed effects, smooths, and person-level intercepts are shown below. We used the default priors set by the *brms*[15] package. With the exception of the flat β_x priors, they are somewhat regularizing, designed to ease computation.

[15] Bürkner P (2017). "brms: An R Package for Bayesian Multilevel Models Using Stan." Journal of Statistical Software, 80(1), 1–28. doi:10.18637/jss.v080.i01.

$$\alpha_1,\ \alpha_2,\ \ldots,\alpha_{15},\sim \text{Student}(3,0,2.5)$$
$$\beta_1,\beta_2,\ \ldots,\beta_{15}\sim \text{U}(-\infty,\infty)\ \text{[flat]}$$
$$\tau_1,\tau_2,\ \ldots,\tau_{15}\sim \text{Student}(3,0,2.5)$$

$$\begin{bmatrix}\alpha^{no}_{Person[i]}\\ \vdots \\ \alpha^{sd}_{Person[i]}\end{bmatrix}\sim \mathcal{N}\left(\begin{bmatrix}0\\ \vdots\\ 0\end{bmatrix},\mathbf{SRS}\right)$$

$$\mathbf{S}=\mathbf{I}_{16}\{\sigma_1,\sigma_2,\ldots,\sigma_{16}\}$$

$$\mathbf{R}=\begin{bmatrix}1 & \rho_{1,2} & \cdots & \rho_{1,16}\\ \rho_{2,1} & 1 & \cdots & \rho_{2,16}\\ \vdots & \ddots & \ddots & \vdots\\ \rho_{16,1} & \rho_{16,2} & \cdots & 1\end{bmatrix}$$

$$\sigma_1,\sigma_2,\ldots,\sigma_{16}\sim \text{Student}(3,0,2.5)$$
$$\mathbf{R}\sim \text{LKJ}(2)$$

We then fit this model on ten years of Medicaid enrollment data, considering only members who never experienced the PACE program, and then sampling them on their birthdays (in order to reduce the modeling burden[16] but consistently have annual approximations of their states). Because many of these members had missing LT-101 scores, we imputed those based on their age, sex, and starting eligibility group.

Sampling was done using the *brms* package, which uses *cmdstanr*[17] interface to the Stan HMC sampler[18].

The end result of this model is the ability to predict a random series of annual transition matrices for an individual with a given age, sex, and LT-101 score. A simplified example for a person on the Community Choices waiver with a low LT score is shown in Figure 12, where blue lines indicate the annual probability of remaining on the waiver, the brown lines indicate the probability of transitioning to a nursing home, and the gray lines indicate probability of dying.

We then apply the model to a cohort of those PACE members with known LT-101 scores that were assessed after the rubric changed in 2016.

Once each member has a series of predicted counterfactual transition probability matrices, we simulate out thousands of trajectories using the *markovchain*[19] package and average them out over the cohort,

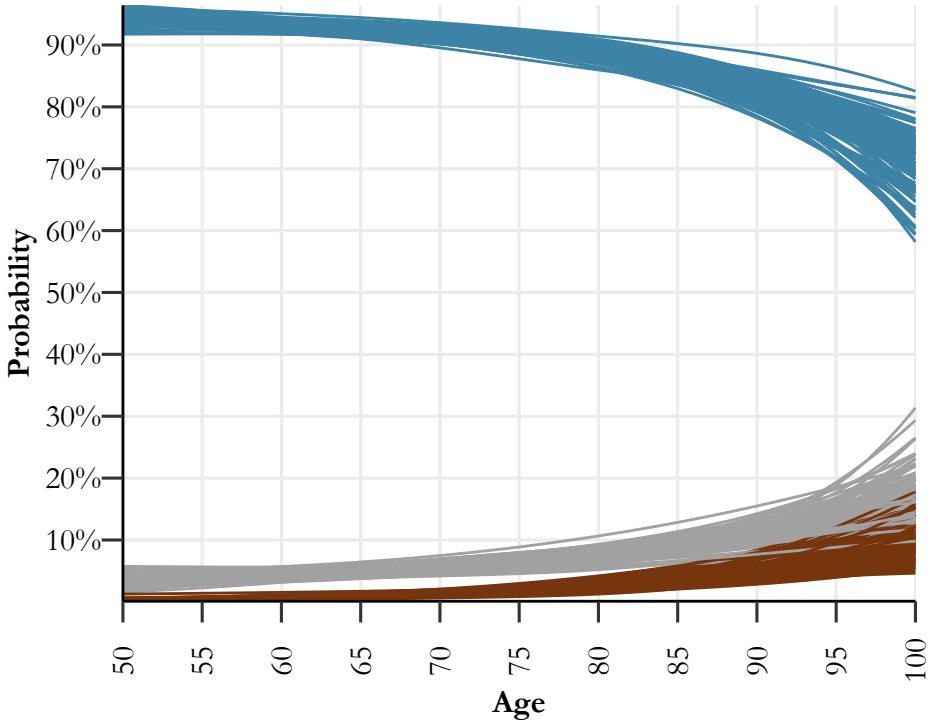
[16] With 37,806 observations nested within 8,118 total Medicaid members, the model, as is, took over a week to fit on a 12-core computer

