

2016 Edition



Upper Payment Limits and Medicaid Capitation Rates for Programs of All-Inclusive Care for the Elderly (PACE®)

ABSTRACT

The Program of All-Inclusive Care for the Elderly (PACE®) is a federal and state program that provides comprehensive, integrated and highly coordinated care to frail older adults who meet state eligibility criteria for a nursing home level of care. This policy brief reviews the Medicaid rates that states pay to PACE organizations compared to state calculations of the costs the Medicaid program otherwise would incur to provide care to a PACE population.

INTRODUCTION

The Program of All-Inclusive Care for the Elderly (PACE®) is a federal and state program that provides comprehensive, integrated and highly coordinated care to frail older adults who meet state eligibility criteria for a nursing home level of care. Individuals enrolled in PACE organizations receive all services covered by Medicare and Medicaid, as well as additional benefits, directly from the PACE organization or through its network of contracted providers. PACE organizations receive per member per month (PMPM) capitated payments from Medicare, Medicaid and private pay sources for which they assume full financial risk for all services, including long-term institutional care.

The PACE Model of Care has grown substantially since the first PACE organizations received Medicare and Medicaid waivers to operate in 1990. As of January 2016, 116 PACE organizations in 32 states (see Attachment 1) served approximately 38,285 enrollees, 90 percent of whom were dually eligible for both Medicare and Medicaid services.¹ Nine percent of enrollees were eligible for Medicaid only, while the remaining 1 percent was comprised of Medicare-only individuals or individuals who were not eligible for either Medicare or Medicaid.

As states look for fully integrated and cost-effective solutions for beneficiaries needing long-term services and supports (LTSS), many are considering building upon the 25-plus years of PACE experience. The relationship between Medicaid payment rates for PACE and the costs states otherwise would incur for nursing home-eligible beneficiaries is an important consideration for future PACE expansion.

This policy brief reviews the Medicaid rates states pay to PACE organizations compared to state calculations of the costs the Medicaid program otherwise would pay fee-for-service (FFS) programs to provide care to a comparable population. States develop these calculations using an upper payment limit (UPL) methodology, which the Centers for Medicare & Medicaid Services (CMS) requires in order to assure that payment rates for PACE do not exceed the costs of other Medicaid-covered services for beneficiaries eligible for a nursing home level of care.

¹ Source: NPA Enrollment and Medicaid Capitation Rate Survey Results for Jan. 1, 2016.

The information in this policy brief was collected from PACE organizations and state agencies that administer the payments of their Medicaid program. The Medicaid payment rate information consists of self-reported data provided by 115 out of the 116 PACE organizations operating at the time of data collection (Jan. 1, 2016).² Information on UPLs was collected for 22 of the 32 states with a PACE program.³ Much of the data and analyses provided in this brief utilizes averages of PACE organization-level data to provide insights into PACE payments.

MEDICAID RATE SETTING FOR PACE

PACE Medicaid capitation rates are negotiated between PACE organizations and their State Administering Agency. Federal regulations require states to set prospective monthly capitation rates consistent with the following criteria:

- ▶ the capitation rate is less than the amount that states otherwise would have paid if the participants were not enrolled in the PACE program;
- ▶ the rate accounts for the frailty of the PACE participants;
- ▶ the rate is a fixed amount regardless of changes in the participant's health status; and
- ▶ the rate can be renegotiated on an annual basis.⁴

To ensure that Medicaid rates comply with federal regulations, CMS reviews the rate-setting approach of each state. The focus of the CMS review is to confirm that Medicaid rates for PACE are no greater than the corresponding UPLs. In 2015 CMS issued rate-setting guidance that included expectations on how the state would document and calculate the amount that otherwise would have been paid for a comparable population and expectations for the development and documentation of the PACE rates.⁵

To set Medicaid capitation rates for PACE programs, states use three basic approaches:

- ▶ A UPL approach sets the monthly PACE capitation rate as a percentage of the UPL.
- ▶ An approach using PACE experience sets the monthly PACE capitation rate based on the services provided, cost reports, or a combination of the two in previous time periods, trended forward to the current rate period.

