# PACE AWOP and Rate Setting Frequently Asked Questions

1. **What is the definition of AWOP?**

   Answer: AWOP stands for the amount that would have otherwise been paid. This replaces the term "Upper Payment Limit" (UPL) previously referenced in PACE rate development to describe the amount that would otherwise have been paid under the State plan if the participants were not enrolled in PACE.

2. **How do you determine the AWOP when the individual is enrolled in PACE?**

   Answer: Individuals enrolled in PACE should be excluded from the AWOP calculation. Instead, the AWOP should be calculated based on the projected per member per month (PMPM) costs for comparable individuals eligible, but not enrolled, in PACE.

3. **Currently states receive guidance related to their establishment of the AWOP and rates through several sources: State Plan Amendment preprints, three-way PACE program agreements, PACE regulations, a rate setting checklist dated September 10, 2002, and a PACE Medicaid Capitation Rate Setting Guide issued in December 2015. Does CMS intend for the PACE Medicaid Capitation Rate Setting Guide (effective January 1, 2025) to be used in combination with these other sources or is the more recent guidance intended to supersede these other sources?**

   Answer: The PACE Medicaid Capitation Rate Setting Guide includes additional guidance to states and summarizes the required documentation states should submit to support CMS's review and approval of the PACE rates. The PACE Medicaid Capitation Rate Setting Guide is to be used as a supplement in combination with the state plan amendment preprints, three-way PACE program agreements, and PACE regulation. The guide effective January 1, 2025 replaces the guide issued in December 2015. The development of the AWOP and PACE rates should be consistent with (and not in conflict with) what is in the State Plan. A rate checklist previously developed for CMS internal use was never formally issued to the public as a resource and should not be used as a resource.

4. **If states use a mix of Community and nursing facility (NF) residents to estimate the amount that would have otherwise been paid should the amount be consistent with the mix a state would expect to enroll in the absence of PACE for beneficiaries with comparable levels of clinical needs and functional limitations?**

   Answer: The population mix of Community and NF members used to estimate the AWOP should reflect the mix a state would expect for a comparable population otherwise eligible to enroll in PACE. The most current population mix should be projected to reflect the expected enrollment mix of the comparable population otherwise eligible for PACE in the rating period. Documentation should be provided supporting the projection assumptions, including the historical changes in mix over the past three years. To the extent the projection assumptions

deviate from the historical enrollment mix trends, the reasons behind the deviation should be properly explained.

5. **How should pharmacy rebates be considered in developing the AWOP?**

   Answer: Pharmacy rebates are usually projected based on the ratio of the rebates to total drug costs in the base period data. The trends and other assumptions used in rebate dollar projection should be sufficiently supported in the documentation. The State should provide documentation as to how the rebates were allocated specific to the PACE eligible population and how the data are reviewed for reasonableness. The AWOP could be gross or net of federal pharmacy rebates. If the former is chosen, the state should confirm that they collect the federal rebates for PACE enrollees.

6. **Are benefit carve-outs allowed in PACE?**

   Answer: No. PACE plans are required to cover all Medicaid state plan and applicable waiver services. There should not be any benefit carve-outs in PACE.

7. **When using managed care encounter data and managed care financial data and reports, are states required to make other adjustments that are required under the state plan or under state law, such as those requiring the amount that would have otherwise been paid to reflect the costs under fee-for-service delivery?**

   Answer: States have the flexibility to calculate the AWOP using Medicaid fee for service data, Medicaid managed care data (other than PACE) or both. If Medicaid managed care data is used, the state is expected to make appropriate adjustments so that the costs under managed care take into account the comparative frailty of the PACE eligible population and reflect the amounts that would have otherwise been paid under managed care for state plan covered services. Managed care data should also be adjusted for any eligibility and benefit differences between PACE and Medicaid managed care. Managed care data does not need to be adjusted for estimated utilization or cost savings between a managed care delivery system and a fee-for-service delivery system unless otherwise required by the approved State Plan.

8. **How should states account for programmatic changes that affect the cost of services provided to beneficiaries or groups used to determine the amount that would have otherwise been paid?**

   Answer: The rate package should include and document any material changes to covered benefits or services from the base period to the rating period. An estimated fiscal impact of the programmatic change, as well as a description of the data, assumptions and methodologies used to develop the adjustment should be included in the documentation provided to CMS. Immaterial changes should be documented along with an explanation of the analysis done to determine that the change was immaterial.

