

2016 PACE Medicaid Rate Setting Guide

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PACE Programs

Peter Hansel	CalPACE
Eileen Kunz	On Lok, San Francisco
Laura Wagner	East Boston Elder Service Plan
Cindy Noordijk	Providence ElderPlace Portland
Kathy McGuire	Rochester General Health System
Bruce Kinosian	NewCourtland LIFE

Actuaries/Consultants

Maria Dominiak	Airam Actuarial Consulting, LLC
Gabe Smith	Mercer Government Human Services Consulting
Susan Maerki	Price Waterhouse Coopers, LLP
Steve Hanson	Milliman
John Meerschaert	Milliman
Cabe Chadwick	Lewis-Ellis, Inc.
Debby McNamara	Health Management Associates
Barry Jordan	Optumas
Chris Dickerson	Optumas

State Agency Staff

Bhanu Molabanti	Virginia Department of Medical Assistance Services
Wendy Boggs	Virginia Department of Medical Assistance Services
Gayle Lee	Ohio Department of Aging
Lawrence Tam	Colorado Department of Health Care Policy and Financing
Oswaldo Bernal-Flores	Colorado Department of Health Care Policy and Financing

A. Purpose and Context

The purpose of this guide is to inform state Medicaid policy-makers, program officials and actuaries about key issues and considerations in setting rates for Programs of All-Inclusive Care for the Elderly (PACE). Its premise is that appropriate rate setting for PACE results in rates that are cost-effective and sustainable for both the state and the PACE program. The guide updates two earlier guides (1999 and 2009) to address changes related to a number of factors:

- 1. Acceleration of Medicaid Managed Long-Term Services and Supports:** Nearly half of all states now operate managed long-term services and supports (MLTSS) programs – three times the number in 2009. This shift directly affects the comparable population that is used to set the upper payment limit (UPL), which Medicaid PACE rates cannot exceed.
- 2. Rebalancing of Institutional and Home and Community-Based Services:** The trend toward greater use of home and community-based services (HCBS) to meet people’s LTSS needs is changing the underlying cost basis for state Medicaid programs that is used to set UPLs and PACE rates.
- 3. Increasing Interest in Data Reporting:** As states begin to tie payment to encounters and quality measures, there is more interest in the ability of PACE organizations to generate data for rate setting.
- 4. Recent Changes in Federal Guidance to States Regarding Rate Setting:** The Centers for Medicare & Medicaid Services (CMS) issued guidance in 2015 on how states set PACE rates that have raised the standard for the timeliness of data used and frequency of rate updates. In addition, though not directly applicable to PACE, recent federal rules for Medicaid managed care programs have led to greater scrutiny of the data, assumptions and methods used to develop capitation rates.

This guide examines these issues and the impact they are having or can be expected to have on how states set PACE capitation rates. As with previous guides, its contents are based on discussions at a workshop sponsored by NPA. Representatives of PACE organizations, state Medicaid agencies, and actuarial firms that contract with states to develop Medicaid rates for PACE programs participated in the workshop on April 6, 2016 (see Acknowledgements).

The guide has three sections and an appendix:

- Section B describes recent policy changes and reforms in the financing and delivery of LTSS and explains their implications for Medicaid rate setting in PACE programs.
- Section C explains federal rules related to state Medicaid rate setting for PACE programs.
- Section D presents three basic approaches used by states to set the capitation rates for PACE. It includes guidance to state Medicaid officials and actuaries on key issues to consider when setting the UPL and PACE capitation rates in each model.

The appendix provides greater detail and discussion of 10 common issues that are important to setting the UPL and/or PACE capitation rates and considerations specific to each of the three models.

B. Recent Policy Changes and Trends: Challenges for Medicaid PACE Rate Setting

Since the passage of the Affordable Care Act of 2010 (ACA), the nation has witnessed enormous changes in the health care system. Important reforms in the financing and delivery of MLTSS also have swept across the country, driven by federal and state policy decisions. Many of these changes and trends have important implications or create significant challenges for Medicaid PACE capitation rate setting.

1. Expansion of MLTSS Erodes Fee-for-Service Basis for UPL

The number of states switching from fee-for-service (FFS) systems for delivering MLTSS to managed care arrangements is increasing. In 2004 eight states (Arizona, Florida, Massachusetts, Michigan, Minnesota, New York, Texas and Wisconsin) had MLTSS programs operating in all or selected regions. By 2014 nearly two dozen states operated MLTSS programs, and many more were planning to make the change. In FY 2013 managed care accounted for about 10 percent, or approximately \$14.5 billion, of total Medicaid LTSS spending – nearly three times the total of \$5 billion in FY 2009, although both are conservative estimates due to challenges in reporting MLTSS spending (Eiken et al., 2014; Kasten et al., 2011).

In states where MLTSS programs are the dominant delivery model for serving older adults and people with disabilities, FFS data quickly diminish. States require MCOs to report encounter data, which are records of individual services provided to enrollees. While similar to FFS claims data, encounter data do not include a Medicaid paid amount since the MCOs pay providers directly, making it difficult for states to track actual costs (Byrd, Nysenbaum

& Lipson, 2013). While states and MCOs are improving the accuracy of encounter data, in many cases it remains incomplete. Both the decline in FFS data and incomplete encounter data from MLTSS plans complicate the task of estimating the UPL for PACE programs.

2. Growth of Medicare-Medicaid Integrated Care Plans

Accompanying the growth of MLTSS has been the expansion of Medicare-Medicaid integrated care programs. In 2005 programs in a handful of states enrolled approximately 18,000 people. The ACA ushered in a new generation of programs that, like PACE, combine Medicare and Medicaid benefits and payment to deliver a comprehensive and coordinated service package. In 2014 nine states (California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Minnesota and Texas) participated in the CMS Financial Alignment Initiative, known as the duals demonstration, enrolling nearly 400,000 people. Colorado, Virginia and Washington began duals demonstration programs in 2015; and Rhode Island began in 2016.

Since the duals demonstration combines Medicare and Medicaid benefits, state Medicaid officials view the programs as similar to PACE and may be inclined to use the same rate-setting approaches and capitation rates. However, there are important differences between PACE and integrated care plans, such as enrollee characteristics, scope of benefits covered, plan size, and financial risk when the health status of enrollees or their need for institutional care changes. The growth of MLTSS and Medicare-Medicaid integrated plans heightens the need to make appropriate risk adjustments to all capitation rates, including those for PACE. However, national risk adjustment models for LTSS do not exist, and only New York and Wisconsin have developed models on the state level. Developing risk adjustment models for LTSS is challenging for states that do not collect uniform, comparable data on functional and cognitive status – the main drivers of LTSS costs – for all programs and integrated care plans covering LTSS.

3. MLTSS System Rebalancing Effects on PACE UPL

Over the past two decades Medicaid LTSS policies and programs have led to a pronounced increase in the use of HCBS and a decrease in the use of nursing facility and other institutional care. The 1999 *Olmstead v. L.C.* ruling granted everyone the right to live in the “most integrated setting” in the community, and programs like the Money Follows the Person demonstration have helped more than 60,000 people who once lived in institutions to move back to the community. Many states have expanded section 1915 (c) HCBS waiver programs and increased the availability of and access to state Medicaid plan HCBS, such as personal care assistance and participant-directed programs. Many states also have added new state plan options authorized by the ACA, such as section 1915(i) HCBS, which removes the requirement that HCBS programs require beneficiaries to meet institutional level of care criteria, as required by traditional HCBS waiver programs, and section 1915(k) Community

First Choice, which covers HCBS attendant services and supports through models that emphasize beneficiary control over the services they receive.

