

# Medicaid Rate Setting for PACE



## 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 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 Jan. 1, 2018, 124 PACE organizations in 31 states served more than 45,000 enrollees.<sup>1</sup> Of those individuals served by PACE, 90 percent were dually eligible for both Medicare and Medicaid services, 9 percent were eligible for Medicaid only, and 1 percent were Medicare-only individuals or individuals who were not eligible for either Medicare or Medicaid.

This policy brief reviews how states currently set rates for PACE and explores best practices for rate setting.

## Medicaid Rate Setting for PACE

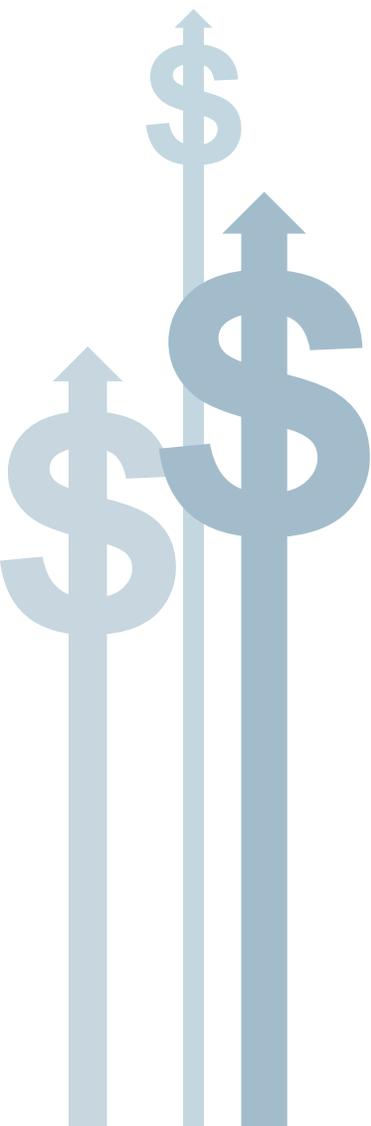
PACE programs operate through a three-way partnership among the provider, state and federal government. While the federal government provides overarching guidance regarding rate setting, PACE Medicaid capitation rates are negotiated between PACE organizations and the states. Federal regulations require states to set prospective monthly capitation rates consistent with the following criteria:

- » the capitation rate is less than the amount states would have paid if the participants were not enrolled in PACE programs;
- » 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.<sup>2</sup>

To ensure that Medicaid rates comply with federal regulations, the Centers for Medicare & Medicaid Services (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 Upper Payment Limits (UPLs). Upper Payment Limits are estimates of the amount the state otherwise would have paid to provide care for individuals similar to those served by the PACE program. In

<sup>1</sup> Source: NPA Enrollment and Medicaid Capitation Rate Survey Results for Jan. 1, 2018.

<sup>2</sup> 42 CFR § 460.182



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.<sup>3</sup>

States generally use three different approaches to set Medicaid capitation rates for PACE programs<sup>4</sup>:

- » Setting the monthly PACE capitation rate as a percentage of the UPL.
- » Using PACE experience to set 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.
- » Using Medicaid Long-Term Services and Supports (MLTSS) experience to set the PACE capitation rate based on the actual or expected cost of services provided to a comparable population through managed care plans.

When setting Medicaid payment rates, states also may consider an enrollee's eligibility status, age and/or geographic location. Table 1 (on page 4) summarizes the extent to which states set distinct payment rates based on these factors.

## Eligibility Status

Twenty-eight of the 31 states with a PACE program have rates for individuals with Medicaid-only coverage distinct from those who are dually eligible for Medicare and Medicaid coverage.<sup>5</sup> The state Medicaid-only rate tends to be substantially higher than the dual Medicaid rate to compensate for the fact that PACE organizations provide the same services to Medicaid-only participants but do not receive the Medicare portion from the federal government.

## Rate Setting Based on Age

Of the 31 states with PACE, seven calculate distinct PACE payment rates based on age. When rates are based on age, states typically distinguish between enrollees ages 55-64 and those 65 and over. However, two 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.