9. **Can incentive payments be paid to PACE plans?**

   Answer: States may make additional incentive payments to PACE plans as long as the total payment (PACE capitation rate plus incentive payment) to the PACE plan is less than the AWOP for each rate cell and the incentive arrangement is approved by CMS. States that have an incentive arrangement in place with the PACE plans should include documentation describing the incentive arrangement and the expected amount of the incentive payment for CMS review and approval as part of their annual rate package for CMS approval. States are not required to submit additional documentation of the final incentive payments made to PACE plans when those incentive payments are made, but the state is required to make sure: 1) the actual payments made are equal to or below the expected amount of the incentive payment included in the approved rate package, and 2) the total PACE capitation rates plus actual incentive payments made are below the AWOP for each rate cell in the approved rate package.

10. **How should quality incentive payments made to PACE plans be considered and documented in the PACE rate calculations?**

    Answer: The documentation should include a description of how the quality incentive payments are to be calculated and quantify the expected impact of any incentive payment on the PACE rates. The State should provide the expected amount of the incentive payment and demonstrate that the sum of the PACE rate and the expected incentive payment is below the AWOP for each rate cell. The incentive arrangement should be documented in the State Plan.

11. **How should administrative costs be included in the AWOP? How should risk/profit margin be included?**

    Answer: Administrative costs included in the amounts that would have otherwise been paid should only represent state costs for administering the program, including amounts paid to Medicaid managed care plans for individuals otherwise eligible but not enrolled in PACE. Risk/profit margin should not be included in the calculation of the AWOP unless it represents amounts paid to Medicaid managed care plans for individuals otherwise eligible but not enrolled in PACE. The assumptions for the administrative cost allowance must be documented and submitted with the rate approval package.

12. **PACE programs frequently operate at a loss for the first few years of their operation due to their extensive fixed costs and relatively small enrollment base. What special rate setting adjustments or provisions should be included for start-up programs incurring these costs?**

    Answer: States have the flexibility to account for startup losses a new PACE program may experience by taking that into consideration when negotiating the PACE rate for the organization as long as the PACE capitation rate is less than the AWOP. The AWOP may only include state costs for administering the program and should not include any PACE specific administrative costs.

13. **CMS states when rates are rebased, base data should not be more than three years old. In subsequent updates after rates are rebased, can the base data exceed this three-year limit?**

    Answer: The base data for the AWOP included with the rate package should not exceed the three-year limit regardless of when the AWOP was last rebased. When multiple years of data are used, the mid-point of the most recent 12-month period in the base data used to determine the AWOP should not exceed three years from the mid-point of the rating period. States have flexibility to use data older than three years, if necessary, as long as the State explains why the older data was appropriate for use.

    Example: For the rating period CY 2025 (January 1, 2025 through December 31, 2025), the most recent base data available for use in calculating the AWOP is CY 2023 data. Based on the midpoints of the rating periods (July 1, 2025) and base data (July 1, 2023) this base data is two years old and acceptable for use in calculating the AWOP. For CY 2026 the same base data could be used since the base data would be three years old at this point. However, for any rating periods after this point (CY 2027 and beyond), the AWOP would need to be rebased as the base data is now over three years old.

    Example: The State is developing the AWOP for the rating period CY 2025. The State determines the most complete and accurate source of base data for the AWOP is a blend of CY 2021 and CY 2022 data. With the most recent year of base data being within the three-year limit, this source of base data would be acceptable for use in creating the AWOP assuming the State describes the process and necessity for blending the two data sources. For CY 2026, the same base data could not be used since the most recent base data (CY 2022) would be over three years old. Instead, the base data used to calculate the AWOP would need to be updated to include data from CY 2023 or later.

14. **Section 1.b.ii indicates that the amount that otherwise would have been paid should be calculated for a period no longer than 12 months. However, Section 2.c.ii indicates that the effective dates of rates should be no less than one year but no more than two years. Is CMS providing guidance that PACE rates can be effective and approved for a time period that does not align with the period covered by the amount that otherwise would have been paid?**

    Answer: PACE rates are required to be less than the AWOP for the same time period. While the AWOP should be calculated for a period no longer than 12 months, PACE rates may be determined for a longer period (up to two years). For rates that are effective for a period longer than one year, separate AWOPs must be submitted to CMS. States must submit separate AWOPs for each year of the proposed rating period at the time of the submission. The State should consider updating the base period data, assumptions and methodologies used to develop the adjustments, factors and costs applied to the base data and submit the second AWOP separately, at a later time.

    Example: The State submits rates for a two-year period, CY 2025 through CY 2026, calculated using an actuarial method. With the submittal of this rate package, the state only includes an

AWOP for CY 2025. Because the AWOP is only effective for a 12-month period, a new AWOP must be calculated and submitted with this package for CY 2026 in order for the rates to be approved for a two-year period. The PACE rates for each rate cell must then be compared to each AWOP to determine whether the rates fall above or below the AWOPs. If the PACE rate is above or equal to the AWOP then the rate must be adjusted for that rate cell and rating period.