[17] Gabry J, Češnovar R, Johnson A (2023). cmdstanr: R Interface to 'CmdStan'. https://mc-stan.org/cmdstanr/, https://discourse.mc-stan.org.

[18] Stan Development Team. 2023. Stan Modeling Language Users Guide and Reference Manual, 2.26. https://mc-stan.org

[19] Spedicato G (2017). "Discrete Time Markov Chains with R." The R Journal, 9(2), 84–104. https://journal.r-project.org/archive/2017/RJ-2017-036/index.html.

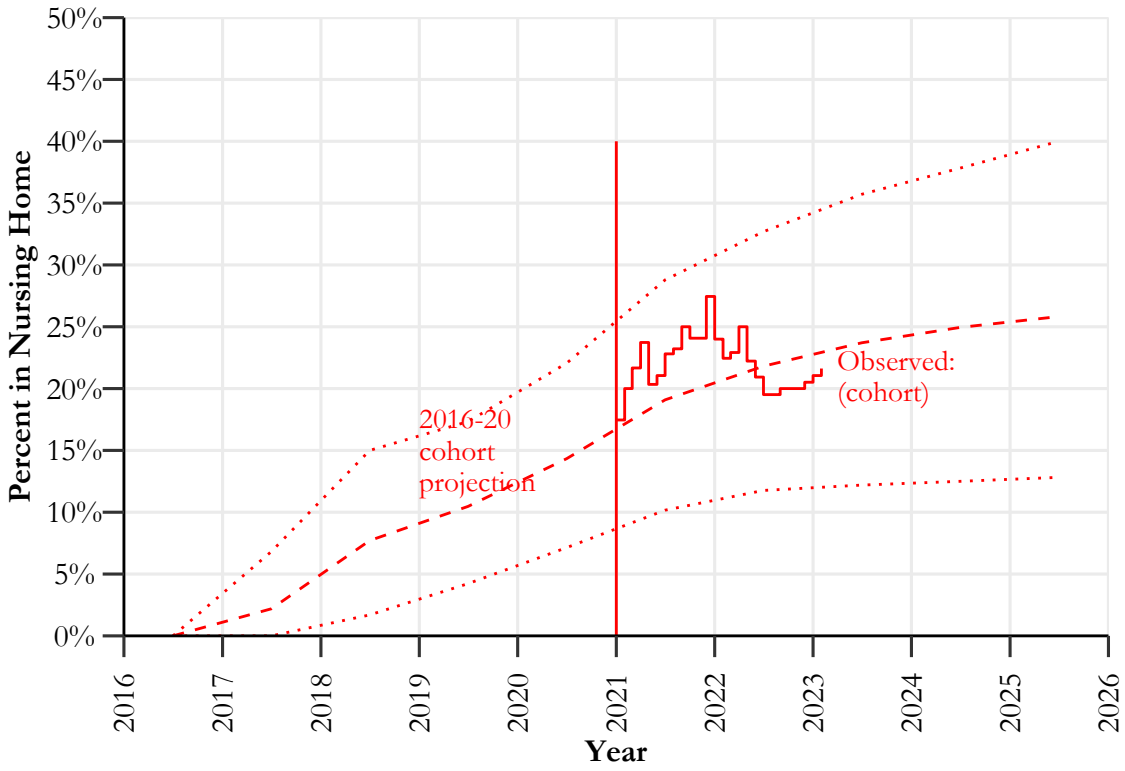
Figure 12: Average (no varying effects) transition probabilities for a low-acuity person starting on the waiver