² The rates for one PACE organization were not available during the time of data collection.

³ UPLs are missing for DE, KS, MO, NJ, NM, NY, OH, PA, SC and TN.

⁴ 42 CFR § 460.182

⁵ [PACE Medicaid Capitation Rate Setting Guide, December 2015](#)

- ▶ An approach using Medicaid Long-Term Services and Supports (MLTSS) experience sets the PACE capitation rate based on the actual or expected cost of services provided to a comparable population through managed care plans.

PACE payment rates may be set based on an enrollee's eligibility status, age or geographic location. Table 1 (on page 5) summarizes the extent to which states set distinct payment rates based on these factors. Twenty-nine of the 32 states with a PACE program have distinct rates for individuals with Medicaid-only coverage from those who are dually eligible for Medicaid and Medicare coverage. The Medicaid-only rate is substantially higher than the dual Medicaid rate to compensate for the fact that the PACE organizations provide the same services to Medicaid-only participants but do not receive the Medicare portion. Alabama, Oregon and Wisconsin have no distinct Medicaid-only rate.

RATE SETTING BASED ON AGE

Some states develop distinct rates based on the age of a PACE participant. A minority of states set rates based on age in combination with disability. Of the 32 states with PACE, eight calculate distinct PACE payment rates based on age and disability categories.

When based on age, states typically distinguish between enrollees ages 55-64 and those 65 and over. However, a few states have additional payment features:

- ▶ Kansas has distinct rates for dually eligible PACE enrollees under and over age 75;
- ▶ North Dakota has different dual-eligible rates for those under 65, those ages 65-74, and those 75 and over;
- ▶ Washington has several rate categories for those who are Medicaid-only, dually eligible and disabled. Among Medicaid-only individuals, the state utilizes a distinct rate for those ages 55-64 and those 65 and over, with a higher rate for those who are disabled within those two age categories. Among dual-eligible individuals, the state utilizes a distinct rate for those ages 55-64 and 65 and over, with a higher rate for those who are disabled within those two age categories.
- ▶ Maryland sets distinct Medicaid-only and dual-eligible rates based on those who are aged and those who are disabled.

RATE SETTING BASED ON GEOGRAPHY

Additionally, geographic location is used by multiple states to establish distinct payment rates. Of the 16 states with more than one PACE program, 11 develop distinct rates based on the cost experience in the specific geographic service area of the program. However, two states – North Dakota and Oregon – each have one program but different rates based on geography.

TABLE 1*State Use of Distinct Payment Rate Types*

Distinct Rate Type	Number of States Using Rate Type (Out of 32)	States
Eligibility Status (Dual, Medicaid-Only)	29	AR, CA, CO, DE, FL, IN, IA, KS, LA, MA, MD, MI, MO, NC, ND, NE, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, WA, WY
Age	8	AR, CO, IA, KS, MD, ND, RI, WA
Disabled	2	MD, WA
Geography	13	CA, CO, FL, IA, KS, LA, MI, ND, NY, OK, OR, TX, VA

* AL and WI have PACE programs but do not use these distinct rate types.

MEDICAID PAYMENT RATES FOR PACE

Dual-eligible individuals, including enrollees age 55 and over, typically make up 90 percent of PACE enrollment. As of January 2016, the weighted average dual-eligible Medicaid rate is \$3,620, and the median rate is \$3,406.

PAYMENTS FOR DUAL-ELIGIBLE ENROLLEES 65 AND OVER

In 2016 the average Medicaid monthly capitation rate of PACE organizations for dual-eligible beneficiaries age 65 and over was \$3,433, and the median rate was \$3,406. The 25th percentile was \$3,231, while the 75th percentile was \$3,644, representing the middle 50 percent of PACE capitation rates for dually eligible enrollees 65 and over. Weighted for enrollment, the average PMPM Medicaid capitated payment for a dual-eligible PACE enrollee age 65 and over is \$3,666.