15. **After the guidance is finalized, how much lead time will states be given before they are expected to comply with the guidance in their future rate packages?**

    Answer: States are expected to comply with the PACE Medicaid Capitation Rate Setting Guide effective January 1, 2025, for PACE rate submissions in 2025 and later. States should continue to use the December 2015 PACE Medicaid Capitation Rate Setting guide for PACE rate submissions through 2024.

16. **Will the documentation sent to CMS by states be available to PACE organizations for review so that PACE organizations can understand how PACE rates have been developed?**

    Answer: States have the flexibility to determine the appropriate level of documentation to share with PACE organizations.

17. **Is there a timeframe within which states will have to send the proposed rates to CMS prior to the rates being implemented?**

    Answer: For states that have a state law or policy that requires CMS approval of the PACE rates prior to the effective date of the rates, CMS requests that the rate package be submitted at least 90 days prior to the start of the rate period. As a general matter, states are encouraged to submit rate packages to CMS at least 90 days prior to the effective date of the rates. All PACE rates are subject to CMS review and approval in order for the state to receive federal matching funds. States could risk loss of federal matching funds if rates are not approvable.

18. **What are the consequences if states do not use this guidance?**

    Answer: The PACE Medicaid Capitation Rate Setting Guide includes additional guidance to states and summarizes the required documentation states should submit to support CMS's review and approval of the PACE rates. To the extent the information required by the Guide is not followed, there is the potential for the approval process to be delayed or rates not approved.

19. **What is CMS' proposed plan of action if a state does not provide an actuarial certification?**

    Answer: An actuarial certification of the AWOP and/or PACE rates is encouraged by CMS but not required by Federal regulation 42 CFR 460.182. If an actuarial certification is not provided, states are still required to include the necessary documentation described in the PACE Medicaid Capitation Rate Setting Guide to support the data, assumptions and methodologies used in determining the AWOP and PACE rates.

**20. Are the AWOP or PACE rates required to be developed by an actuary?**

Answer: Federal regulation 42 CFR 460.182 does not require the AWOP or PACE rates to be developed by an actuary. However, because PACE is a full risk capitated program with frail participants, CMS recommends that states engage actuaries to develop the AWOP and PACE rate development.

**21. The guidance indicates that rates should remain in effect for a full year. Will CMS consider allowing interim rates for limited circumstances? Will CMS require the AWOP to be recalculated for interim rate adjustments?**

Answer: States should discuss the need for an alternative rating period length of less than one year, such as for interim rate adjustments, with the CMS Managed Care Analyst in advance of developing the rates. 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 or rate 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 or PACE rates in writing to CMS for approval prior to submitting a revised rate package to CMS for review. PACE rates are required to be less than the AWOP for the same time period. If the interim rate adjustments impact the data, assumptions and methodologies used in determining the AWOP, CMS may require the AWOP and PACE rates to be recalculated.

22. **As many states make the move to more managed long-term services and supports (MLTSS), less and less fee-for-service data is available to properly calculate the AWOP and payment rates. Are states required to use FFS data in developing the AWOP? What should states consider when selecting the most appropriate base data source?**

Answer: CMS does not prescribe the specific base data source to use in developing the AWOP. Acceptable data may include fee for service (FFS) experience, managed care plan encounter data, and/or managed care plan financial data and reports. States should select the highest quality data source(s) from the most recent three-year period prior to the rating year that are most reflective of the cost and utilization for a comparably frail population eligible but not enrolled in PACE. For states with MLTSS programs, states should consider: 1) how prevalent MLTSS is in the state and 2) how closely the specific MLTSS program design and state eligibility requirements align with the PACE program. For example, states that have a significant portion of PACE eligible individuals receiving some or all benefits through Medicaid managed care should include the Medicaid managed care data as part of the base data. Explanations and supporting documentation of its impact on the AWOP should be provided if the state chooses to exclude Medicaid managed care data as base data in AWOP development.

**23. How should rate comparisons between PACE and other managed care options reflect appropriate adjustments for the range of services, acuity of the population served, and level**

**of financial risk for covered services, specifically for long term nursing facility placement, in PACE?**

Answer: States should consider how closely the Medicaid managed care program data is aligned with the PACE program and thus, what additional adjustments are required to appropriately use the Medicaid managed care data to properly calculate the AWOP and PACE rates. Adjustments should be made to ensure that the base data used to calculate the AWOP and PACE rates is reflective of those beneficiaries that have an age and frailty level comparable to PACE eligible participants and that all state plan services, including long term nursing facility placement, are reflected in the base period data. In the case where a Medicaid managed care program has eligibility requirements that are broader than PACE, Medicaid managed care data may need to be adjusted to remove those members who are not otherwise eligible for PACE due to age, frailty status, and/or geography. In some cases, Medicaid managed care data may need to be supplemented by FFS data, to the extent a significant number of PACE eligible beneficiaries and/or services continue to be covered under the FFS delivery system.