looking purely at the percentage of nursing home eligibility months out of the total, over time.

The model results for this particular cohort are shown in Figure 13, and the modeled estimates (dashed lines, with 90% uncertainty region shown with the dotted lines) are consistent with the actual observed post-PACE experience (solid line).

Figure 13: Modeled estimate of nursing home percent for 2016-20 cohort

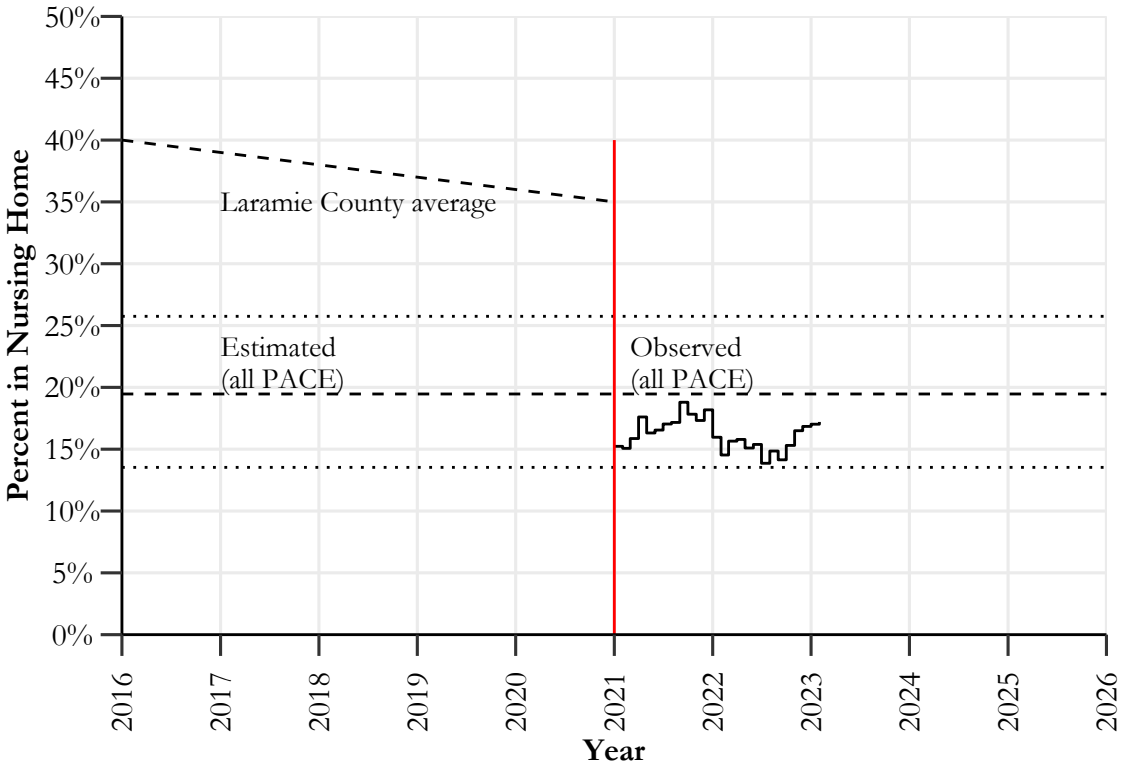


Because the PACE rate is intended to incorporate all future long-term care risk, we re-sample this cohort to the steady-state size of the PACE program (140 people) and then average over all predicted percent nursing home states for all predicted trajectories.

