

# **Programs of All-Inclusive Care for the Elderly (PACE)**

## **Chapter 13 – Payments to PACE Organizations**

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## **10 - Introduction**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

This chapter gives an overview of the policies and methods CMS follows in determining the amount of payment a PACE organization will receive for coverage of benefits for PACE participants who are enrolled in their plan as provided by 42 CFR § 460.180 of the PACE Regulations. In addition, this chapter outlines PACE organization responsibilities, payers, premiums, and Medicare Part D.

### **10.1 - General Payment Principles**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

The following basic principles distinguish the PACE financing model:

- Obligation for payments is shared by Medicare, Medicaid, and individuals who do not participate in Medicare and Medicaid;
- Medicare, Medicaid, and private payments for acute, long-term care, and other services are pooled;
- The capitation rates paid by Medicaid are designed to result in cost savings relative to expenditures that would otherwise be paid for a comparable nursing facility-eligible population not enrolled under the PACE program;
- Medicare rates are pre-Affordable Care Act (ACA) rates, unadjusted for Indirect Medical Education (IME), and adjusted for risk and frailty;
- The PACE organization accepts the capitation payment amounts as payment in full from Medicare and Medicaid.

[71 FR 71318 (Dec. 8, 2006)]

## **20 - PACE Organization Responsibilities**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

PACE organizations are paid monthly prospective payments for each eligible enrolled PACE program participant in accordance with Sections 1853 and 1894(d)(1) of the Act. For Medicare Part A-only participants who are also eligible for Medicaid, the State is obligated to pay some Medicare Part B premiums under Section 1902(a)(10) of the ACT.

The PACE organization is required to do the following:

- Verify at time of enrollment whether the participant is dually eligible for Medicare and Medicaid and whether the participant has Medicare Part A and/or Part B;

- Remind participants that unless they are dually eligible, they will need to continue to pay their Medicare Part A premium, if not free, Part B (if not eligible for State coverage) and/or Part D premiums, if applicable;
- Submit risk adjustment/encounter data (when applicable) to CMS;
- Identify payers that are primary to Medicare;
- Determine the amounts payable by those payers;
- Coordinate benefits to Medicare participants with the benefits of primary payers.

[42 CFR §§ 460.150, 460.152(a), 460.180; 71 FR 71309, 71318; (Dec. 8, 2006)]

### **30 - Payment Methodology**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

#### **30.1 - Part A and Part B of Medicare**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

CMS makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicare participant in the payment area. Prospective payments are made up of the pre-ACA county rate, unadjusted for Indirect Medical Education (IME), and multiplied by the sum of the individual risk score and the organization frailty score. This payment methodology is described in the PACE program agreement. The following three sections provide a brief description of PACE payment and the differences between PACE payment and payment for other Medicare Advantage plans.

#### **30.2 – County Rates**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

The prospective payment rates for PACE are based on the applicable amount under section 1853(k)(1) of the Act, unadjusted for IME. The applicable amount is the pre-Affordable Care Act rate, which will be phased-out under the Affordable Care Act for other Medicare Advantage plans. The applicable amount will not be phased out for PACE. In rebasing years, this rate is the greater of: 1) the county's FFS rate for the payment year or 2) the prior year's applicable amount increased by the payment year's National Per Capita Medicare Advantage Growth Percentage. In non-rebasing years, this rate is the prior year's applicable amount increased by the payment year's National Per Capita Medicare Advantage Growth Percentage.

Section 1853 (k)(4) of the Act requires CMS to phase out Indirect Medical Education (IME) amounts from MA capitation rates. PACE programs are excluded from the IME payment phase- out under that section.

Effective CY 2006 and subsequent years, CMS makes advance monthly per capita payments for aged and disabled enrollees based on the bidding methodology established by the MMA. PACE plans are not required to bid, however.

### **30.3 – Risk Adjustment**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

For the final payment rate, the county rate for the PACE organization is multiplied by the individual participant risk score. Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries. The individual participant risk score for Medicare Advantage and PACE is calculated using the CMS–HCC model (community, long-term institutionalized, End-Stage Renal Disease (ESRD) or new enrollee) published in the Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (Rate Announcement).

A frailty factor is added to each individual’s risk score for PACE plan payment. Risk adjustment predicts (or explains) the future Medicare expenditures of individuals based on diagnoses and demographics. But risk adjustment may not explain all of the variation in expenditures for frail community populations. The purpose of frailty adjustment is to predict the Medicare expenditures of community populations with functional impairments that are unexplained by risk adjustment. The frailty score added to the beneficiary’s risk score is calculated at the contract-level, using the aggregate counts of ADLs among HOS-M survey respondents enrolled in a specific organization. More information regarding the HOS-M can be found in Chapter 10, Section 30.7. Because the CMS-HCC model has been designed to pay appropriately for the long-term institutionalized population, frailty adjustments are added to the risk scores only for community-based and short-term institutionalized enrollees (i.e., the frailty adjustment for long-term institutionalized enrollees is zero). Updated frailty factors are published in the Rate Announcement for the payment year in which they are first used.

