

PACE Medicaid Capitation Rate Setting Guide

Effective January 1, 2025

The Centers for Medicare and Medicaid Services (CMS) is releasing an update to the December 2015 PACE Medicaid Capitation Rate Setting Guide. This updated guide (effective January 1, 2025) is intended to serve as a resource for states related to their activities in development of PACE Medicaid Capitation rates under the Programs of All-inclusive Care for the Elderly (PACE).

States should continue to submit their proposed rates and supporting documentation to the CMS PACE rates mailbox (PACERateActions@cms.hhs.gov) for review and approval. States should complete and include the PACE AWOP & Rate Package Submission Cover Sheet (provided in Appendix B of the guide) in their submissions. The CMS analyst reviewing the rates will continue to work with the state during the review process and request any additional information as needed. Once approved, CMS will notify the state in writing of approval of the rates. The state must then notify the PACE organization(s) in writing to confirm the rates and effective dates.

In order for CMS to determine if the proposed PACE rates are consistent with the PACE Medicaid rate requirements of 42 CFR 460.182, it is important that the information outlined in this guide be supported in the rate documentation that is submitted to CMS.

Please note that rates must be approved by CMS prior to approval of a PACE application for a new organization.

The guide includes critical elements of rate setting that incorporate both the state development of the amount that would have otherwise been paid if individuals were not enrolled in PACE, and development of the PACE rates. This document may continue to be updated in the future to provide more detailed clarification in certain areas when necessary.

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Background

The Program of All-inclusive Care for the Elderly (PACE) is a fully integrated Medicare program and Medicaid state plan option that provides community-based care and services to people aged 55 or older who meet a state's nursing home level of care criteria. Federal regulations at 42 CFR 460.182 require that states make a prospective monthly capitation payment to a PACE organization for a Medicaid participant enrolled in PACE which:

- Is less than the amount that would have otherwise been paid (AWOP) under the state plan if not enrolled in PACE;
- Takes into account comparative frailty of participants;
- Is a fixed amount regardless of changes in a participant's health status.

To assist states in preparing PACE rates, CMS has developed a set of critical elements that should be considered as part of the rate development process and an associated set of questions that should be addressed in writing and submitted by states as part of their PACE rate setting packages.

The PACE rate setting package must include:

- PACE AWOP & Rate Package Submission Cover Sheet (see Appendix B)
- AWOP and PACE rates by rate cell for the rating period
- Supporting documentation

States must submit PACE rate documentation to CMS for review that addresses these critical elements. Documentation is reviewed against regulatory requirements and this guidance. Additional information is requested as needed.

The critical elements of rate-setting include the following:

1. Development of the amount that would have otherwise been paid (AWOP) and the required documentation:
 - a. Identify the AWOP separately by rate cell
 - i. The AWOP is calculated on a per member per month basis and includes all Medicaid covered services for the eligible population
 - ii. Demonstrate basis for rate cells applied
 1. Separate rate cells may be used to more accurately project amounts that would have otherwise been paid.
 2. Rate cells can vary by age, gender, geographic region, eligibility category, Medicare status
 3. Rate cells should not cross-subsidize payments in another cell.
 - b. Identify the future effective date for the projected AWOP

- i. The AWOP should be established prospectively
 - ii. The AWOP should be calculated for a period no longer than 12 months. Mid-year changes to the AWOP are not allowed without CMS's prior approval.
 1. CMS recognizes there may be unanticipated changes in costs and conditions during the year, but it is the expectation that those changes would be addressed by the state during the next rate period. In limited circumstances, CMS may consider a mid-year update to the AWOP in circumstances such as mandated across the board state legislative rate changes to be effective on a specific date that is within the rate period already approved. States are required to submit documented justification for a mid-year change to the AWOP in writing to CMS for approval prior to submitting a revised rate package to CMS for review.
 - iii. For rates that are effective longer than 12 months, separate AWOPs must be calculated, so that each AWOP is no longer than 12 months.
 1. States must submit separate AWOPs for each year of the proposed rating period at the time of the submission.
- c. Describe how the state determined the AWOP under the state plan
- i. Base period data used,
 1. Demonstrate that cost and utilization data used is reflective of the population consistent with frailty and age of PACE participants
 2. Acceptable data may include fee for service (FFS) experience, managed care plan encounter data, managed care plan financial data and reports
 3. Document how the base data was reviewed and validated, along with any concerns related to the quality of the data and steps being taken to enhance data quality
 4. Clearly identify the time period of the base data used - most recent available year of data should be used, but should not be more than 3 years older than the rating period.
 - ii. Provide a narrative description of the data, assumptions and methodologies used to develop every adjustment, factor and cost applied to the base data used for the AWOP. Explanations should be provided for all adjustments, factors and costs listed below, including those that are not applicable:
 1. Completion factors applied (such as any adjustments to account for claims that have been incurred but have not yet been paid).
 2. Adjustments applied, including:
 - a. Payments/Recoupments not processed through the MMIS
 - b. Retrospective eligibility costs
 - c. FQHC/RHC cost settlements
 - d. Disproportionate Share Hospital Payments
 - e. Graduate Medical Education
 - f. Pharmacy rebates
 - g. Third Party Liability Payments

during the next rate period. In limited circumstances, CMS will consider a mid-year update to the PACE rates in circumstances such as mandated across the board state legislative rate changes. States are required to submit documented justification for a mid-year change to the PACE rates in writing to CMS for approval prior to submitting a revised rate package to CMS for review.

- d. PACE organizations must be at full financial risk. Risk sharing and other risk mitigation mechanisms are not permitted for PACE.
- e. Include additional documentation needed for CMS to make a determination of compliance with requirements.
 - i. Comparison of the PACE rates to the AWOP by rate cell
 - ii. Documentation of any incentive arrangements
 1. Describe how the arrangement is implemented.
 2. Quantify the incentive payments' expected impact on PACE rates.
 3. Provide the expected amount of the incentive payment and demonstrate that the sum of the PACE rate and the incentive payment is below the AWOP for each rate cell.
 4. States are not required to submit additional documentation of the final incentive payments made to PACE plans, but the state must make sure:
 - a. The actual payments made are equal to or below the expected amount of the incentive payment included in the approved rate package.
 - b. The total PACE capitation rate plus actual incentive payments made are below the AWOP for each rate cell in the approved rate package.
 - iii. Projected member months for each rate cell
3. While federal regulations at 42 CFR 460.182 do not require an actuary to certify the amounts that would have otherwise been paid or the payment rates paid to PACE organizations, CMS encourages states to submit an actuarial certification with their rate package. If an actuary provides a certification, the rate review package should contain adequate actuarial documentation to support the data, assumptions and methodologies used. The actuary should provide sufficient documentation as described by the Actuarial Standards of Practice.