Updated CMS guidance on Medicaid rate setting for PACE organizations: Key changes and implications

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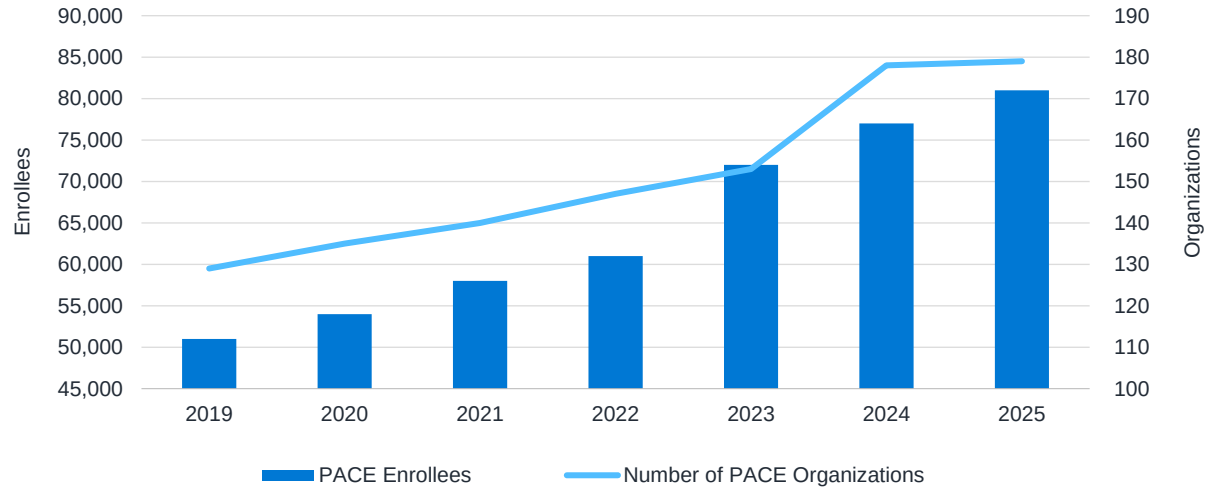
On December 6, 2024, the Centers for Medicare and Medicaid Services (CMS) published an update to existing guidance concerning Medicaid rate setting for Program of All-Inclusive Care for the Elderly (PACE) organizations.[1] This is the first update to PACE Medicaid rate setting guidance since CMS last issued guidance in 2015. The guidance serves as a resource for states and the states' actuaries in developing and documenting the development of PACE Medicaid capitation rates. Key changes outlined in the updated rate setting guide include clarification around the use of fee-for-service (FFS) and managed care data, considerations and adjustments to be used when developing the amount that would have otherwise been paid (AWOP), guidance on retrospective rate adjustments, and enhanced documentation requirements. This article provides a high-level overview of the new guidance, as well as background on the PACE program and its payment sources.

PACE overview

The PACE program is a fully integrated Medicare and Medicaid program to provide community-based care to individuals age 55 and over who meet the nursing home level of care criteria as defined by their state's state plan amendment (SPA). PACE programs are composed of organizations providing comprehensive, community-based healthcare services under an integrated, interdisciplinary team primarily through adult day health centers. The penetration of PACE programs varies by geography, and there has been substantial growth in PACE enrollment and in the number of PACE organizations in recent years. The chart below illustrates the growth in total PACE enrollment[2] and the number of PACE organizations from 2019 through January 2025.[3]