As more people using LTSS are served in home and community settings, the mix of HCBS and institutional care spending in total Medicaid LTSS expenditures has changed. In 2005 HCBS spending was about a third of total Medicaid LTSS spending and somewhat less (about 26 percent) for individuals age 65 and over and those under 65 with physical disabilities. In 2013 the latest year for which data are available, HCBS spending comprised 51 percent of total Medicaid LTSS expenditures and 40 percent for older adults and people under age 65 with physical disabilities (Eiken et al., 2015).

As the balance of spending and services has shifted to HCBS, historical assumptions about the UPL for PACE rates have changed as well. When PACE first was authorized by federal legislation in 1997, the prevailing assumption was that all or most PACE participants would be in long-term institutional care. As a result, the UPL, the amount that Medicaid would have otherwise paid for a comparable group of individuals not enrolled in PACE, largely was tied to the cost of nursing home care. As the mix of total Medicaid LTSS comprised by institutional care drops, the UPL declines as well, driving down Medicaid PACE rates. Moreover, if states experience rapid shifts in the mix of HCBS to institutional care, the UPL and corresponding PACE capitation rates quickly become outdated.

These changes underscore the importance of making sure the population used to determine the UPL is adjusted to assure its comparability to the population served by PACE.

4. Mounting Demand for Encounter Data

Medicare and, to an increasing extent, Medicaid agencies require PACE programs to submit encounter data in order to track service utilization, monitor quality of care, and set capitation rates. Since 2012, Medicare has required PACE programs to report encounter data for Medicare-covered services for which they have claims. This generally translates for most PACE programs into submitting hospital and medical specialist claims. Currently, there are no requirements for encounter reporting for internal services provided directly by the PACE organization to its participants. In 2016 CMS reiterated its expectations for PACE programs to submit Medicare encounter data and its intention to use the diagnosis codes from encounter data to calculate risk scores (CMS, 2016). In 2017¹ CMS will continue to calculate PACE enrollee risk scores as it did in 2016, pooling diagnoses from three sources to calculate a single risk score with no weighting.²

¹ CMS, Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Section K, p. 62.

² CMS, Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter. Section M, p. 47.

On the Medicaid side, only two states – New York and Wisconsin – have required PACE programs to submit encounter data to their Medicaid programs. Other states, including California and New Jersey, are planning to require PACE programs to submit encounter data soon. Recently issued federal regulations for state Medicaid managed care programs will push more states to do so as well, as the reporting of accurate, complete and timely encounter data reporting by a state will be a condition for receiving federal matching payments.

PACE program managers acknowledge the importance of encounter data and note that without accurate and complete encounter data, their actual services and costs may be underreported. However, encounter data reporting involves several challenges. PACE programs are required to invest in, or reprogram, electronic health record systems, which can be very expensive. Programs in New York have hired new staff for this purpose, which has increased their administrative costs. In addition, for benefits covered by both Medicare and Medicaid, such as home health services and durable medical equipment, PACE programs must distinguish between the two in encounter data reports. The need to track services separately distracts staff from spending time providing direct services and supports to enrollees and undermines an advantage of the PACE program: its flexibility to blend the two funding streams to meet the needs of each enrollee.

Capturing encounters for services provided in PACE centers also can be difficult. Unlike most encounters reported by insurer-sponsored MCOs, which can be tracked through paid claims submitted for payment to the MCO by network providers, just a subset of PACE services is delivered by providers that submit claims to the PACE program. In fact, most services are delivered in the PACE center, by PACE staff, and therefore do not generate claims. This includes interdisciplinary team (IDT) meetings, which involve numerous PACE staff, and the many “touches” that occur throughout the day by dietitians, nurses, aides and social workers. Some PACE services (e.g., personal care, socialization, monitoring and supervision) lack national procedure codes since they are non-medical in nature, so they cannot be included in common encounter data record formats. Multiple staff may be involved in providing services, and multiple participants may receive group services simultaneously, which make them hard to divide into separate encounters. Encounter data also may mask the intensity of a nursing encounter. For example, a nurse administering an oral medication takes less effort than administering intravenous medication. Some PACE programs report that multiple encounters in the same day have been rejected because this is not allowed under Medicare or Medicaid rules, even though this is not unusual in the PACE program. Moreover, some PACE services, such as chaplain care, are not covered by Medicare unless provided in a hospice center.

5. Focus on Value-Based Purchasing

The ACA spurred several reforms designed to improve the value of health care, providing better quality for the same or lower cost. As a result, Medicare and Medicaid agencies are tying payment to quality outcomes and holding health plans and providers accountable for quality and cost. For example, by 2018 CMS aims to link 90 percent of FFS Medicare payments to quality or value through efforts like the Hospital Value-Based Purchasing and Readmissions Reduction Programs. CMS also is seeking to increase the use of alternative payment models, such as shared savings with accountable care organizations (ACOs) and bundled episode payments. In 2016 nine state Medicaid agencies contracted with ACOs, and eight more were developing such purchasing strategies. More states are requiring Medicaid MCOs to contract with ACOs. For instance, MCOs in Iowa must have at least 40 percent of members served through value-based contracts with provider organizations by 2018.

This trend is beginning to appear in state PACE programs as well, creating both opportunities and challenges. For example, in 2014 Oregon began a value-based purchasing initiative for its PACE programs modeled on a similar value-based purchasing model used for Coordinated Care Organizations in the state. Now in its third year of operation, the state and PACE programs select five quality measures and targets, such as emergency department visit rates, hospital readmissions and pressure ulcers. PACE programs submit quarterly reports on their performance. Programs that achieve at least three of the targets can earn an extra \$50 per member per month (PMPM), \$75 PMPM for meeting four of the targets, and \$100 PMPM for meeting all five. The bonus payments help to increase revenue above the state-established capitation rate, which currently is set at 93 percent of UPL. For example, a program with 1,200 enrollees can receive up to \$1.4 million each year.

New York also began a quality incentive program for PACE programs in 2014. The state established a quality funding pool, which was funded by withholding 2 percent of the PACE capitation rate. PACE programs can earn back the withheld amount by meeting quality and performance targets. While the state has not yet decided on all of the quality measures to be used, it began with enrollee satisfaction based on a state-administered survey. The state also is considering tying payments to maintenance or improvement in functional status. PACE programs can receive funds from the pool if they meet standards (data validation) for timely and accurate encounter reporting (75 percent of financial data must match 75 percent of encounter data costs).

6. CMS PACE Medicaid Capitation Rate Setting Guide, 2015

In December 2015 CMS issued guidance to states to inform the development of PACE capitation rates and clarify CMS expectations in deciding whether to approve the rates. The guidance did not stem from any changes in federal law or regulations, nor did it require

material changes in the methods used to set PACE rates. However, it signaled to states and PACE organizations that CMS would apply greater scrutiny to the data, assumptions and methods used to set PACE rates. As a result, most states and their actuaries will need to provide more information describing the data and methods used to establish PACE rates. In addition, while actuarial certification of PACE rates is not required, the 2015 CMS guidance encourages states to obtain actuarial review and certification of PACE rates in accordance with Actuarial Standards of Practice.