### **30.4 – Additional Payment Information**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

For additional, more detailed information about PACE Medicare payment, see the following documents:

- Risk Adjustment, Chapter 7, Medicare Managed Care Manual. <http://www.cms.gov/manuals/iom/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326&intNumPerPage=10>
- Payments to Medicare Advantage Organizations, Chapter 8, Medicare Managed Care Manual. <http://www.cms.gov/manuals/iom/itemdetail.asp?filterType=none&filter>

[ByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326&intNumPerPage=10](#)

- CMS publishes changes to the Medicare Advantage payment methodologies in the Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Advance Notice) in mid February at <http://www.cms.gov/MedicareAdvtgSpecRateStats/> for public comment. The final payment methodologies are published in the Announcement of Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (Rate Announcement) on the first Monday in April at the same website.

[42 CFR § 460.180(a) through (c); 71 FR 71318 through 71319 (Dec. 8, 2006)]

### **30.5 - Medicare Part D Payment**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

In order for PACE organizations to continue to meet the statutory requirement of providing prescription drug coverage to their enrollees, and to ensure that they receive adequate payment for the provision of Part D drugs, beginning January 1, 2006, PACE organizations began to offer qualified prescription drug coverage to their enrollees who are Part D eligible individuals. The MMA did not impact the manner in which PACE organizations are paid for the provision of outpatient prescription drugs to non-part D eligible PACE participants.

PACE organizations are required to annually submit two Part D bids: one for a Plan Benefit Package (PBP) for dually eligible enrollees and one for a PBP for Medicare-only enrollees. The Part D payment to PACE organizations comprises several pieces, including the direct subsidy, reinsurance payments, and risk sharing. Payments for eligible enrollees of either PBP will include a low-income premium subsidy and a low-income cost-sharing subsidy for basic Part D benefits. Payments for dually eligible enrollees will also include an additional amount to cover nominal cost sharing amounts (“2% capitation”), and an additional premium payment in situations where the PACE plan’s basic Part D beneficiary premium is greater than the regional low-income premium subsidy amount.

[PACE Program Agreement Appendix M: Medicare and Medicaid Payment Amounts]

### **30.6 - Medicaid**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

Each State that elects PACE as a Medicaid State Plan option must develop a payment amount based on the cost of comparable services for the State’s nursing-facility-eligible population. Generally, the amounts are based on a blend of the cost of nursing home and community-based care for the frail elderly.

Under a PACE Program Agreement, the State Administering Agency makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid participant.

The monthly capitation payment amount is negotiated between the PACE organization and the State Administering Agency, and specified in the PACE Program Agreement. The amount represents the following:

- Is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program;
- Takes into account the comparative frailty of PACE participants;
- Is a fixed amount regardless of changes in the participant's health status;
- Can be renegotiated on an annual basis.

Under Sections 1894(f)(2)(B)(v) and 1934(f)(2)(B)(v) of the Act, the PACE organization must be at full financial risk. The State may not share risk with the PACE organization. The PACE organization must accept the capitation payment amount as payment in full for Medicaid participants and may not bill, charge, collect or receive any other form of payment from the State Administering Agency or from, or on behalf of the participant, except as follows:

- Payment with respect to any applicable spenddown liability under 42 CFR §§ 435.21 and 435.831 and any amounts due under the post-eligibility treatment of income process under 42 CFR § 460.184;
- Medicare payment received from CMS or from other payers in accordance with 42 CFR § 460.180(d).

State procedures for the enrollment and disenrollment of participants in the State's system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in the month, is included in the PACE Program Agreement.

[42 CFR §§ 460.180; 460.182; 460.184; 42 CFR §§ 435.21; 435.831; 71 FR 71321 (Dec. 8, 2006)]

### **30.7 - Post-Eligibility Treatment of Income**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

Section 1934(b)(1)(A)(i) of the Act states that a PACE organization shall provide to eligible individuals, all covered items and services without application of deductibles,

copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid. States are permitted to use post-eligibility treatment of income in the same manner as it is applied for individuals receiving services under a home and community-based services waiver program under Section 1915(c) of the Act.

An argument could be made that Sections 1934(b) and (i) of the Act are in conflict since under 1934(i) of the Act, PACE participants may incur limited liability for part of the cost of their services. However, the type of Medicaid participant liability permitted by Section 1934(i) of the act is not cost sharing prohibited by Section 1934(b)(1)(A)(i) of the Act.

Section 1902(a)(17) of the Act permits an individual (or family) who has more income than allowed for Medicaid eligibility to reduce excess income by incurring expenses for medical or remedial care to establish Medicaid eligibility. However, this spenddown process is used in establishing Medicaid eligibility rather than being the type of cost sharing prohibited by Section 1934(b)(1)(A)(i) of the Act which refers to deductibles, copayments, coinsurance or other cost sharing beyond participant liabilities related to Medicaid eligibility.