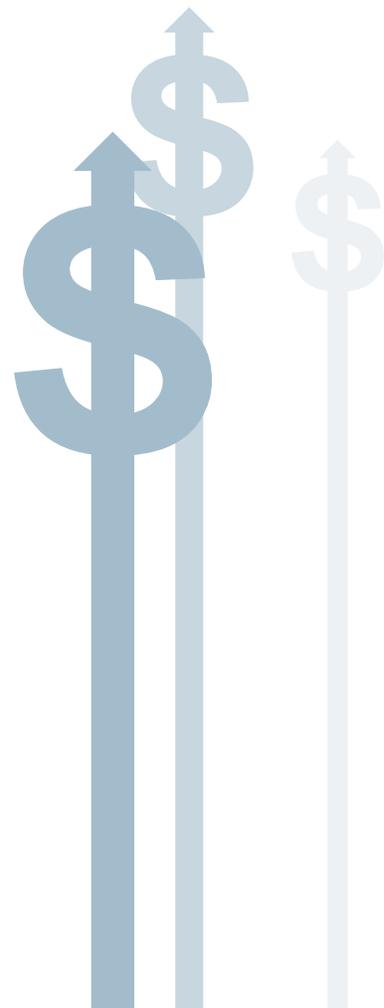
For states that distinguish rates based on age, some differences are nominal (less than \$100) and some are more substantial (\$500 to \$1,000).

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<sup>3</sup> CMS Rate-Setting Guidance

<sup>4</sup> 2016 PACE Medicaid Rate Setting Guide, September 2016

<sup>5</sup> The three states that do not have a distinct Medicaid-only payment are Alabama, Oregon and Wisconsin.



## Rate Setting Based on Geography

Additionally, geographic location is used by multiple states to establish distinct payment rates. Of the 18 states with more than one PACE program, 13 develop distinct rates based on the cost experience in the specific geographic service area of the program. However, North Dakota has one program but different rates based on geography.

**Table 1: States Use Distinct Payment Rate Types**

Distinct Rate Type	Number of States (of 31) Using Rate Type	States
Eligibility Status (Dual, Medicaid-Only)	28	AR, CA, CO, DE, FL, IA, IN, KS, LA, MA, MD, MI, NC, ND, NE, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, WA, WY
Age	7	CO, IA, IN, KS, ND, RI, WA
Geography	13	CA, CO, FL, IA, IN, KS, LA, MI, NY, ND, OK, TX, VA

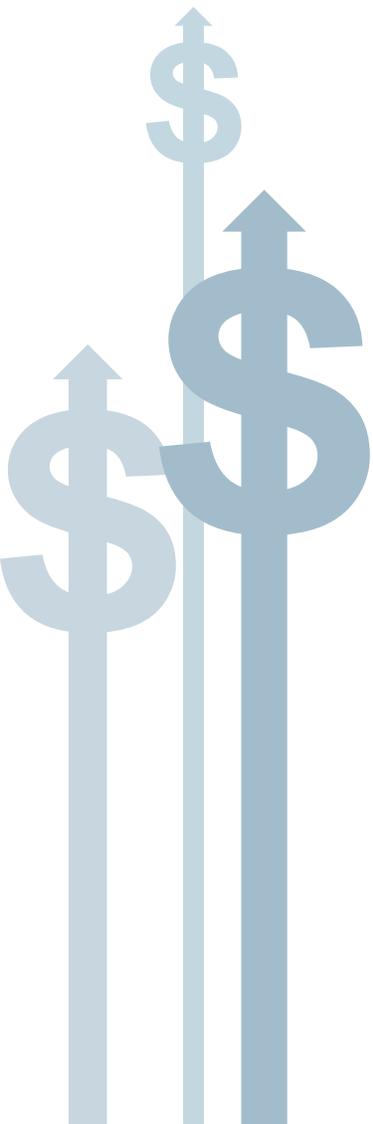
## Future Trends and Practices in Rate Setting

### 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 or at least every three years. Many states that responded for this brief indicated they review and update their UPL and rates, as appropriate, annually or every two years. Two states reported they update the UPL on an annual basis but have not updated the rates in several years, noting that the current rate is still actuarially sound. One state reported it had not updated the UPL in several years but was in the process of reviewing and updating rates for the upcoming fiscal year.