The 2015 CMS guidance also clarified that the prospective per person monthly amount that otherwise would have been paid (the UPL) if not enrolled in PACE for the applicable rate period should be calculated for a period of no longer than 12 months, and the UPL should be “rebased” annually or at least every three years. Likewise, the PACE capitation rate must be effective for at least a year, but no more than three years. Some states have not updated their UPL or PACE capitation rates in the past three years. For example, as of 2014, the UPLs in effect in 24 states were more than six years old (6.2) on average, and the PACE rates in effect were almost four years old (3.8). States will need to devote time and resources to these tasks. Given the rapid changes in the financing and delivery of Medicaid LTSS that are shifting care for the population to which PACE is compared toward home and community-based settings, more frequent updating of the UPL and PACE capitation rates will reflect this trend. Because the UPL represents a higher percentage of HCBS relative to institutional care, the UPL may decline since HCBS generally costs less than institutional care and the PACE capitation rate decreases proportionally. Such declines may be offset by rate adjustments that take into account inflation, so the absolute UPL and PACE rates can at least keep up with general price increases if rates are updated more frequently.

C. Federal Rules Related to State Medicaid Rate Setting for PACE

Federal rules stipulate the use of two separate but related components when setting PACE rates. States must establish the UPL, which is the amount that Medicaid would have otherwise paid for a comparable group of individuals who are not enrolled in a PACE program (42 CFR 460.182). In addition, they must establish a PMPM payment – the capitation rate – for PACE programs, which must be less than the UPL. The monthly capitation rates must take into account the frailty of the PACE participants, and the rates cannot be changed over the course of the contract period, even if a participant’s health status changes. PACE capitation rates can be renegotiated on an annual basis. States have considerable flexibility within these guidelines to define the UPL and may use various data sources, methods and assumptions in developing capitation rates that are no more than the UPL.

D. PACE Medicaid Rate Setting: Key Issues and Considerations for States

This section discusses PACE capitation rates within three models that are most commonly used by states. It is designed to inform decisions by state Medicaid officials and their actuaries regarding the most appropriate methods for setting accurate UPLs and cost-effective PACE rates in each model. It reviews federal requirements applicable to all models, and lists 10 issues that are common to all models (see Table 1). Then, it briefly discusses issues that are particularly important or relevant to each model. For states currently using one model, but considering changing to another one due to a conversion from FFS to MLTSS or other reasons, the Appendix contains a detailed discussion of all 10 issues and the way in which they factor into each model.

State PACE Rate-Setting Models

Workshop participants discussed three basic models to setting Medicaid capitation rates for PACE programs:

1. UPL-based, which sets the monthly PACE capitation rate as a percentage of the UPL;
2. PACE experience-based, which sets the monthly PACE capitation rate based on the actual cost of care provided to PACE participants in previous rate periods, trended forward to the current rate period;
3. MLTSS experience-based, which sets the PACE capitation rate based on actual or expected costs of services provided through managed care plans.³

While the models have similarities, they generally differ in how they define the comparable population for purposes of establishing the UPL; whether the PACE capitation rate is tied to the UPL, as in the first model, or developed independently of the UPL, as in the second and third models; and the extent to which rates are adjusted to account for differences among PACE participant characteristics (including frailty), PACE program benefits and administrative costs, and other factors affecting PACE program costs, relative to the comparable population. The specific methods or adjustments within the models may vary.

States often decide to use a particular model based on their circumstances, such as the delivery systems through which Medicaid LTSS are provided, including FFS, managed care or a combination; the availability, completeness, reliability and timeliness of cost, quality and other data to develop and adjust the rates; and the time and resources available to execute the model, as some require more effort than others.

³ The term “model” does not connote endorsement; neither NPA, nor the workshop participants, regard any one model as better or preferable to the others.

Table 1. Issues and Considerations by Model

Issues	Considerations	Model 1 UPL-Based	Model 2 PACE Experience- Based	Model 3 MLTSS Experience- Based
DATA				
1. Availability and quality of data source(s)	Accuracy, completeness and most recent year of FFS claims, PACE cost reports, MLTSS encounter records, enrollee assessments or other data	Typically relies on FFS claims data for utilization and costs; adjustments needed to reflect services unique to PACE	Include N/A in the blank boxes or something to indicate they are intentionally left blank	MLTSS encounter data often less accurate, complete and timely than FFS claims data
2. PACE administration and capital cost data	How administrative costs unique to PACE programs are factored into capitation rates	Adjustments for PACE administrative costs		Adjustments for PACE administrative costs
3. Reporting burden to PACE programs and state Medicaid agencies	Time and effort required to collect, validate, and audit encounter data, cost reports and other data; need for new or updates to electronic health record systems	Large burden on PACE programs if encounter data are required; little burden if PACE programs submit only cost reports	Value of PACE encounter data to rate setting relative to reporting burden to PACE programs and validation/auditing burden to states	
UPPER PAYMENT LIMITS				
4. Identifying the comparison population to establish the UPL	Narrow to Medicaid LTSS beneficiaries who are like PACE eligibles or enrollees on all observable characteristics	Calculating UPL based on costs incurred in FFS and/or MLTSS for populations with same characteristics as PACE enrollees, e.g., age, gender, health, frailty, level of need for LTSS, covered benefits, risk of admission to institutions		
5. Weighting of HCBS: Institutional costs in the UPL	Historical (retrospective) trends in LTSS system rebalancing and speed of rebalancing in comparable populations	Weight according to PACE experience or state FFS and/or MLTSS average for comparable groups? State average or ratio in each PACE program region?		

Issues	Considerations	Model 1 UPL-Based	Model 2 PACE Experience- Based	Model 3 MLTSS Experience- Based
RATE SETTING				
6. Risk adjustment for differences in demographic, health, functional status, other characteristics	Extent to which the PACE capitation rate-setting method accounts for differences in enrollees of each PACE program, relative to index		Risk adjustment across PACE programs relative to state average (“dividing the pie”)	Risk adjusting PACE rates to account for differences between characteristics of PACE and MLTSS enrollees
7. Frequency of updates	How often to update and rebase rates based on time and resources required, and speed and extent of changes affecting the UPL and PACE capitation rates	Relevant to all models		
8. Compliance with CMS rules and guidance	Extent to which model meets expectations of CMS for up-to-date, complete and reliable data, assumptions and methods used to set PACE rates and rates updated and rebased annually or at least every three years; actuarial review and certification of PACE rates is encouraged but not required	Relevant to all models		

Issues	Considerations	Model 1 UPL-Based	Model 2 PACE Experience- Based	Model 3 MLTSS Experience- Based
PAYMENT INCENTIVES				
9. HCBS incentives	Extent to which the rate structure promotes greater use of HCBS over rate period (prospective)	HCBS-nursing facility blend assumed in UPL establishes target for HCBS; sites have incentive to exceed HCBS target	In addition to setting the share of enrollees expected to use HCBS, this method should account for greater intensity (more HCBS per user) among PACE enrollees	PACE may have stronger incentives to promote HCBS than MLTSS plans since their rates are fixed for the year regardless of changes in participant health status (42 CFR 460.182)
10. Quality incentives	Withholds or bonuses for meeting quality targets; choosing quality measures that are appropriate and feasible for PACE programs	Potential to earn back a portion of the UPL discount for meeting quality targets	Potential to earn back a portion of capitation withholds or qualify for bonuses for meeting quality targets	

Model 1: UPL-Based (Discount Taken Off UPL)

In this model the UPL usually is established by calculating the total cost of all Medicaid services delivered by PACE programs, whether paid on an FFS basis or via MLTSS capitation rates, to a population comparable to PACE enrollees and setting the monthly PACE capitation rate as a percentage of the corresponding UPL. Historically, the percentage discount has ranged from 80 percent to 95 percent across states. Assumptions regarding the mix of HCBS and nursing facility use and costs for PACE enrollees are based on a comparable population, which may be defined either as individuals who would be eligible for PACE but are not enrolled or a subset of individuals whose demographic, health and functional characteristics closely match those of PACE participants. States generally set the UPL based on historical trends in the ratio of Medicaid LTSS beneficiaries using HCBS to those residing in institutions, although the data may not be up to date. States also must adjust the UPL to account for differences in PACE benefits, the level of financial risk related to costs incurred by PACE for long-term institutional placements, the expected share of cost for participants subject to cost-sharing, administrative savings to the state agency, and other state-specific considerations.