These results are shown in Figure 14, which compares the modeled estimate (20% expected average nursing home, with uncertainty between 14% and 26%) with the actual experience (solid line) that we observed post-PACE.

Because this modeled estimate is a little less than half that of the underlying rate assumption (i.e., the Laramie County average nursing home percent, which declined from 40% to 35% between 2016 and 2020), it's clear that a cost-effective PACE rate would have been significantly lower than what was actually paid.

Figure 14: Modeled estimate of nursing home percent for entire PACE program



Section 8: Responses from PACE stakeholders

Prior to publication, the Department sent out a draft version of this report to various interested parties for feedback.

We received many helpful suggestions that were incorporated into this version. However, recognizing that the findings in this report are not without controversy, we also offered to include any formal comment letters.

We received one letter, from the National PACE Association. Please find it attached.

October 20, 2023

Mr. Franz Fuchs
Wyoming Department of Health
401 Hathaway Building
Cheynne, WY 82002

Dear Mr. Fuchs,

Thank you for the opportunity to review the draft report "Aging in Wyoming Part III: Reviewing the Program of All-Inclusive Care for the Elderly and Alternatives." The National PACE Association (NPA) is a national organization representing all 155 PACE organizations (POs) in 32 states and the District of Columbia. We also represented PACE Wyoming when it was an operating PACE organization.

POs serve among the most vulnerable of Medicare and Medicaid populations– medically complex older adults over age 55 who are state certified as requiring a nursing home level of care. The objective of PACE is to safely maintain the independence of older adults and people with disabilities in their homes and communities for as long as possible. PACE is a capitated care model that assumes full financial risk and receives a monthly per person payment to deliver all necessary medical, biopsychosocial and long-term care for enrolled frail elders. PACE payments are predictable and do not change based on service use.

NPA appreciates that the state of Wyoming wanted to reexamine what would be required to restart PACE in terms of the monthly capitation rate and if there are possible providers that would be interested in operating PACE. While this report takes a comprehensive look at PACE in Wyoming, there are several areas of the report that NPA does not agree with or has questions. Below are general comments about the overall report as well as specific comments regarding various sections within the report. NPA would be happy to discuss these points in more detail if that would be useful.

General comments
We value and appreciate the time and effort associated with drafting this important report, especially in light of legislative consideration of re-establishing PACE as service option for frail older adults in need of long-term services and supports. As such, NPA strongly recommends that areas of the report containing opinions, general statements and recommendations be either substantiated by research, facts or data, or entirely removed. We are concerned that many of the inferences or observations leading to the recommendation to not "'re-start" PACE are either inaccurate, in conflict with federal and state requirements, or lack factual merit.

NPA has a comprehensive bibliography of research on PACE services, outcomes, and participants we are willing to share as a resource to assist the state in obtaining facts and details for various sections within the report. Without substantiation, we are concerned that

many statements in the report will understandably and unfortunately likely lead to an erroneous conclusion to not re-establish PACE in the state of Wyoming.

Specific Section Comments

Section 2.5 – PACE revenue comes through fixed premiums – In this section, the report includes the following language: "While their services are community-based, PACE programs are therefore (in theory) also liable for the cost of institutional care, ranging from assisted living facility (ALF) services, to skilled nursing facility (SNF), memory care, and even lock-down units." NPA objects to the wording "in theory" because POs *are* responsible for providing and paying for institutional placement should a PACE participant need that level of care. In fact, when PACE Wyoming closed in 2021, they reported having nine participants living in a SNF for which they made contractual payments, as required under federal statue and regulation. An individual not fully aware of the PACE model may read "in theory" and get the impression that POs do not actually provide this level of care.