PAYMENTS FOR MEDICAID-ONLY ENROLLEES

Payments to PACE organizations are higher for enrollees who are only eligible for Medicaid. These enrollees receive the same care as dually eligible individuals, but there is no Medicare payment for services. As a result, the cost of enrollment is borne fully by the state Medicaid program. Most programs (112 of 116) receive the same Medicaid-only rate without regard to the age of the enrollee.

For the 112 PACE organizations in 29 states that are paid a single Medicaid-only rate regardless of an enrollee's age, the average capitated rate is \$5,020, and the median rate is \$4,809. The 25th percentile is \$4,350, while the 75th percentile is \$5,862, representing the middle 50 percent of PACE capitation rates for Medicaid-only enrollees. If weighted for enrollment to reflect the mean capitation paid for Medicaid-only PACE enrollees, the average PMPM Medicaid capitated payment is \$5,896 among the 29 states.

TRENDS IN MEDICAID PAYMENT RATES

There has been a great deal of variation in payment growth rates between Jan. 1, 2011, and Jan. 1, 2016. For Medicaid dual-eligible payment rates, four states saw an average decrease of 2.40 percent, 10 states experienced nearly no change, and 13 states observed an average increase of 3.43 percent in their compound annual growth rates over five years.⁶ Overall, there was a 1.33 percent increase in the compound annual growth rates of dual-eligible Medicaid payments.

Table 2 provides a more detailed comparison. (Note: The data only include the 27 states that consistently maintained at least one PACE organization between 2011 and 2016.⁷)

TABLE 2

Compound Growth Rates: Dual-Eligible Payments, 2011-2016

Growth Category	Number of States	States	Average Growth	Median Growth
Negative	4	LA, NJ, PA, WA	-2.40%	-2.6%
Approximately Zero	10	AR, CA, CO, MA, MD, NC, OH, OK, RI, TX	0.10%	0.00%
Positive	13	FL, IA, KS, MI, MO, ND, NM, NY, OR, SC, TN, VA, WI	3.43%	2.96%

⁶ The compound annual growth rate is the year-over-year growth rate over a specific period of time. The formula used is $\left(\frac{\text{Ending Value}}{\text{Beginning Value}}\right)^{\frac{1}{\text{Number of Years}}}-1$

⁷ The states included in the comparison are AR, CA, CO, FL, IA, KS, LA, MA, MD, MI, MO, NC, ND, NJ, NM, NY, OH, OK, OR, PA, RI, SC, TN, TX, VA, WA and WI.

Similar to the trends observed in Medicaid dual-eligible rates, there was a fair amount of variation in the Medicaid-only payment rate trends between 2011 and 2016. The average compound annual growth rate in Medicaid-only payments among the 27 states with at least one PACE program during the five-year period was 1.72 percent, which is not substantially different from the percent change in the compound annual dual-eligible Medicaid payment rates.

Only two states – two fewer than observed in the Medicaid dually eligible rates – saw an average decrease of 2.38 percent. Ten states had virtually no change in Medicaid-only payment rates, while 15 states experienced an average increase of 3.52 percent. (See Table 3.)

TABLE 3

Summary of Compound Annual Medicaid-Only Payment Growth Rates in 27 PACE States, 2011-2016