Key Issues and Considerations

- **Selecting Populations Comparable to PACE Enrollees:** When PACE capitation rates are pegged to the UPL, it is critical to define and identify the comparable population to match the characteristics of PACE enrollees. States must determine whether the comparable population consists of all PACE-eligible individuals, i.e., everyone over age 55 who meets nursing home level of care criteria; PACE-eligible individuals with the same demographic, health status and functional need profile as current PACE enrollees; or a combination of the two. For example, PACE-eligibles include all those who are age 55 and older, but the average age of PACE enrollees in the state may be 72. To ensure the UPL reflects what it would cost otherwise, states should narrow the comparable population to those who have the same characteristics as PACE enrollees. Since functional and cognitive status are major determinants of Medicaid LTSS costs and utilization, states should identify the comparable population based on having similar functional and cognitive status – not just age, gender, and type of disability.
- **HCBS Incentives (Prospective):** When applying a discount to the UPL, states gradually may increase the discount rate each year of the applicable PACE rate period to reflect the expected mix of people using HCBS and institutional care over time. Using an ambitious target for greater use of HCBS can pose a financial risk to PACE programs because federal rules prohibit PACE capitation rates from being adjusted over the course of a year if a large share of PACE enrollees experience significant

deterioration in health or functional status and must be admitted to a nursing facility. To avoid this risk, states may keep the same discount percentage each year but award bonuses to PACE programs that can keep more people at home or in the community each year than the discount assumes.

Model 2: PACE Experience-Based

As in the previous model, the UPL is established based on historical FFS utilization and costs, the average monthly capitation rates for MLTSS plans, or a mix of the two depending on the data available and the LTSS delivery arrangements that exist in each state. However, rather than set the PACE rate as a percentage of the UPL, the rate under a PACE experience-based approach is set independently of the UPL using the costs, encounters or both of the PACE organization. The resulting rate must fall below the UPL. This approach is referred to as “experience-based” because it reflects the actual costs and utilization of services associated with providing care to PACE enrollees. The experience of the PACE organization may be adjusted for any changes in benefits, medical inflation, and expected risks and costs of increasing frailty in the PACE participant population. The rate also may be adjusted to allow for a margin to maintain reserves needed to cover costs that are higher than expected and to recognize a “managed care efficiency factor” (savings attributable to care coordination).

- One version of this model calculates monthly PACE capitation rates based on the costs of operating PACE programs in the state, as reported in PACE cost reports and financial reports. States that use this approach require PACE programs to use a common cost reporting form or template, although states differ in the amount of detail required.
- A less common version of this model calculates monthly PACE capitation rates based on the actual or estimated costs of PACE programs as reported to the state Medicaid agency in encounter records. When these records are aggregated, encounter data represent the number of services (in units) and the unit prices for all PACE services provided to enrollees in the PACE center, as well as claims paid for professional services (hospital, nursing home, physician and home-based services) delivered outside the PACE center.
- Because data limitations associated with cost reports and encounter records may result in an incomplete picture, states are developing approaches to combine the two models for purposes of establishing an experience-based rate.

The choice to use one of the above approaches usually depends on the type of cost data each state collects from PACE programs. But some states use both. For example, even when a state primarily uses encounter data from PACE programs to set rates, the state still may need to “shadow-price” encounters for services lacking health care procedure codes. In these situations state officials or actuaries estimate the price of the services based on PACE cost reports. Because the two versions of the experience-based model are similar and may complement each other, they are discussed as one model.

Key Issues and Considerations

- **Data Availability and Reporting Burden:** Some state Medicaid agencies require PACE programs to submit PACE cost reports as well as encounter data to track PACE program utilization and costs as fully and accurately as possible. The two data sets also can be used for data validation. States that require PACE programs to submit encounter data should consider the difficulty of accurately capturing PACE services delivered in day centers, as discussed above, and the additional reporting burden. PACE program administrators with experience in encounter data reporting indicate that tracking all services by unit takes valuable time away from direct care delivery and may harm quality. Therefore, states that are considering mandating encounter data reporting by PACE programs must weigh these challenges against the expected value of the data for rate-setting purposes.
- **Administrative Costs:** To evaluate whether PACE costs are reasonable compared to other LTSS delivery systems, PACE cost and financial reports should contain cost categories that are comparable to those in FFS claims or MLTSS encounter data and financial reports, as well as administrative and other costs unique to PACE. PACE programs, like MLTSS, have administrative costs related to health plan functions when they pay claims for bills submitted by providers who serve PACE enrollees in hospital, physician offices and other settings. However, PACE programs also have administrative costs related to direct service delivery through day health centers, for which they incur capital and facility-related costs, which MLTSS plans do not. Large MLTSS plans also can spread administrative costs across thousands of members, while PACE programs must spread these costs across a few hundred in typical PACE programs.

Model 3: Managed LTSS Experience-Based

In this model the UPL is linked to capitation rates set for MLTSS plans. PACE rates also are developed through an actuarial approach, using MLTSS cost experience (based on encounter data and MCO financial reports) to estimate utilization rates for PACE-covered services in the comparable population, with total costs estimated by assigning unit prices to each service or actual health plan payment rates to providers for covered services. PACE

administrative costs and reserves may be calculated differently than those for MLTSS plans since the two delivery systems have different overhead expenses.

This model is now, or expected to be, used by states that have converted all or most LTSS services provided to individuals eligible for PACE (i.e., older adults and people age 55 and over with disabilities) to managed care programs. In these states there is no comparable FFS population. The UPL is tied to the monthly capitation rates or rate ranges for MLTSS plans and can equal or be set at a percentage of these rates. PACE rates then should be adjusted to take into account differences between PACE and MLTSS program enrollees, as well as differences in benefits covered by each program and the level of financial risk for nursing home admission or other services.

Key Issues and Considerations

- **Weighting of HCBS to Institutional Costs:** States that set PACE rates based on the experience of MLTSS plans are implicitly using the MLTSS HCBS to institutional mix ratio to set the mix for PACE programs. However, states should not assume that the risk of institutional admission, or the ratio of HCBS to institutional care costs, is the same for PACE as it is for MLTSS plans. For example, PACE serves people age 55 and over, while MLTSS programs often serve all adults age 18 and over. Younger adults with disabilities usually have a lower likelihood of nursing home admission. PACE programs have proven their ability to keep frail older adults at home for long periods of time, even if their health or functioning declines. The ability of all MLTSS programs to achieve the same has not been demonstrated universally.
- **Risk Adjustment:** In states that link PACE rates to MLTSS capitation rates, it is especially important to use risk adjustment to account for differences in enrollees' level of care needs, age and other eligibility criteria, as well as covered benefits and other program features. New York and Wisconsin have risk adjustment models that apply to MLTSS and PACE programs alike, using uniform assessment data collected from all LTSS beneficiaries, including PACE. As more states adopt MLTSS programs, the need to develop LTSS risk adjustment models becomes greater.

