



Medicare and Medicaid Payment to PACE Organizations

PACE® organizations receive monthly capitated payments from Medicare and Medicaid for each of their dual-eligible enrollees. These payments are pooled by PACE organizations and used to provide program participants the full range of Medicare- and Medicaid-covered services, as well as other services determined necessary to improve or maintain participants' overall health. PACE organizations assume full financial risk for all Medicare Parts A and B and Medicaid-covered services. In addition, Medicare makes payments to PACE organizations for Part D-covered prescription drugs.

A small number of PACE participants are eligible for Medicaid or Medicare but not both. For participants eligible only for Medicaid, PACE organizations receive a single monthly capitation payment from Medicaid that is higher than the Medicaid payment for dual-eligibles. For these individuals, Medicaid is the payer for services that would otherwise be covered by Medicare when furnished to dual-eligibles, including hospital and physician services. For participants who are eligible only for Medicare, PACE organizations receive a monthly capitation payment from Medicare plus a monthly premium from the participant that is equivalent to the Medicaid capitation payment for dual-eligibles. In addition, Medicare-only participants pay a monthly Part D beneficiary premium.

Medicare Rate-Setting Methodology for PACE

Medicare Part A and B payment for beneficiaries without end-stage renal disease (ESRD)

In general, Medicare payments to PACE organizations for Part A and B benefits are based on county payment rates established by the Centers for Medicare & Medicaid Services (CMS), multiplied by PACE participants' individual risk scores. These numeric risk scores are based on each participant's demographic and diagnostic characteristics and, for community-based enrollees, an additional frailty adjuster. The frailty adjuster reflects the overall level of functional impairment reported by the participants of each PACE organization in response to the annual Health Outcomes Survey-Modified (HOS-M) and accounts for variations in Medicare costs not explained by the demographic and diagnostic characteristics of individuals. The following equation represents how each PACE participant's payment is calculated:

$$\text{Part A/B Payment} = \text{PACE County Payment Rate} \times (\text{Diagnostic/Demographic Risk Score} + \text{Frailty Adjuster})$$

Differences between Part A and B payment methodology for PACE organizations and MAOs

Both PACE organizations and Medicare Advantage organizations (MAOs) receive monthly, capitated risk-adjusted payments, but there are significant differences in rate-setting that reflect key differences between the programs:

1. County payment rates published by CMS are the basis for the risk-adjusted payment to PACE organizations. Conversely, MAOs submit bids under Part C. The difference reflects that PACE organizations provide comprehensive, fully integrated benefits inclusive of services covered by Medicare and Medicaid and that a bid based only on Medicare-covered services is inconsistent with the nature and objectives of the PACE model. The explicit objective of PACE organizations is to avoid the need for high-cost, often inpatient care by providing a greater range and intensity of services in the community. Relying on a bid that includes only Medicare-covered services is not an equitable basis for payment.

2. PACE county payment rates are calculated under the methodology used before the enactment of the Affordable Care Act (ACA) – the greater of the prior year’s county payment rate trended forward or per capita fee-for-service cost. PACE county payment rates are not equivalent to the rates determined under the blended benchmark methodology used for MAO payment. Current benchmarks compensate for inadequacies in risk adjustment for the Medicare beneficiaries eligible to enroll in PACE – those with multiple complex chronic conditions and physical and/or cognitive impairment. In addition, PACE organizations currently are not eligible for quality bonus payments under the statute, unlike MAOs.
3. Because the CMS hierarchical condition categories (CMS-HCC) risk-adjustment model does not adequately account for Medicare costs related to functional impairment, the payment calculation of PACE organizations includes a frailty adjuster. This is necessary due to the nature of PACE participants, who meet state eligibility criteria for nursing home level of care. The majority have significant levels of functional impairment. (Note: Frailty adjustment is a component of payment for a small subset of MAOs. These fully integrated dual eligible special needs plans have average levels of frailty similar to PACE.)

Medicare Part A and B payment for ESRD beneficiaries

For purposes of calculating Medicare payment, enrollees with ESRD are divided into three categories: dialysis enrollees; transplant enrollees; and functioning graft enrollees who have undergone a successful transplant. PACE organizations, unlike MAOs, enroll beneficiaries with ESRD. Like MAOs, they continue to serve beneficiaries who develop ESRD while enrolled. The payment methodology for PACE and MAOs for beneficiaries with ESRD is very similar. For beneficiaries on dialysis, a statewide ESRD rate is risk-adjusted to reflect individual-level demographic and diagnostic characteristics. For beneficiaries receiving a transplant, higher payments are made over a three-month period to reflect the costs associated with transplant. Payments for functioning graft enrollees who have undergone successful kidney transplants are based on the risk-adjusted county payment rates of PACE organizations.

Part D

The Part D payments of PACE organizations are based largely on the Part D payment methodology used for all Medicare prescription drug plans. Like MAOs, PACE organizations submit Part D bids. For their dual-eligible enrollees, they receive risk-adjusted monthly subsidy payments and reinsurance and low-income cost-sharing subsidies from CMS. They also receive premium and cost-sharing add-ons because PACE organizations are prohibited from charging Medicaid-eligible enrollees premiums or cost-sharing amounts. For Medicare-only beneficiaries, PACE organizations receive risk-adjusted monthly subsidy payments from Medicare and monthly Part D premiums from beneficiaries. No reinsurance payments are made on behalf of Medicare-only PACE enrollees, however, because under PACE requirements they are unable to pay cost-sharing amounts that trigger reinsurance payments.

Medicaid Rate-Setting Methodology for PACE

Medicaid rates are set by states in consultation with PACE organizations and reviewed by CMS to assure they are consistent with federal requirements. In general, states calculate Upper Payment Limits (UPLs) – monthly per-capita expenditure amounts – on the basis of their expenditures for fee-for-service populations comparable to PACE, typically nursing home-eligible populations consisting of nursing home residents and home and community-based waiver recipients. Some states set the PACE rate as a percentage of the UPL. Others use an alternative rate-setting approach, e.g., the rate is based on the cost experience of PACE organizations. The PACE rate must never exceed the UPL. In years when the state does not recalculate its UPL, the PACE rate is trended forward. However, recent trends have yielded stagnant or even declining payment rates in many states as they struggle with growing numbers of Medicaid-eligibles, rising health care costs, and stagnant or declining revenues. According to a recent analysis by NPA, PACE programs save Medicaid an average of 15 percent relative to the costs the state would have incurred otherwise (see *Upper Payment Limits and Medicaid Capitation Rates for Programs of All-Inclusive Care for the Elderly*).