This section includes the first of many references to "cherry picking" and "dumping." NPA strongly objects to this language anywhere in the document. Later in the report, cherry picking is defined as "…when plans selectively recruit members by designing their benefit plan to attract healthy people and repel the sick." Under federal law, POs **cannot** "cherry pick." Federal statute mandates that to enroll in PACE an individual must:

- Be 55 years of age or older;
- Be determined by the State Administering Agency to need the level of care required under the State Medicaid plan for coverage of nursing facility services;
- Reside in the PACE organization's service area;
- Be able to live in a community setting at the time of enrollment without jeopardizing his/her health or safety based on criteria set forth in the program agreement; and
- Meet any additional program-specific eligibility conditions imposed under its respective PACE Program Agreement.[1]

If for some reason, an enrollment is denied because of his or her health or safety would be jeopardized by living in a community setting, the PO is required to complete the following steps:

- Notify the individual in writing of the reason for enrollment denial and their appeal rights;
- Refer the individual to alternative services as appropriate;
- Maintain supporting documentation of the reasons for denial; and
- Notify the Centers for Medicare and Medicaid Services (CMS) and the State Administering Agency and make the documentation available for review. [2]

Therefore, suggesting that a PO is "cherry picking" is misleading and stands in contrast to state and federal requirements. If for some reason, a PO improperly denies enrollment, there are steps an individual can take to appeal that decision. If an individual does appeal the decision, CMS and the state can review the decision and information and either uphold or reverse the enrollment decision.

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[1] 42 CFR 460.150

[2] 42 CFR 460.122

The report defines "dumping" as "where organizations try to off-load high-cost clients on other organizations. The classic example here is a nursing home discharging a patient to a hospital and refusing to take them back." Like enrollment of a PACE participant, there are strict requirements about when a PO can involuntarily disenroll someone, which include:

- Failure to pay – A participant who fails to pay, or make satisfactory arrangements to pay any premiums due, to the PO after a 30-day grace period;
- Disruptive or threatening behavior;
- Relocation outside of the PACE service area;
- Non-renewal or termination of the Program Agreement – The PO's program agreement with CMS and the State Administering Agency is not renewed or terminated;
- Inability to provide services – The PO is unable to offer health care services due to the loss of state licenses or contracts with outside providers;
- Ineligibility – It is determined that the participant no longer meets the state Medicaid nursing facility level of care requirements and is not deemed eligible, the participant may be disenrolled.[3]

Before an involuntary disenrollment is effective, the State Administering Agency must review it and determine in a timely manner that the PO has adequately documented acceptable grounds for disenrollment.

Given these federal requirements, we urge the report to either remove any mention of cherry picking and dumping and/or include these requirements; or, as an alternative offer facts and data to support such an allegation. It seems significantly important that the report clarify this erroneous discussion so readers understand the process a PO must go through if they deny enrollment or proceed with an involuntary disenrollment.

Section 2.6.4 – PACE premiums provide predictable revenue – NPA does not object to this language, but we think it is worth noting that predictable rates are also helpful to the state. Knowing how much money will be spent on each participant allows the state to properly budget for costs associated with care for these individuals.

Section 2.7.1 – Members have less choice in providers – It is true that POs have an established "network" of providers that most participants interact with. However, if a participant has a long-standing relationship with a provider and they want to keep that continuity of care, POs have the option of working and contracting with that provider.

This section also notes that home visits and transportation can operate on a reduced schedule or limit services, particularly during inclement weather. NPA believes it would be helpful to clarify that each participant has a specific and detailed care plan. In that care plan, the interdisciplinary team – a crucial component of the PACE model – assesses the various needs of each participant. If for some reason that care plan does not meet the participant's needs, the participant or his/her designated representative may make a service delivery request, which could initiate, eliminate, or continue a particular service.[4]

[3] 42 CFR 460.164
[4] 42 CFR 460.104(d)(2)

Section 3.6.1 – PACE administrative overhead was disproportionately high for the state – The report notes Wyoming Medicaid had to employ two full-time equivalent (FTE) employees to manage the PACE program. This seems to imply that these two individuals *only* worked on PACE. However, the report also notes that those individuals also worked for the larger Community Choice waiver program. It would be helpful for the report to clarify how much of their time was spent on PACE. Administering and overseeing PACE does require time and effort. However, when NPA checked with various states, it was reported that the number of staff ranged from less than one FTE (in smaller PACE states) to 5 FTEs (in larger PACE states). Having two FTEs working solely on PACE in a state with one PO seems disproportionate.