Conclusion

Changes in how Medicaid programs provide coverage for LTSS, a continuing trend toward rebalancing institutional and HCBS services, and updated federal rate-setting guidance are driving state approaches to PACE rate setting. Establishing a UPL for PACE rates requires identifying a population comparable to the PACE population and determining the Medicaid costs incurred. In addition to the longstanding challenge of determining comparability that

reflects health care needs and the frailty that this presents, states face a lack of FFS cost data for setting the UPL as more people are served by managed care models. For both of these reasons, reliance on setting the PACE rate as a percentage of the UPL may diminish. As an alternative, states may seek to apply the utilization and cost experience of PACE or of managed care plans serving people with LTSS needs to their rate-setting methodologies. States that rely on managed care plans experience to set rates will need to adjust for differences in the PACE and managed care plan populations, as well as potential differences in coverage and risk.

Appendix

Detailed Discussion of Key Issues in Setting PACE Medicaid Rates

Regardless of which PACE rate-setting model is used, Medicaid programs must address many common issues and questions. This appendix contains a detailed discussion of 10 key issues, their relevance to the UPL and PACE capitation rate setting, and important considerations for each model.

1. Availability and Quality of Data Source(s)

Issues: Regardless of the model or approach, the development of accurate capitation rates depends on having complete, reliable, and timely data on the costs and utilization of services covered by PACE programs. There are three major sources for such data:

- 1. FFS Claims:** Before the growth of MLTSS, nearly all data for Medicaid-covered LTSS came from FFS claims. FFS data generally are regarded to be more complete and reliable than encounter data, although both types may leave out LTSS services that are reimbursed through lump-sum payments, such as home modifications and non-emergency transportation. Total FFS Medicaid expenditures on LTSS may be less than the actual costs if Medicaid provider payment rates are less than market rates.
- 2. Managed Care Encounter Data:** This source contains records of services delivered to Medicaid beneficiaries enrolled in managed care plans or PACE programs and usually are based on claims that providers submit to managed care plans to receive payment for services.⁴ Nationally, Medicaid encounter data have been regarded as too incomplete and unreliable to be used for rate-setting purposes. But an increasing number of states have high-quality encounter data for inpatient and outpatient services and prescription drugs that meet minimum “usability” thresholds for encounter data in national datasets (Byrd & Dodd, 2012). The accuracy and reliability of encounter data for LTSS – institutional care or HCBS – have not been investigated systematically. Some cross-state studies of the data are now in progress.

⁴ Federal rules (42 CFR 438.242) also require state-contracted managed care organizations (MCOs) to collect encounter data, ensure that the data are accurate and complete, and report the data to the state.

- 3. PACE Cost and Financial Reports:** While these data sources accurately capture PACE program costs, state Medicaid agencies may set limits on allowable costs and require independent audits or extra documentation to justify the costs. Florida, for example, designed a special template to collect financial data from PACE programs, as well as MCOs participating in the statewide MLTSS program.

Data Source Considerations in PACE Rate-Setting Models

- **UPL-Based:** The traditional model used to establish the UPL and develop PACE rates relies almost entirely on FFS claims data. Because providers have an incentive to submit all of the information required to receive payment from the state, FFS claims data generally are complete, though payment may lag if claims do not have all the required codes. However, certain types of LTSS not paid through claims may be missing from FFS data and must be obtained from other sources. For example, assessment and case management services provided to HCBS waiver participants may be paid through grants to area agencies on aging. Extra services provided to Money Follows the Person demonstration participants – those who resided in nursing homes for at least 90 days and transition back to the community – also may be missing from claims data.

While states may assume that individuals age 55 and older enrolled in HCBS waiver programs or residing in institutions are equivalent to PACE enrollees, differences in health conditions and functional and cognitive status should be examined to adjust PACE rates for participants' frailty relative to the comparable population. Because data on health and functional status often are incomplete or missing from FFS claims data, it is important to supplement FFS claims with information from functional and cognitive status screening and eligibility systems.

- **PACE Experience-Based:** PACE experience-based rate-setting models largely rely on PACE cost reports. State forms for reporting PACE costs vary. Some are very detailed, while others fit on one page. For example, PACE cost reports provide important details about the IDT meetings, a hallmark of PACE programs, that help to distinguish this from less intensive forms of care coordination performed by MCOs. In addition, cost reports reveal important differences in administrative costs between PACE and MLTSS plans. For instance, MLTSS programs generally do not operate day centers as PACE programs do. In addition, for the most part MLTSS plans can spread administrative costs across many thousands of members, rather than a few hundred in typical PACE programs. PACE cost reports also may be useful for recording the costs of transportation to and from the PACE center and showing how they differ from per-ride costs covered by Medicaid non-emergency medical transportation (NEMT).

While states that require PACE programs to report encounter data do so in order to track PACE program utilization and costs as fully and accurately as possible, PACE program managers are concerned that the data reporting burden diminishes care quality. They find that having to divide the services of a highly integrated program like PACE into individual units takes time away from direct care delivery. Encounter reporting also requires PACE program staff to understand the differences between Medicare- and Medicaid-covered benefits, a complicated task for even the most experienced program managers. For example, Medicare covers skilled nursing facility services for up to 100 days, but not all 100 days of an individual's stay in a nursing facility may be eligible for Medicare coverage if the person does not require skilled nursing care every day. Consequently, states that are considering mandating encounter data reporting by PACE programs must weigh the burden of reporting against the expected benefit of the data for rate-setting purposes.

- **MLTSS Experience-Based:** When states switch from FFS delivery arrangements for LTSS to managed LTSS, FFS data gradually become less available and less useful. In the early years of the transition, FFS data still may be useful but diminishes in relevance and availability over time as the MLTSS program matures. Older FFS utilization and cost data do not reflect changes in the intensity of services, medical technology, or use of assistive devices and technology to help older adults and people with disabilities to live at home, and it can be difficult to adjust the rates for all of these changes as a whole.

Instead, encounter data from MLTSS programs becomes more important. The UPL becomes a function of MLTSS rate setting, using either the data for setting the base rates or the MLTSS capitation rate itself, with adjustments to account for differences in the populations enrolled (age, gender, frailty); benefits covered or excluded; and the ratio of HCBS to institutional services that will be used. For example, Florida actuaries summed costs in its managed LTC program for all enrollees in the community, nursing home and hospice care to establish UPL for PACE programs. However, Florida officials acknowledge shortcomings in encounter data that make it challenging to conduct all needed adjustments.

2. PACE Administration and Capital Costs

Issues: PACE programs have higher administrative costs than insurers. Like insurers and MCOs, PACE programs pay bills for services delivered by providers such as hospitals, specialists and pharmacies to enrollees, either directly or under contract with a third-party administrator. In addition, PACE programs pay capital, maintenance and other overhead costs for operating PACE centers, where a substantial share of PACE services are provided, including primary care, rehabilitation, social activities and meals.

Regardless of the model used to establish PACE capitation rates, states must recognize the distinct administrative cost structures of PACE programs and take them into account when setting limits or benchmarks for PACE administrative expenses. These costs may show up in PACE cost reports, shown separately from claims or encounters, or rolled up into claims. Due to the relatively small numbers of enrollees compared to most managed care organizations, PACE programs cannot spread out their administrative costs, making them as much as five times higher per enrollee than those for typical Medicaid MCOs. States and their actuaries also should consider the allocation of administrative costs across Medicare and Medicaid and agree on the principles for allocating them appropriately in consultation with PACE programs.