[42 CFR § 460.184; 71 FR 71322 (Dec. 8, 2006)]

## **40 - PACE Premiums**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

### **40.1 - Definition of Premiums**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

The term “premiums” as used in this section does not include spenddown liability under 42 CFR § 435.121 and 42 CFR § 435.831, or post-eligibility treatment of income under 42 CFR § 460.184. A participant’s “share of cost” responsibility under Medicaid is not considered a premium. PACE organizations may continue to collect any liability due to them under Medicaid spenddown and post-eligibility processes, but that liability is not a premium.

[71 FR 71322 (Dec. 8, 2006)]

### **40.2 - Categories**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

Based on Sections 1894(i) and 1934(j) of the Act, CMS believes the Congress intended to permit individuals with Medicare Part A, Medicare Part B, Medicaid, any combination of the above, or none of the above mentioned benefits, to participate in PACE. 42 CFR § 460.150(d) states that a potential participant is not required to be Medicare enrolled or Medicaid eligible.



A participant's monthly premium responsibility depends upon his or her eligibility under Medicare and Medicaid.

[42 CFR § 460.150(d); 71 FR 71309 (Dec. 8, 2006)]

### **40.3 - Premiums for Persons who are Medicare Eligible**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

Nearly all Medicare participants have both Part A and Part B, and the capitation amount that Medicare pays is the sum of the Part A and Part B capitation rates. However, Section 1894(a)(1) of the Act permits a PACE program eligible individual who is entitled to Medicare benefits under Part A or enrolled under Part B to enroll in the PACE program.

For persons who are eligible under only one part of Medicare, the Medicare capitation amount will be only the portion for that part. Such a participant is required to make up the difference through payment of an additional premium amount equal to the missing piece of the Medicare capitation amount. The premiums for Medicare-only participants are as follows:

- For a participant who is entitled to Medicare Part A and enrolled under Medicare Part B, but is not eligible for Medicaid, the premium equals the Medicaid capitation amount;
- For a participant who is entitled to Medicare Part A, but is not enrolled under Part B and is not eligible for Medicaid, the premium equals the Medicaid capitation amount plus the Medicare Part B capitation rate;
- For a participant who is enrolled only under Medicare Part B and is not eligible for Medicaid, the premium equals the Medicaid capitation amount plus the Medicare Part A capitation rate.

No premium may be charged to a participant who is dually eligible for both Medicare and Medicaid or who is only eligible for Medicaid.

[42 CFR § 460.186; 71 FR 71322 (Dec. 8, 2006)]

### **40.4 - Participant Part B Premiums**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

Unless a PACE participant is Medicaid eligible, he or she is responsible for paying the Part B premium. CMS regulations specifically prohibit PACE organizations from offering gifts or payments to induce enrollment. Thus, the payment of Part B premiums by a PACE organization would essentially constitute an inducement for certain individuals (those who pay Part B premiums out of pocket) to enroll in PACE.

Such payment may also violate Section 231(h) of the Health Insurance Portability and Accountability Act of 1996 [Section 1128(A)(5) of the Social Security Act, codified at 42 U.S.C. Section 1320a7a(a)(5)]. That provision imposes civil money penalties on parties who provide inducements to Medicare or Medicaid beneficiaries that they know or should know are likely to influence a beneficiary's choice of a provider, practitioner, or supplier of Medicare or Medicaid items or services. Although the Office of the Inspector General has not issued an advisory opinion on this topic with respect to PACE, the OIG has reviewed similar proposals from Medicare fee-for-service providers and managed care organizations and has found them to be inappropriate.

[42 CFR § 460.82(e)(3)]

#### **40.5 - Part D**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

As specified in Sections 1894 and 1934 of the Act, PACE organizations shall provide all medically necessary services including prescription drugs, without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid.

PACE program participants who have Medicare only will receive their qualified prescription drug coverage through Medicare Part D and will be responsible for a monthly premium. PACE program participants who have Medicare and also qualify for the State Medicaid program will be deemed eligible for the Part D Limited-Income Subsidy which will cover their monthly premium for Medicare Part D. As part of the PACE Program Agreement, the PACE organization agrees to calculate and collect beneficiary Part D premiums, to the extent applicable, in accordance with 42 CFR §§ 423.286 and 423.293.

#### **40.6 - Premiums for Persons who are Medicaid Only**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

No premium may be charged to a participant who is only eligible for Medicaid. For Medicare Part A-only participants who are also eligible for Medicaid, the State is obligated to pay Medicare Part B premiums under Section 1902(a)(10) of the Act.

[71 FR 71318 (Dec. 8, 2006)]

#### **40.7 - Premiums for Persons who are Private Pay (without Medicare or Medicaid)**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

The statute does not specify the premium that may be charged to non-Medicare and non-Medicaid PACE participants. As CMS has indicated in the preamble to the final rule, it is

acceptable for a PACE organization to charge the combined Medicare and Medicaid capitation rates as the premium for these individuals.

[71 FR 71309 (Dec. 8, 2006)]

### **Transmittals Issued for this Chapter**

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<a href="#">R2PACE</a>	06/09/2011	Initial Publication of Manual	06/03/2011	NA
R1_SO	06/03/2011	Initial Publication of Manual - Rescinded and replaced by Transmittal 2	06/03/2011	NA

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