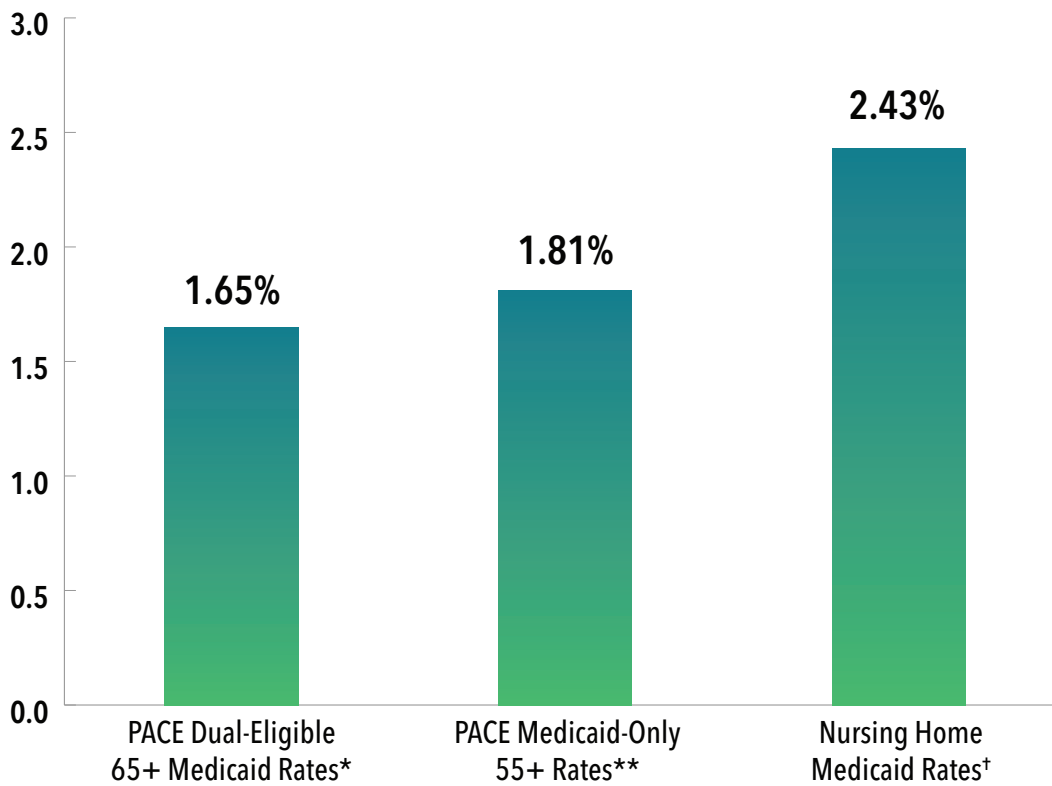
Growth Category	Number of States	States	Average Growth	Median Growth
Negative	2	AR & CO	-2.38%	-2.38%
Approximately Zero	10	LA, MA, MI, NC, NJ, NM, OH, OK, RI, SC	-0.16%	-0.30%
Positive	15	CA, FL, IA, KS, MD, MO, ND, NY, OR, PA, TN, TX, VA, WA, WI	3.52%	3.92%

Making a generalization about PACE payment rates is challenging due to the great diversity in payments as depicted in Tables 2 and 3. At an aggregate level, however, average PACE compound annual growth rates have grown at a slower rate than in other sectors of the long-term care industry. Between 2010 and 2015, for which adequate comparable data exist, both PACE dual-eligible payment rates for participants age 65 and over and the Medicaid-only rates for PACE enrollees age 55 and over increased at a compound annual growth rate of less than 2 percent. In a review of 18 states, where at least one PACE organization existed between 2010 and 2015 and where data consistently were reported for nursing homes, the PACE Medicaid dual-eligible rate grew at 1.65 percent, while the PACE Medicaid-only rate grew at 1.81 percent. During the same four-year period, nursing home rates increased at a compound annual growth rate of 2.43 percent.⁸ (See Graph 3.)

⁸ States included in the comparison: CA, CO, FL, IA, KS, MA, MD, MO, ND, NJ, NY, OH, OK, PA, TX, VA, WA, WI.

GRAPH 3

Compound Annual Growth in PACE and Nursing Home Payment Rates for 18 States, 2010-2015



SOURCES:

* PACE-Medicaid Rate for Duals, Age 65+: NPA Analysis

** PACE-Medicaid Rate for Medicaid-Only, Age 55+: NPA Analysis

† Nursing Homes – Medicaid Rates: A Report on Shortfalls in Medicaid Funding for Nursing Home Care, Eljay LLC, December 2010-2015

STATE UPPER PAYMENT LIMITS

The requirements specified by CMS for state UPL calculations are intended to establish UPLs that reflect the cost that a Medicaid program otherwise would incur for the population enrolled in PACE. In following these requirements, the UPL methodology considers the costs of the Medicaid program for people eligible for a nursing home level of care, e.g., nursing home residents and recipients of home- and community-based services. Medicaid costs for all services—including nursing facility care, home- and community-based services, and other Medicaid-covered services—are incorporated into the UPL calculation.