Section 3.6.2 – Administration was also heavy for the PACE provider – NPA agrees that operating a PO requires significant work and commitment. However, NPA takes issue with referring to this work as a "burden" as noted in the fourth paragraph. NPA has not heard any PO call this level of commitment a "burden." Given the lack of background, data or facts to substantiate this claim we would recommend it be removed from the report.

Section 3.6.4 – The state did investigate and substantiate some complaints – Generally speaking, PACE is effective and efficient in treating individuals with multiple and complex health care needs. However, there are times when issues and deficiencies in care occur. NPA believes it is important for strong oversight of the state and CMS to ensure that these instances are rare and when they occur a corrective action plan is put in place.

Section 4.1 – A cost-effective PACE rate depends on where PACE members would have been served without PACE – As noted in the report, PACE rates must be less than the state would have to pay for those individuals if they were not enrolled in PACE. That estimate – as well as the PACE rate – is determined by the state and the state's actuarial firm. As states develop these rates there are often assumptions that need to be made. In addition, states and actuarial firms should take a longitudinal view of costs as the care a participant will evolve and change over time.

Knowing that states are often curious about the cost and value of PACE, NPA often conducts research to better understand these comparisons. Most recently, NPA worked with IBM Consulting to compare calendar year (CY) PACE 2019 PACE Medicaid capitation rates to the CY 2019 Medicaid per-member per-month (PMPM) costs of a nursing facility (NF) level of care (LOC) population defined as those (1) enrolled in other (non-PACE) state Medicaid programs requiring NF LOC; or (2) who had at least 90 Medicaid-covered days in a NF during the year. The study was broken down into three groups: (1) Mostly HCBS – more than 50% of beneficiaries in the NF LOC population were enrolled in Medicaid HCBS programs; (2) Mostly NF – more than 50% of beneficiaries in the NF LOC population had at least 90 Medicaid-covered days in a NF; and (3) All NF – more than 95% of beneficiaries in the NF LOC population had at least 90 Medicaid-covered days in a NF. Wyoming was included in the study since it had an operating PO in 2019 and Wyoming was in Group 1 (mostly HCBS). The analysis found that for the full benefit dual eligibles, Wyoming PMPM for HCBS beneficiaries exceeded the PACE capitation rates by about 30%. Were additional costs for beneficiaries residing in Medicaid funded NFs included the costs savings to the state from PACE would increase. Further, the PMPM exceeded the PACE capitation rate by more than 50% for the

Medicaid-only PMPM costs.[5] The IBM analysis supports the concept that PACE capitation rate is less than what the state would otherwise pay.

4.3 Remaining problem: is PACE for life – or not? – The report accurately states that an individual can voluntarily disenroll from PACE at any time. However, NPA objects to implication that POs are "persuading" people to drop out of PACE. There are instances of individuals who voluntarily disenroll from PACE when they are permanently moved to a nursing facility. However, NPA is unaware that it is occurring because of some sort of persuasion effort. Instead disenrollments often occur due to a preference in the nursing home that they'll need to reside in or to be closer to certain family members. Recognizing that the inferences in this section are not linked to facts, data or research we would recommend this section be removed.

5.1 Very few providers in Wyoming would be capable of bringing PACE back, regardless of the rate paid – NPA acknowledges that opening and operating a PACE organization takes substantial effort and commitment. The authors of this report know the current provider landscape in Wyoming better than NPA. Therefore, we trust that the providers listed in the report are the most viable options currently in the state. However, there are other potential providers across this country that are very interested and invested in operating PACE. If none of the current providers have the bandwidth to operate PACE, the state should be willing to look beyond Wyoming. Like other areas of the report including inferences not supported by facts, research or data will likely only service to mislead the reader if the report. We suggest this section be removed from the report.