FIGURE 1: PACE PROGRAM GROWTH – 2019 THROUGH JANUARY 2025

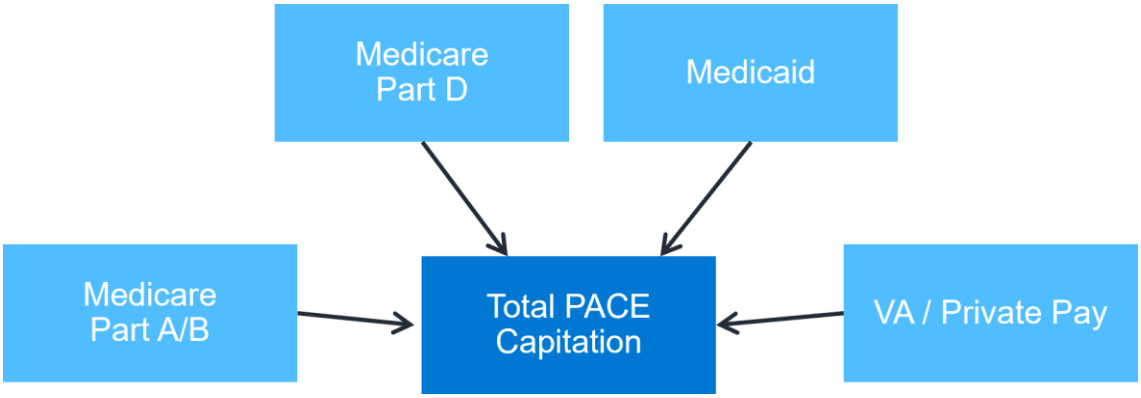


1. CMS-10398 #84. (December 6, 2024). Centers for Medicare and Medicaid Services. Available from www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing/cms-10398-84.
2. A Look at PACE Growth by the Numbers: States, Organizations, and Enrollment. (July 2024). ATI Advisory. Retrieved March 4, 2025, from https://atiadvisory.com/resources/a-look-at-pace-growth-by-the-numbers-states-organizations-and-enrollment.
3. PACE in the States. (January 2025). National PACE Association. Retrieved March 4, 2025, from www.npaonline.org/docs/default-source/public-files/public_pace_in_the_states_1.25.pdf?sfvrsn=fe60d706_1.

PACE financing overview

PACE organizations receive most of their revenue through federal and state capitated payments and take significant risk for the ultimate service costs incurred by their members. The revenue received by PACE organizations for each member varies based on whether they are enrolled in both Medicare and Medicaid (dually eligible) or they are only enrolled in Medicaid. Additionally, a small number of members are Medicare-only. These members are responsible for monthly premiums, which cover the long-term care portion of the PACE benefit and Medicare Part D drugs. As of 2021, 84% of PACE members were dually eligible.[4] For members enrolled in both Medicare and Medicaid, each program pays a prospective monthly capitation rate to the PACE organization. The Medicare capitation rate, paid by CMS and financed by the federal government, covers most acute care services and prescription drug coverage, as well as limited home health and skilled nursing facility services. Medicare does not cover most of the long-term services and supports (LTSS) that PACE members receive. The Medicaid capitation rate, paid by the state and jointly financed by the federal and state governments, covers Medicaid-covered services not otherwise covered by Medicare, including LTSS, dental care, non-emergency medical transportation, and other ancillary services. In addition, the Medicaid capitation rate covers Medicare cost-sharing amounts, and the Medicaid agency covers Medicare premiums outside of the capitation rate. This leaves PACE members with no out-of-pocket costs for PACE-provided services beyond the member's Medicaid share of cost in the event the member's income exceeds the state's Medicaid threshold. For members not enrolled in Medicare, the Medicaid capitation rate covers the full package of PACE-covered services with no out-of-pocket costs for the member. In FY 2023, approximately 60% of the PACE program revenue was provided through the Medicaid capitation rate and approximately 40% through Medicare capitation rates, including Part A/B and Part D. A small portion of PACE financing comes from the Department of Veterans Affairs and enrollees paying privately.[5]

FIGURE 2: PACE FINANCING OVERVIEW



While Medicare capitation rates for non-pharmacy services are based on a uniform formula and methodology across the country, the methodology for developing Medicaid capitation rates is unique to each state and is outlined in that state's SPA, which is submitted to CMS. Medicaid capitation rates are required to be cost-effective, meaning that capitation rates result in lower costs to the state compared to what the state would otherwise incur for a comparable population receiving coverage through the state's alternate service delivery programs. In CMS rate setting guidance, this is referred to as the AWOP and previously referred to as the upper payment limit (UPL).