3. Reporting Burden to PACE Programs and State Medicaid Agencies

Issues: PACE programs understand the importance of operating efficient programs and the need to report costs, claims and other financial data to state Medicaid officials to justify rates. At the same time, states need to consider the burden to PACE programs of reporting such data and the resources required by the state and its actuaries to make good use of the data collected.

Reporting Burden in PACE Rate-Setting Models

- **UPL-Based:** States that set PACE capitation rates by taking a discount off the UPL pose the lowest reporting burden to PACE program administrators and Medicaid agencies. However, all or most states seek to substantiate that the PACE rate covers the reasonable costs of an efficiently operated PACE program documented in cost reports.
- **PACE Experience-Based (Cost Reports):** States that use PACE cost reports to set capitation rates place less burden on PACE programs than those requiring encounter data and allow PACE managers and staff to spend more time on participants' needs and care. However, the total administrative burden depends on what other supplemental data must be collected and reported. For states, this method requires resources to be spent auditing and validating the cost reports.
- **PACE and MLTSS Experience-Based:** States with large MLTSS programs can take advantage of the same techniques and resources for validating encounter data for MLTSS and PACE programs alike. But as noted before, encounter data reporting places a large burden on PACE programs. PACE programs must purchase or completely revise electronic health records systems, hire and train staff to record all encounters and costs appropriately, and track every PACE center activity in detail. They also must invest in data security systems to be able to send and share the data with the state. In the initial stages of implementation, PACE programs that report encounter data had

to re-engineer their entire workflow, which detracted significantly from their ability to focus on person-centered care. One program manager said turnover among home care nurses rose after implementing new data reporting systems because of the extra burden. Consequently, states considering new requirements for PACE programs to report encounter data must assess whether the benefit is worth the extra resources and the risk to PACE service quality.

4. Identifying the Comparison Population to Establish UPL

Issues: Federal statute requires states to identify a population comparable to PACE enrollees for purposes of establishing the UPL. When PACE was first authorized in 1997, individuals considered to be like PACE enrollees were, for the most part, residing in institutions. Since then, however, adults age 55 and over with significant health, functional and cognitive impairment are more likely to live in their home or another community residence. As states expand programs and options for receiving HCBS, identifying people who are PACE-eligible or look like PACE enrollees in all observable ways but are not enrolled in the program has become more difficult.

There are several challenges and questions when identifying costs for the comparable population. How should the costs for Medicaid beneficiaries receiving HCBS and nursing home care be weighted, since PACE is an alternative to care in both settings? States should calculate the UPL based on the weight or mix of person months spent in each setting, but should the weight be adjusted to reflect a higher risk of long-term nursing home placement, given the increasing frailty of PACE participants over time? When states cover personal care services as a state plan benefit, should these costs be factored into the comparison group if those receiving services are not eligible for nursing home care? How often should the UPL be updated or rebased to reflect changes in each state's LTSS system balance?

Comparison Populations: Considerations in PACE Rate-Setting Models

- **UPL-Based:** When establishing the UPL in the traditional model, which usually defines the comparable population as all Medicaid beneficiaries receiving LTSS in nursing homes and in HCBS waiver programs, states must decide whether to include all PACE-eligible individuals (those who meet the age and nursing home level of care criteria); restrict the comparison group to those who are eligible for PACE and have the same demographic, health and functional profile as current PACE enrollees; or a blend of the two. For example, PACE-eligibles include all those who are age 55 and over, but the average age of PACE enrollees in the state may be 72. To what extent should – or can – the state narrow the comparable population to those who have the same characteristics as PACE enrollees?

In practice, there are many challenges to identifying a population comparable to PACE

enrollees. For example, one of the most important factors affecting Medicaid LTSS costs and utilization rates is functional status, yet most states lack uniform assessment tools that allow for direct comparisons between PACE-eligibles or PACE enrollees and comparable Medicaid LTSS beneficiaries in other state LTSS programs. In addition, many states have limits on the number of people who can be served in HCBS waiver programs and establish waiting lists for those who cannot be accommodated under the cap. Should the costs of the comparable population be adjusted for the demand for services if individuals on waiting lists were enrolled in PACE instead? HCBS costs and utilization in the comparable population may be lower than what they would be otherwise if the services and providers required to meet all of their needs were unavailable. By contrast, PACE programs are required by statute to meet all needs of PACE enrollees. Regional differences in costs and utilization are also striking; for this reason, PACE programs may be concerned about expanding to rural areas where LTSS utilization and costs tend to be much lower than what PACE programs normally experience. All of these factors make it difficult to construct a comparison group for PACE.

- **PACE Experience-Based:** Defining a comparable population for purposes of comparing PACE costs is only necessary to establish the UPL. Rate setting for PACE programs using cost and financial reports does not depend on creating a utilization and cost profile for a population similar to PACE enrollees. However, if states wish to determine if PACE costs are reasonable, relative to those for similar populations, PACE cost data cannot be readily compared to that for people enrolled in FFS or MLTSS arrangements. It is also difficult to compare health and functional status between PACE enrollees and other LTSS populations, unless the state has Medicare diagnostic information for all dual enrollees and comparable functional assessment data. Without such data, states cannot tell if higher PACE costs are due to serving a population with higher needs or to the greater intensity of services provided in PACE programs, rather than excessive PACE costs.
- **MLTSS Experience-Based:** When using MLTSS utilization and cost experience to set the UPL, differences in eligibility criteria must be taken into account. Some states mandate enrollment into MLTSS for all groups using LTSS: older adults age 65 and over; people under age 65 with physical disabilities; individuals with intellectual and development disabilities (IDD); and individuals with serious mental illness (SMI), among other groups. By contrast, PACE programs serve people age 55 and over and generally do not serve people with IDD or SMI. Some MLTSS programs limit enrollment to people who are determined to require institutional level of care; others allow individuals who are dual eligibles to enroll, even if they do not qualify for Medicaid LTSS. When comparing rates between PACE and MLTSS, it is critical

to account for such differences in eligibility criteria and the characteristics of the enrolled populations.

5. Weighting of HCBS to Institutional Costs

Issues: Historically, the UPL, which must equal the amount that otherwise would be paid for PACE enrollees, was set at or close to nursing facility costs. This assumed that since PACE enrollees must be eligible to receive care in an institution, the UPL should reflect institutional costs. As the number of people who meet institutional level of care criteria are opting to receive Medicaid HCBS instead, the UPL must be adjusted to reflect the costs of HCBS, which are much less per person each year than institutional care costs.

Several questions arise in establishing the ratio of HCBS to institutional care costs. For example, the ratio of HCBS to institutional care varies by age, type and level of functional impairment, and region. Should states use the regional ratios for each PACE program located in the same area? Virginia chose not to do so. Although this ratio differs across regions, the state adjusts HCBS to institutional costs for PACE UPL and PACE rate-setting purposes based on statewide average. South Carolina takes a more data-intensive approach, matching HCBS and nursing facility care beneficiaries to PACE participants, based on the same characteristics, and applying the corresponding ratio to PACE. Regardless of the approach used, it is important for states to demonstrate how the ratio is derived and take into account how policy decisions – like HCBS waiver enrollment limits and expenditure caps – affect the ratio.