5.1.3 Post-COVID staffing shortages make things more difficult now and 5.1.4 "All-inclusive" services require a robust provider network – The points raised in 5.1.3 and 5.1.4 are valid and real concerns. The report tacitly acknowledges this, but it would be helpful if the report is very clear that these are valid and real concerns for all different types of health care providers and not just limited to the PACE model of care.

5.2 No capable providers have expressed interest – As previously noted there are several providers that are very interested in exploring PACE in unserved areas and unserved states. However, it is not surprising that these providers have not reached out to Wyoming, since the state closed its one PO just a couple of years ago. As the report highlights, operating PACE is a commitment and requires significant upfront costs. A potential provider is not going to invest those types of resources without a clear commitment from the state, which currently does not exist in Wyoming. If the state of Wyoming becomes serious about bringing PACE back to the state, NPA suspects there would be potential providers that would express interest and would be willing to work with the state to make it happen. Should the state be interested in engaging with interested providers NPA could identify and facilitate such engagement.

6.2 The State should not attempt to restart PACE – NPA is very disappointed in this decision and strongly urges the state to reconsider this recommendation.

[5] "PACE Medicaid Cost Comparison Study: Methodology and Findings – Wyoming"

6.3 Instead, it should consider three alternative options – Below are our specific concerns and questions about these options. However, in general, the report seems to go to great lengths to not recommend PACE – a proven model of care that provides high quality care – and instead pursue untested options and models of care that may or may not save the state money or provide better care to this vulnerable population.

6.3.1 Mild: Increase select home-and community-based service rates – The report clearly states that the PACE rate should be lower. However, this recommendation urges a higher home and community-based rate to help ensure that adult day care and non-emergency medical transportation (two important components of the PACE model) are properly utilized. When discussing the adult day care option, the report specifically notes that staffing, capital requirements, and rates are primary barriers to this option and that higher rates could help offset those concerns. However, throughout the report, those are some of the same concerns, barriers, and reason not to bring back PACE. It is unclear to NPA why this would be a better alternative to PACE.

6.3.1 Medium: Implement bundled "PACE light" services – The report notes that this option would allow for bundling core PACE services, but "avoid the 'all-inclusive' PACE risk of open-ended long-term care, pharmacy, specialist, inpatient, and other costs." There could be some type of benefit to bundling these services, but the costly services that would not be included do not go away. Individuals in Wyoming will still need long-term care, hospitalization, etc… and the state will have to pay for those services for individual who rely on Medicaid. Instead of pursuing PACE, which leads to a predictable all-inclusive capitation rate, the state will have unpredictable costs.

6.3.2 Spicy: Study establishment of state-operated Medicare Advantage plan – NPA feels that this is a complicated and risky option. It is also unclear if this arrangement would be viable, cost-effective, or provide better care than PACE. As the state considers this option, they should be aware that the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning found that PACE participants, when compared to Medicare Advantage enrollees were "significantly less likely to be hospitalized, to visit the ED, or be institutionalized[.]"[6] It is unclear why the state would want to embark on this endeavor just to avoid restarting PACE in the state.

Final Comments – NPA recognizes that this comment letter primarily focuses on questions and concerns regarding this report. We are disappointed with some of the findings in the report and the overall recommendation to not restart PACE. However, NPA does want to acknowledge that the report does try to present the advantages as well as the disadvantages of the PACE model of care. We hope that the state will reconsider the decision not to move forward with PACE either now or sometime in the future. If and when the state does reconsider its decision, NPA hopes that the state will see the association as a trusted resource to ensure that the next PO is truly successful in ensuring the state saves money while providing the best care possible to this vulnerable population.

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[6] U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Office of Behavioral Health, Disability, and Aging Policy. "Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care: Final Report." September 2021.

NPA welcomes the opportunity to continue dialogue with the state of Wyoming and offers any additional resources that could be useful if the state reconsiders its decision to restart PACE. Please feel free to reach out to me at ShawnB@npaonline.org or Liz Parry, Senior Director, State Policy at LizP@npaonline.org.

Sincerely,

Shawn Bloom
President and CEO
National PACE Association