### Shift Away from Fee-for-Service

Most states still base their UPL on Fee-for-Service (FFS) data. However, the number of states switching from the FFS system 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 are diminishing. 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.

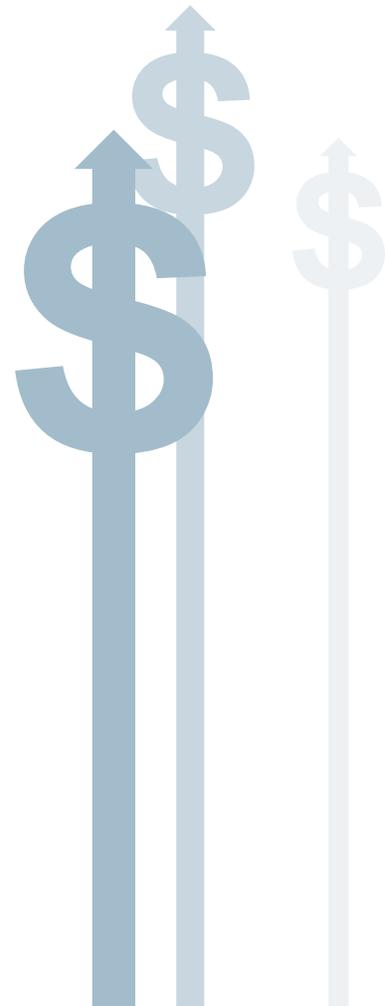


## Alternative Approaches to Rate Setting

As FFS data become less available, states are considering approaches other than using a percentage of the UPL to set rates. For example, California, Florida, New Jersey, New York and Wisconsin have begun using alternative approaches for rate setting. The two alternative approaches states most commonly use are setting rates based on PACE cost and utilization experience and setting them based on MLTSS cost and utilization experience. The approach using PACE experience reflects the actual costs incurred by the PACE program, with adjustments to provide a margin for risk reserves to cover higher than expected costs and in some cases to account for expected “managed care efficiency” (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.

In addition, New York and Wisconsin use risk-adjusted models in their rate setting for MLTSS programs, including PACE. Risk adjustment is a statistical method for modifying capitation rates paid to health plans based on the characteristics (e.g., demographics, coverage, acuity and frailty) of the population they enroll. These characteristics are used to predict the expected costs of providing care to their enrollees. Risk adjustment models have been used for many years by Medicare and Medicaid to adjust rates paid to health plans. Using risk adjustment models for MLTSS programs can account for differences in functional status, a key driver of LTSS costs. Using a risk-adjusted model in developing PACE rates can help reflect the costs of providing care to PACE enrollees based on their characteristics, including frailty.

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



## Rate Setting Recommendations for States

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. Accurate and fair Medicaid rate setting is central to the financial sustainability of PACE organizations, as well as the responsible stewardship of state financial resources. Appropriate rate setting for PACE results in rates that are cost-effective and sustainable for both the state and the PACE program. Therefore, as states set rates, regardless of the methodology, they should consider the following:

- » Payment accuracy can be improved by establishing distinct rate cells for subpopulations within the PACE-eligible population. These distinct rate cells can address differences in costs by age cohort (e.g., under 65), location of care, and coverage status (e.g., Medicaid-only).
- » As states develop risk adjustment models to capture the distinct nature of the PACE population, they should consider factors that include physical frailty and cognitive impairment, behavioral health, substance abuse, disability, clinical complexity, demographic factors and socioeconomic factors.
- » States should establish rates that reflect the comprehensive nature of PACE services. Rates should capture all the services and factors PACE organizations provide, including transportation, meals and home modifications.
- » For states that use cost experience or capitation rates from other managed care options to develop the PACE UPL and rates, the experience should be adjusted to assure that the relative level of financial risk for institutional care between PACE and those alternative options is accounted for in the methodologies applied.