4. O'Gara, B. & Gerber, D. (September 19, 2024). Understanding the Program of All-Inclusive Care for the Elderly Model. Medicaid and CHIP Payment and Access Commission. Retrieved March 4, 2025, from www.macpac.gov/wp-content/uploads/2024/09/04_September-Slides_Understanding-the-Program-of-All-Inclusive-Care-for-the-Elderly-PACE-Model-1.pdf.

5. NPA FY 2023 PMPM Benchmarking Report (available to members of the National PACE Association)

There are a variety of different methodologies for determining the prospective Medicaid capitation rate ultimately paid to PACE organizations outlined in the updated rate setting guidance. The state is required to demonstrate that the ultimate capitation rate is lower than the AWOP. As outlined in the new rate package checklist included in the updated rate setting guidance, state agencies are required to establish the Medicaid rate setting methodology as part of the SPA submitted to CMS and the actuary must then confirm the capitation rates are developed consistently. The two most common approaches are experience-based rates and rates that are a percentage of the AWOP.

- Experience-based rates will use historical PACE experience directly in rate setting and will rely on a variety of data sources (including PACE program experience, experience in similar programs, and state and national trends) to project future experience for the PACE organization. Non-benefit costs are set to reflect the administrative and profit requirements of the PACE organization. This experience-based rate is required to be lower than the AWOP for each rate cell.
- Alternatively, states can elect to set the capitation rates as a percentage of the AWOP. Generally, the percentage used is based on a negotiation with the PACE organizations. This percentage is always less than 100% in order to produce a rate below the AWOP.

Each of these mechanisms allows the state some level of flexibility to account for unique challenges or situations that may impact a PACE organization during the contract year, such as high initial start-up program costs in the initial years of operation. The final capitation rate must be lower than the AWOP, regardless of any specific consideration or treatment given.

CMS rate setting guidance—update overview

The updated rate setting guide provides guidance on both the calculation of the AWOP and the calculation of the Medicaid capitation rate and reflects the significant differences in Medicaid's long-term care landscape between the previous guide and today. In particular, states have expanded the use of managed care delivery mechanisms for LTSS coverage and have expanded coverage of home- and community-based services (HCBS). Increasingly, states have relied on experience under these managed care programs to develop the AWOP rather than data under the states' FFS delivery mechanisms. CMS has provided improved guidance on the use of managed care encounter data and managed care plan financial data in AWOP development. Additionally, CMS has outlined documentation required to be provided as part of Medicaid rate submissions, including additional technical documentation of the AWOP and capitation rate calculation.

The rate setting guide is effective for all rate submissions starting January 1, 2025. Separate guidance is provided for the AWOP calculation and the capitation rate calculation. The updated guidance includes new documentation requirements such as the rate package cover sheet and checklist that must accompany the PACE rate package. CMS continues to not require (but does encourage) an actuarial certification for the AWOP and Medicaid capitation rate. States are required to include actuarial documentation and follow actuarial standards of practice (ASOP).

CMS rate setting guidance—calculation and documentation of the AWOP

CMS requires that PACE organizations provide comprehensive care in an efficient and cost-effective manner. Cost-effectiveness is measured relative to the costs that the Medicaid program would incur for PACE enrollees in the absence of the PACE program, referred to as the AWOP. States and their actuaries are required to demonstrate that the final capitation rate is below this AWOP. The AWOP should be established prospectively and is effective for a period of no more than 12 months. The AWOP must be regularly recalculated.

BASE DATA CONSIDERATIONS

CMS provides flexibility for states to consider what sources of data are used as part of the AWOP, as clarified in the updated rate setting guide. This can include experience under the state's FFS delivery mechanism, managed care plan encounter data, or managed care plan financial data. States with a high proportion of PACE-eligible individuals enrolled in managed LTSS programs are encouraged to use data from these programs. In CMS's Frequently Asked Question (FAQ) document included with the updated rate setting guide, they state that in some situations, it may be necessary to supplement this data with FFS data if a significant cohort of PACE-eligible individuals are not covered

under the managed care program or if there are PACE-covered services that are covered under FFS instead of managed care. Justification for the reliance on Medicaid managed care data, how the data is incorporated in the AWOP calculation, and the actuarial rate certification associated with the Medicaid managed care program (if applicable) must be provided in the PACE rate setting documentation.