DUAL-ELIGIBLE UPPER PAYMENT LIMITS

Based on the information collected in 2016, the average UPL of PACE organizations for dual-eligible enrollees age 65 and over was \$3,968, and the median UPL was \$3,845. The 25th percentile for UPLs was \$3,651, and the 75th percentile was \$4,214. These two values represent the UPL applied to the middle 50 percent of all PACE organizations.

COMPARING PACE MEDICAID CAPITATION RATES AND STATE UPLS

To assess the cost savings attributable to PACE, PACE payment rates can be compared to their corresponding UPLs. Table 4 summarizes payment rates and UPLs for dual-eligible enrollees age 65 and over.

TABLE 4

PACE Rates Vs. Upper Payment Limits

Statistic	65-Plus UPL*	Medicaid 65+ Dual-Eligible PACE Rate**	Estimated Savings in Percent PMPM Through PACE	Estimated Cost Savings PMPM Through PACE	Estimated Savings Per Member Per Year Through PACE
Average	\$3,968	\$3,315	16.5%	\$653	\$7,836
Median	\$3,845	\$3,330	13.4%	\$515	\$6,180

* UPL rates were not available for DE, KS, MO, NJ, NM, NY, OH, PA, SC and TN.

** NPA did not have access to rates for one program. Additionally, an average was used in cases where rates were different for multiple counties for one program. The analysis represents data from 75 of 116 PACE programs.

DUAL-ELIGIBLE SAVINGS

For dual-eligible individuals age 65 and over, the average payment rate for PACE participants is 16.5 percent less than the average cost to states for providing services to PACE-eligible individuals through other programs (as estimated by the UPL). This represents an average annual savings of \$7,836 per dual-eligible PACE enrollee age 65 and over. However, the analysis only includes payment data where comparisons are possible. Since UPL data are only available for 22 states, the analysis is limited to assessing PACE Medicaid payment data for programs in the same 22 states. As a result, the analysis represents data from 75 of 116 PACE programs (65 percent).

FUTURE TRENDS AND PRACTICES IN RATE SETTING

FREQUENCY OF UPDATING THE UPL

The 2015 rate-setting guidance issued by CMS recommends that amounts that otherwise would have been paid should be rebased annually and at least every three years. Many states that responded for this brief indicated they update their UPL annually. However, some states reported that the UPL has not been updated in a number of years. Thus, there is cause for concern that rates based on out-of-date UPL cost data will not be actuarially sound.

SHIFT AWAY FROM FEE-FOR-SERVICE

The number of states switching from FFS systems for delivering MLTSS to managed care arrangements is increasing. In states where MLTSS programs are the dominant delivery model for serving older adults and people with disabilities, FFS data quickly diminish. States require managed care organizations (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. While states and MCOs are improving the accuracy of encounter data, in many cases the data remain incomplete. Both the decline in FFS data and incomplete encounter data from MLTSS plans complicate the task of estimating the UPL for PACE programs.

ALTERNATIVE APPROACHES TO RATE SETTING

Setting monthly PACE capitation rates as a percentage of the UPL remains the most common approach. However, this is becoming more difficult as more states move away from FFS. Two other approaches include using PACE experience and MLTSS experience. The approach using PACE experience reflects the actual costs associated with the frailty of PACE enrollees, as well as a margin to maintain reserves to cover higher-than-expected costs and a “managed care efficiency factor” (savings attributable to care coordination). The other approach is based on

MLTSS experience. PACE rates are developed through an actuarial approach, using MLTSS cost experience (based on encounter data and MCO financial reports) to estimate utilization rates for services covered by PACE in the comparable population. The total costs are estimated by assigning unit prices to each service or actual health plan payment rates to providers for covered services.

For more information about these approaches, review the [NPA 2016 PACE Medicaid Rate Setting Guide](#).