Weighting of HCBS to Institutional Ratio: Considerations in PACE Rate-Setting Models

- **UPL-Based:** The traditional model for PACE rate setting typically uses the historical enrollment mix of HCBS to institutional care in a comparable FFS population and applies it to PACE eligibles to set the UPL. To ensure comparability, states should exclude people with very low HCBS costs who were likely to use fewer services than typically needed by PACE enrollees. California, for example, divides LTSS users into several groups based on level of care and uses the upper percentile in each group to establish the comparable population for PACE rate setting.
- **PACE Experience-Based:** If PACE rates are set based on PACE cost reports, the HCBS to institutional cost mix will reflect the needs of PACE enrollees.
- **MLTSS Experience-Based:** States that set PACE rates based on the experience of MLTSS plans implicitly are using the historical MLTSS HCBS to institutional mix ratio to set the mix for PACE programs. However, states should not assume that the risk of institutional admission, or the ratio of HCBS to institutional care costs, is the same

for PACE as it is for MLTSS plans. For example, PACE serves people age 55 and over, while MLTSS programs often serve all adults age 18 and over, and younger adults with disabilities have a much lower likelihood of nursing home admission. PACE programs have proved their ability to keep frail older adults at home for longer periods of time; the ability of MLTSS programs to achieve the same has not been examined carefully. In addition, some states set MLTSS rates by assuming a prospective mix ratio for each plan, based on the risk profile of each plan's enrollees, and can vary by region, which suggests caution in using the statewide historical average for PACE programs.

6. Risk Adjustment

Issues: Risk adjustment, which is a statistical method for modifying capitation rates paid to health plans based on the expected costs of providing care to their enrollees, is important in developing PACE rates that reflect the costs of providing care to PACE enrollees based on their characteristics, including but not limited to frailty.

Risk adjustment models have been used for many years by Medicare and Medicaid to adjust rates paid to health plans. However, most risk adjustment models have been designed to account for differences in age, gender and health status, based on the diagnoses recorded in patients' medical claims. Only a few states, notably New York and Wisconsin, have developed risk adjustment models for their MLTSS programs that account for differences in functional status, a key driver of LTSS costs. The models rely on data about enrollees' functional and cognitive status collected from uniform assessment tools. For example, Wisconsin developed different risk adjustment models for the three major groups of LTSS beneficiaries: frail older adults, adults under age 65 with physical disabilities, and people with IDD. Both states use these risk adjustment models to adjust the costs of all MLTSS programs, including PACE.

While other states are interested in developing risk adjustment models for MLTSS programs, they face significant challenges (Lipson et al., 2016). In most states functional assessment data are available in paper files or in unconnected electronic files, making it difficult to use in statistical models. In addition, risk adjustment models must have updated functional data to capture changes in enrollee status over time in order to update corresponding risk scores for each plan or program. Because risk adjustment does not account for differences in benefits between PACE and MLTSS programs, extra steps must be performed to ensure fair cost comparisons. Since developing and refining risk adjustment models is resource-intensive, states may restrict it to certain types of enrollees. Florida, for example, risk adjusts PACE rates just for new enrollees.

Risk adjustment also may be used to “divide the pie” or redistribute total funds. Some plans get more of the pie and some get less based on whether their enrollees are expected to cost more or less than the statewide average. For example, the New York model adjusts rates across PACE sites in the state. However, using risk adjustment to redistribute funds across PACE programs will not solve underlying problems in base rates that have not been increased to reflect greater impairment in PACE enrollees over time.⁵

Risk Adjustment Considerations in PACE Rate-Setting Models

- **UPL-Based:** States that set PACE capitation rates by applying a percentage to the UPL should conduct risk adjustment to account for differences between the comparable population and PACE enrollees. In practice, this is uncommon largely due to the lack of data to compare the health and functional status of all LTSS populations served in the FFS system, which can be a serious problem in states that cover personal care as a state plan benefit. While more states are adopting uniform assessment tools to assess functional status, few use just one tool for all aged and disabled populations. Most states use multiple tools, which vary for each population served, or by LTSS program operated within the state.
- **PACE Experience-Based:** Risk adjustment is largely unnecessary in states that set PACE rates based on cost reports or encounter data from PACE programs. An exception is if data are aggregated statewide. In these cases the risk profile of each PACE program relative to the statewide average can be adjusted or attributed to each site.⁶ If encounter data are robust, this method represents an opportunity to calibrate site-specific PACE rates more accurately than using proxy data derived from non-PACE sources. However, it is also important to account for differences in PACE costs due to non-enrollee factors, such as labor costs that differ by region.
- **MLTSS Experience-Based:** In states that link PACE rates to MLTSS capitation rates, it is especially important to use risk adjustment to account for differences in enrollees’ level of care needs, age and other eligibility criteria, covered benefits and other program features. As noted, New York and Wisconsin have risk adjustment models that apply to MLTSS and PACE programs alike, using uniform assessment data collected from all LTSS beneficiaries, including PACE. As more states adopt MLTSS programs, there is greater interest in LTSS risk adjustment models used in other systems (see box).

⁵ Under the risk adjustment models used by Medicare, PACE programs and Medicare Advantage plans receive higher capitation payment for members with multiple chronic illnesses than for members with no or limited health problems; the frailty adjuster and hierarchical condition categories (HCC) model account for worsening health and functional status.

⁶ If PACE program enrollees across the state do not vary significantly, this may not be necessary. Virginia, for example, analyzed information about the frailty of members in each program and found relatively little variation in HCBS need and costs, so the assessment information was not as useful for risk adjustment as expected.

LTSS Risk Adjustment Models

- The Veteran’s Administration (VA) adjusts LTSS rates based on activities of daily living, behavioral risk factors, the amount of clinical nursing required, and the extent of supportive services needed. The VA compared the results of its model to the VA PACE program in New Jersey and found that VA PACE enrollees scored at the higher range, compared to average VA LTSS members.
- A risk adjustment model developed by JEN Associates calculates a frailty index that uses health claims data to predict risk of long-term care services, re-hospitalization within 30 days, mortality and high costs. The index identifies individuals at risk of current and future need for LTSS without conducting a functional assessment and can be used to target early interventions to keep enrollees well. It has been validated with the VA population but has not yet been tested as a risk adjustment tool for payment. For more information, view the [video](#).

7. Frequency of Updates

Issues: The CMS guidance released in December 2015 clarifies the expectation by CMS that states will update and rebase the UPL and PACE capitation rates annually and at least every three years. States must consider how often to update and rebase rates based on the time and resources required to implement each model and the speed and extent of changes occurring in each state that affect the UPL and PACE capitation rates.

Considerations Regarding Frequency of Updates in PACE Rate-Setting Models

- **UPL-Based:** States that use FFS data to establish the UPL and apply a percentage discount to establish the PACE capitation rate are better positioned to perform updates on an annual basis by applying yearly trends to the rates of the previous year. FFS data may not contain all costs, such as lagged claims, and services paid in lump sums or bundled payments, such as non-emergency transportation and cash payments to individuals for participant-directed services. However, actuaries usually are able to apply adjustments for such costs. Rebasing (revisions to base period data) may be done less frequently because it requires more work to incorporate changes in benefits, FFS reimbursement rates, Medicare co-payments, etc. To date, rebasing has ranged from being done every two years to as long as seven years, depending on the state. If HCBS rebalancing is occurring rapidly, less frequent updates increase the risk to the state that it could pay PACE more than it should. Under these circumstances, and to ensure PACE rates are kept current, updates to the PACE rates should be done at least annually. The recent CMS guidance requires rebasing at least every three years.