The updated rate setting guide specifies the base data used—either FFS data or the encounter or financial data underlying the associated managed care capitation rates—must be at most three years old, as measured from the midpoint of the most recent 12-month period in the base data and the midpoint of the period for which the AWOP is effective.

Regardless of the source of the base data, the underlying population must be adjusted to reflect the characteristics of the PACE-eligible population. Any data that includes a broader population than what is defined under PACE eligibility should be adjusted to reflect the age, comparative frailty, and geography of a PACE-eligible population. In the FAQ document, CMS outlines examples of base data adjustments:

- The base experience data may need to be adjusted to remove members that would not otherwise be eligible for PACE.
- States may need to consider adjustments to the AWOP to account for the frailty level of the PACE-eligible members. This may include the impact to the intensity of care required due to differences in frailty level between members in each program, and to account for long-term nursing facility placement rates for PACE-eligible individuals.
- The population mix of community and long-term nursing facility members used in the base data should reflect the mix that is expected for the PACE-eligible population.

Adjustments should be made to ensure all state plan services are reflected in the base data. Importantly, PACE does not allow benefit carve outs—all state plan and waiver services must be covered under the Medicaid capitation rate. This may mean relying on state FFS data for any services that are carved out of the state's managed care program.

FFS BASE DATA

CMS does not prescribe the specific base data source used when developing the AWOPs, and only asserts that the actuary should select the highest-quality data source. For those states that either do not provide LTSS under a managed care arrangement or where the scope and coverage of the managed care program is limited, the actuary will need to rely on experience from the state's FFS program. Adjustments are required in order to align this base period experience with the contract period for the PACE capitation rate. This includes utilization and unit cost trend, as well as adjustments for programmatic changes impacting the state's FFS program.

The FFS base data used should reflect provider reimbursement levels consistent with the FFS program payments. Generally, this is based on the state's FFS fee schedule. The AWOP should be adjusted for any changes to this fee schedule expected from the base period to the contract period of the PACE capitation rate. It should not be adjusted to account for differences in reimbursement levels between the state's FFS program and the PACE organizations. However, the actuary may consider differences in reimbursement rates between the state's FFS program and PACE organizations in calculating the capitation rate, so long as the resulting capitation rate is below the AWOP.

State FFS data may need to be supplemented to account for any costs of providing PACE-covered services incurred by the state and not paid on an FFS basis. This includes supplemental and/or retrospective provider payments directly attributable to utilization by the FFS population.

Additional adjustments applicable to the AWOP development and outlined in the updated rate setting guide include:

- Claims incurred that have not yet been paid (IBNR)
- Payments/recoupments not processed through the state's encounter system
- Retrospective eligibility costs
- FQHC/RHC cost settlements
- Disproportionate Share Hospital (DSH) payments
- Graduate medical education (GME)
- Pharmacy rebates
- Third-party liability (TPL) payments
- Patient liability
- Copayments

MANAGED CARE PROGRAM BASE DATA

As states have increasingly moved to managed care programs to provide long-term care services, states and their actuaries have increasingly used managed care experience in calculating the AWOP. The CMS rate setting guide lists both managed care encounters and managed care financial reporting as acceptable sources of base data. In practice, the development of the AWOP for PACE uses as its basis the managed care capitation rates, which are developed using managed care encounters and managed care financial reporting. Many of the adjustments required to use historical data in calculating the AWOP have already been made as part of the managed care capitation rate setting. This includes:

- Factors used to project base period experience from the base data period to the managed care contract period, including utilization trend, unit cost trend, and programmatic changes. In the event there is a difference between the contract period of the managed care capitation rates and the period the AWOP is covering, an adjustment to these projection factors may be needed.
- Adjustments to base period experience to account for certain state-directed payments, including state-directed payments mandating a minimum or maximum fee schedule for certain services or providers. While PACE organizations are not subject to these directed payment arrangements, their impact must still be included in the AWOP calculation. The actuary may consider the impact of these arrangements in calculating the capitation rate, so long as the resulting capitation rate is below the AWOP.