CONCLUSION

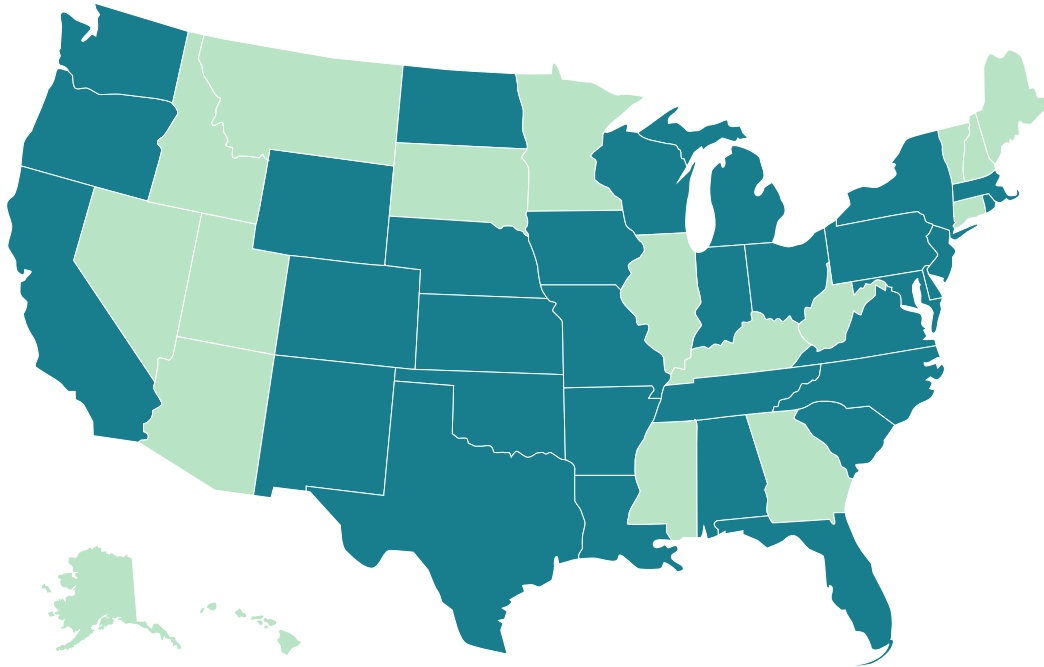
This policy brief addresses the potential savings to state Medicaid programs from serving beneficiaries eligible for a nursing home level of care in PACE. The Medicaid payment rates paid to PACE organizations for dual-eligible enrollees age 65 and over, who make up approximately four out of five PACE enrollees, and for Medicaid-only individuals, who make up approximately one in 10 enrollees, were compared to the costs that states otherwise would have incurred as estimated by their UPLs for PACE. This comparison indicates that PACE programs provide care for a dual-eligible population age 65 and over at a cost that is, on average, 16.5 percent less per person per month than the costs that state Medicaid programs otherwise would incur to provide services to these individuals.

As this brief highlights, there is considerable variation in how states determine payment rates. This variation will continue as more states move to MLTSS and the role of FFS diminishes. States will have to look for alternative approaches to rate setting.

For more information about this policy brief, contact [Liz Parry](#) or [Sam Kunjukuraju](#).

ATTACHMENT 1

■ States with PACE Organizations As of January 2016



ATTACHMENT 2

NPA Survey Data Sources and Response Rates

Type of Information	Source(s)	Response Rate
PACE Payment Rates for Duals 65 and Over	Responses of PACE organizations to the NPA PACE Capitation Rate Survey, Jan. 1, 2016. (There were 116 PACE organizations as of Jan. 1, 2016.)	99% (115 of 116 PACE organizations)
Upper Payment Limit	Responses of PACE organizations to the NPA UPL Survey, and responses of state agencies to a request by NPA.	69% (22 of 32 states)
Upper Payment Limit Methodology	Responses of PACE organizations to the NPA UPL Survey, and responses of state agencies to a request by NPA.	78% (25 of 32 states)