- **PACE Experience-Based:** States that set PACE rates using cost reports may find that they cannot update rates every year. For example, states may need to audit cost reports, which can take a considerable amount of time. PACE cost reports may not be finalized until all costs are recorded; and for some services, like home health aide visits, it can take some time before all visits are billed and recorded to develop final unit costs. In addition, health care organizations may have different fiscal years, which can complicate the time required to close all accounts. Nonetheless, even with lags as long as six months to finalize cost reports, this method may be preferable to encounter data, which can take even longer to collect, validate, and use for rate-setting purposes. Also, since encounter data do not always show the amount paid to providers or the PACE cost, the state must “shadow-price” the encounters.
- **MLTSS Experience-Based:** States that regularly increase MLTSS capitation rates presumably would use the same schedule to update PACE rates if the two are linked. However, states need to decide whether all the changes and adjustments applied to the capitation rates are relevant to both programs.

8. Compliance with CMS Rules and Guidance

Issues: As noted earlier, despite the CMS guidance issued in December 2015, federal rules governing Medicaid PACE rate setting have not changed fundamentally. States still must establish the UPL by calculating the amount that Medicaid would have paid otherwise for a comparable group of individuals who are not enrolled in a PACE program. States still must establish a capitation rate for PACE programs, which must be less than the UPL, and take into account the frailty of the PACE participants. However, the guidance makes clear that, starting in 2016, CMS will apply greater scrutiny to the data, assumptions and methods used to set PACE rates; expect rates to be updated and rebased annually or at least every three years; and encourage states to obtain actuarial review and certification of PACE rates.

Compliance with CMS Rules of PACE Rate-Setting Models

- **UPL-Based:** The traditional model for setting PACE rates by taking a percentage discount off the UPL clearly meets current rules and new guidance. To the extent that state LTSS delivery systems are solely or largely FFS-based and FFS data are up to date, this model remains relevant and relatively straightforward.
- **PACE Experience-Based:** While CMS does not require PACE rates to be set using an actuarial approach, rate setting based on PACE cost reports alone may be at odds with CMS guidance encouraging actuarial certification. Setting PACE rates based on PACE encounter data is an actuarial approach, in essence, although supplemental data likely are needed to set fair and equitable rates reflecting the costs that are unique to PACE programs but not included in encounter data.

- **MLTSS Experience-Based:** Given the problems with encounter data, states that link PACE rates to MLTSS capitation rates may face challenges in assuring CMS that the data used to set MLTSS rates are complete, up to date, and reliable. It also can be challenging to adjust the MLTSS rates to reflect the demographic, frailty and other characteristics of PACE enrollees and make all other adjustments for differences in benefits, financial risk limits and administrative costs between the two programs. States with little or no FFS data have little choice but to confront these challenges. Whether they can do so and pass actuarial standards as well as regulatory scrutiny at CMS has not been widely tested or publicly disclosed.

9. HCBS Incentives

Issues: As in all Medicaid LTSS programs, state officials responsible for overseeing PACE programs want to create incentives to ensure all enrollees can remain in their homes or in community residences as long as safely possible. While the core philosophy of PACE is to support the right of every enrollee to live at home or in community settings, states may choose to reinforce this goal by building incentives into the capitation rate or use other financial incentives external to the capitation rate to ensure PACE programs give preference to HCBS rather than institutional care.

HCBS Incentives in PACE Rate-Setting Models

- **UPL-Based:** When applying a discount to the UPL, states may establish a prospective or expected mix of HCBS and institutional costs for the rate period that assumes a gradual increase in HCBS relative to institutional care over time. This can create financial risk to PACE programs, however, because PACE capitation rates cannot be adjusted over the course of a year if the health or functional status of PACE enrollees deteriorates significantly, they cannot be safely cared for in their home or a community setting, and they must be admitted to a nursing facility. To avoid this risk, some states keep the discount percentage the same each year but award bonuses to PACE programs that are able to keep more people at home or in the community each year than the discount assumes.
- **PACE Experience-Based:** Setting PACE rates based on the costs of prior years or PACE encounter data will, by definition, reflect the actual experience of PACE programs in providing HCBS to PACE enrollees. However, states may be concerned that PACE program managers will deliver more intensive and less cost-effective services than necessary to keep people in the community. Higher HCBS costs then would be built into the rates of subsequent years in this model (subject to the UPL). With only on cost data, however, state officials do not know if the level of need of PACE enrollees is greater than average, which would justify more intensive use of HCBS. Consequently,

states using this model might request additional information from PACE programs to justify high HCBS costs or create incentives to PACE programs to be as cost-effective as possible, so as not to over-utilize HCBS.

- **MLTSS Experience-Based:** MLTSS capitation rates, which this model uses to set the UPL and PACE capitation rates, often are designed to be lower than the total cost of services delivered under an FFS system. This is achieved by assuming a certain degree of savings from managed care, which will result in serving more people in HCBS settings and fewer people in institutional care. However, as PACE is also a managed care program, such savings presumably are built into its rates already. For this reason states should not assume that PACE can achieve even greater use of HCBS relative to institutional care than MLTSS plans. In addition, some MLTSS plans have expressed concern that serving more people in HCBS settings will decrease the capitation rate substantially, so they may not do as much to promote access to HCBS as PACE.

10. Quality Incentives

Issues: With a growing interest in linking payment to quality, some state policy-makers are beginning to ask PACE programs to demonstrate quality outcomes or report performance on specific quality measures. Regardless of the PACE rate-setting model used in a state, there are several issues that arise. Should performance on quality measures be linked to capitation withholds, or should PACE programs be eligible for bonuses on top of the capitation rate? What are the appropriate quality targets and benchmarks? Should they be achievable – at a level that some programs already attain – or set at a much higher level than current performance? What types of quality measures should be tied to payment? It is reasonable to expect PACE programs to have a comprehensive care plan for all enrollees, but it is not evident whether they should be accountable for rates of depression, for example.

As an emerging issue with experience limited to just a few states (Oregon and New York), state policy-makers should design quality incentives or penalties carefully in consultation with PACE program administrators to determine how best to link payment to performance. PACE programs should be able to affect the processes or outcomes and collect and report reliable data and be held to reasonable quality targets. In addition, because the average enrollment in PACE organizations was 325 individuals as of January 2016, performance on quality measures may fluctuate from year to year in sites with very low enrollment numbers since a few outliers can have a disproportionate impact.

Quality and Performance Incentives in PACE Rate-Setting Models

- **UPL-Based and PACE Experience-Based:** States that set rates based on a UPL discount can choose to return some of the discount taken off the UPL to reward PACE organizations that perform well on quality measures. States that set PACE rates based on cost reports and encounter data can consider using performance measures linked to timely and accurate reporting of cost reports and encounter data. While little about care quality can be discerned from cost reports, states that require encounter data reporting can use such data to construct quality measures based on utilization, such as timely follow-up care after discharge from hospitals or nursing facilities. Another possibility is to examine actual costs relative to the projected amounts based on trends. If PACE programs are able to hold costs below the estimated cost, states may consider sharing a portion of the savings with PACE organizations.
- **MLTSS Experience-Based:** Most states do not directly compare the quality outcomes in PACE to MLTSS programs and instead leave the choice of delivery model to Medicaid beneficiaries. However, applying the same standards and quality measures to both PACE and MLTSS plans can help states evaluate which model produces better outcomes for the money spent. Do PACE programs delay nursing facility entry longer than MLTSS programs, for example? States should use caution when considering whether to use the same quality measures and benchmarks as those used for other types of MLTSS programs. For example, in many state MLTSS programs a typical performance standard is a face-to-face assessment done within a specified period of time after enrollment, usually 30, 60 or 90 days. In PACE programs an in-person assessment would almost always occur within a week of enrollment.

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