In certain situations, managed care organizations (MCOs) receive retrospective revenue separate from the prospective capitation rate. This includes state-directed payments paid retrospectively or incentive payments made under the managed care contract. The AWOP is required to be adjusted to include an estimate of the ultimate value of any retrospective payment made to managed care plans. If any of these arrangements do not apply to the PACE organization, the actuary may consider excluding these amounts as part of the PACE capitation rate calculation.

CMS requires additional documentation when the AWOP is developed using managed care data, including the percentage of the PACE-eligible population enrolled in managed care versus FFS, documentation of the eligibility and benefit coverage differences between the managed care program and PACE, and the actuarial certification of the managed care capitation rates.

NON-BENEFIT COSTS

The AWOP may include non-benefit costs that are incurred by the state in the absence of a PACE program. Non-benefit costs included in the AWOP should only include state costs for administering the underlying program, which may include the administrative costs and profit margin already included in the capitation rates paid to Medicaid managed care plans for PACE-eligible individuals that are not enrolled in PACE or the state's costs to administer the FFS program. The administrative cost component of the AWOP should not consider administrative costs, dynamics, or requirements specific to PACE organizations.

CMS rate setting guidance—Medicaid capitation rate development

The rate setting guide provides specific guidance on setting the ultimate Medicaid capitation rate paid to each PACE organization. The capitation rate must meet three criteria:

- The capitation rate must be less than the AWOP.
- The capitation rate must take into account the comparative frailty of PACE members.
- For each member, the amount must be fixed regardless of changes in that member's health status.

Capitation rates can be developed separately for various rating characteristics. These characteristics commonly include the Medicare eligibility, age, and geographic service area. CMS requires that the AWOP be calculated using the same rate cell combinations used in PACE capitation payments, and that the state demonstrates that the AWOP exceeds the PACE capitation rate for each rate cell.

As outlined in the updated guidance, the PACE capitation rate must be effective for a period of at least 12 months, and no more than two years. However, the AWOP can only be calculated for a period no longer than 12 months. If a capitation rate is effective for a period longer than 12 months, the actuary must develop separate AWOPs for each year within the rating period. This new AWOP calculation will require an updated base data period if the data does not satisfy the three-year requirement outlined in the rate setting guide, as well as updated prospective adjustment factors, including service cost trend.

PACE capitation rates are required to be fully prospective in nature, and PACE organizations must be at full financial risk. PACE contracts cannot include retrospective arrangements such as quality withholds or retrospective supplemental provider payments. CMS does not allow risk sharing or risk mitigation arrangements between the state and PACE organizations, even if a risk mitigation mechanism is present in the managed care program used in the AWOP development. If a risk mitigation mechanism or other retrospective arrangement is present in the managed care program, the AWOP should be adjusted to reflect the projected associated payment or recoupment. Generally, this has no impact as most risk mitigation measures, with the notable exception of risk corridors, are designed to be revenue neutral. Under the updated guidance, states are allowed to include incentive arrangements as part of the PACE program, where the payments under the incentive program would occur after the conclusion of the contract period. Importantly, the total payment to the PACE organization, including both the capitation rate and the incentive payment amount, must be below the AWOP.

The updated rate setting guidance provides for more flexibility regarding mid-year changes to capitation rates. Historically, CMS has not allowed states to adjust PACE capitation rates during or after the conclusion of the contract period for any reason. Under the updated guidance, CMS will allow mid-year updates to PACE rates for unanticipated changes in costs, including legislated provider rate changes that impact PACE organizations. CMS requires states to provide justification for the mid-year rate change in advance and must give approval for a rate change before the state can calculate the rate update and submit the rate package to CMS.

Conclusion

The updated PACE Medicaid Capitation Rate Setting Guide is a significant update to existing guidance. It provides additional clarity around the use of managed care and FFS experience and adjustments related to both program eligibility and population acuity expected in both the AWOP and capitation rate development. Additionally, it provides limited flexibility for mid-year capitation rate updates and enhanced documentation requirements. State Medicaid agencies and their actuaries will need to assess how this new guidance might affect their current AWOP and capitation rate development processes and begin to identify necessary changes or new tasks to ensure compliance with future rate development within the required time frames.

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