



## Model Policy: Rate Setting

### Overview

Unlike insurer-based health plans, which rely primarily on contracted provider networks, PACE organizations represent a provider-based model with an interdisciplinary team of health professionals who have a direct care relationship with the enrollee. PACE organizations also differ from most insurer-based managed long-term services and supports health plans in bearing full financial risk, without a capitation rate adjustment, for enrollees who require a long-term nursing facility placement. PACE enrolls *only* the frailest beneficiaries, specifically those who meet their state's eligibility criteria for nursing home level of care and require comprehensive, ongoing and intensive services to meet their chronic health and long-term care needs.

Federal law requires that states make a prospective monthly capitation payment to a PACE organization for a Medicaid participant which:

- Is less than what would otherwise have been paid under the state plan if not enrolled in PACE;
- Considers comparative frailty of participants;
- Is a fixed amount regardless of changes in a participant's health status.

Accurate and fair Medicaid rate setting is central to the financial sustainability of PACE organizations as well as the responsible stewardship of states' financial resources. Appropriate rate setting for PACE results in rates that are cost-effective and sustainable for both the state and the PACE program.

### Model Policy

This [bill/regulation] would require the state to establish adequate payment rates and sustained funding that supports the growth of existing PACE organizations and the development of new PACE organizations.

- A. When the state is identifying comparable populations, states should consider factors including, but not limited to: physical frailty and cognitive impairment, disability, clinical complexity, demographic factors, and socioeconomic factors.
- B. The state should establish rates that reflect the comprehensive nature of PACE services. Rates should capture all the services PACE organizations provide including, but not limited to: transportation, meals, and home modifications.<sup>1</sup>
- C. As states allow pass-through payments for new managed care enrollment or services during a transition period, the state must account for these payments when establishing the upper payment limit for PACE.
- D. Should the state use cost experience or capitation rates from other managed care options to develop the PACE upper payment limits and rates, the experience should be adjusted to assure

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<sup>1</sup> See Appendix A for additional benefits offered by PACE organizations.

that the relative level of financial risk for institutional care between PACE and those alternative options is accounted for in the methodologies applied.

- a. States should establish rates that:
    - i. Recognize and provide allowances for capital costs required to build, maintain, and expand PACE centers.
    - ii. Reflect inherent risk associated with serving exclusively a high-needs population.
    - iii. Recognize the costs of complying with managed care reporting and other administrative requirements.
  - b. If the state allocates MCOs with additional funding for certain services that PACE organizations already provide (e.g. additional care management or additional assistance for beneficiaries transitioning into housing), that additional funding should be accounted for in the PACE UPL and rates.
- E. Should the state have other integrated care options for people of all ages, the state will make the appropriate age adjustments in order keep rates comparable across options.

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<sup>i</sup> This policy is based on several best practices and more of compilation of what some states are doing. No one state is currently doing all of this.

## Appendix A – PACE Services

- Adult day health services
- Alternative care such as massage and acupuncture
- Audiology
- Dental services
- Emergency care
- End of life services
- Hospital and nursing facility services
- Transportation
- In-home care
- Lab and x-ray services
- Meals
- Medical specialists
- Mental health services
- Nursing and medical coverage 24 hours per day 365 days per year
- Nursing care
- Optometry services and eyeglasses
- Personal care
- Pharmaceuticals
- Primary medical care
- Recreational and socialization activities
- Rehabilitation services: physical therapy, occupational therapy, speech therapy, and restorative
- Social services
- Specialized medical equipment (e.g. ramps to ease access in and out of a home)
- Other services as determined by the Interdisciplinary Team