**24. How should adjustments be made on rates for capitated programs that include a broader population before being applied in PACE AWOP development?**

Answer: Capitated programs, such as Dental or Non-Emergency Medical Transportation (NEMT), may include a broader population than PACE. For example, children, adults under age 55 and nursing facility ineligible groups are often included in these programs, but these populations are not eligible for PACE. In calculating the AWOP, states should not use the average capitation rates of these programs without making appropriate adjustments to reflect the age and comparative frailty of the PACE eligible population.

**25. How should PACE rates compare to rates for MLTSS programs?**

Answer: PACE programs are defined in federal statute (42 CFR 460.182) and feature a comprehensive benefit package for people aged 55 or older who meet a state's nursing home level of care criteria. In Medicaid managed care, states have the flexibility to define the eligible populations and services that are covered by the Medicaid managed care program and are often different than those covered under PACE. When comparing rates for managed care populations to rates for PACE, considerations should be given for differences in eligibility requirements, covered services, and rating periods. In addition, PACE rates must be less than the amount that would have otherwise been paid under the state plan if not enrolled in PACE. Managed care rates are subject to actuarial soundness requirements under 42 CFR 438.4 and are projected to provide for all reasonable, appropriate, and attainable costs under the terms of the Medicaid managed care contract.

**26. How should state-directed payments from the Medicaid Managed Care program be handled/documented in AWOP and PACE rate calculations?**

Answer: For states that incorporate Medicaid managed care data into the development of the AWOP, the state-directed payments can be included in the calculation of the AWOP to the extent the payments are for eligible state plan services for individuals otherwise eligible for PACE. The development of the impact of the state-directed payments by service category and by population should be documented in the AWOP. State-directed payments should not be made to PACE plans and should be excluded from the PACE rate.

**27. How should patient liability/post eligibility treatment of income (PETI) be handled in AWOP and PACE rate calculations?**

Answer: States have the flexibility to calculate the AWOP and PACE rates either gross or net of patient liability/PETI. However, the inclusion or exclusion of patient liability/PETI in both the AWOP and PACE rate calculations should be consistent.

**28. What documentation should be provided to support the AWOP calculation?**

Answer: Documentation should include but not be limited to the following: 1) general description of the AWOP methodology 2) Changes in the AWOP methodology from the prior year, if applicable 3) description of rate cells, service areas and services covered 4) description of base data and the development methodologies for each base data adjustment 5) description of how trends are developed for each service category 6) description of each program change and their impact on the projected benefit costs 7) description of how the patient liability is estimated and whether the AWOP is gross or net of patient liability 8) AWOP calculation sheets (preferably in Excel with working formulas) illustrating steps of the AWOP calculation by service category and sub-population. Please refer to the PACE Medicaid Capitation Rate Setting Guide.

**29. What are the most common adjustments applied to AWOP?**

Answer: The most common adjustments should include but not be limited to the following: 1) adjustments to account for claims that have been incurred but have not yet been paid (IBNR/completion factor) 2) payments/recoupments not processed through the MMIS 3) retrospective eligibility costs 4) FQHC/RHC cost settlements 5) Disproportionate Share Hospital payments 6) Graduate Medical Education (including both direct and indirect medical education components) 7) pharmacy rebates (both federal and MCO if applicable) 8) Third Party Liability payments 9) patient liability 10) copayments 11) changes in benefits, fee schedules, or eligibility requirements 12) trend factors 13) risk/acuity adjustment to reflect the expected costs and frailty of the PACE comparable population and case mix of nursing home and community residents 15) non-benefit costs. Please refer to the PACE Medicaid Capitation Rate Setting Guide.

**30. How should risk mitigation mechanisms be considered and documented in PACE rate calculations?**

Answer: Risk mitigation mechanisms are not allowable in PACE. To the extent the Medicaid Managed Care program that is used to determine the AWOP includes risk mitigation

mechanisms, the State should include an estimate of the projected payment/recoupment associated with the risk mitigation program in the AWOP. In most cases, this has no impact on AWOP development since the risk mitigation mechanisms are generally designed to be revenue neutral.

**31. How should the AWOPs and PACE rates be compared to ensure the AWOPs are greater than PACE rates for all rate cells?**

Answer: AWOPs and PACE rates must be compared on a consistent basis by rate cell and rating period to have a proper comparison. For example, both AWOPs and PACE rates must be gross/net of patient liability. The number of rate cells and rating period for both the AWOP and PACE rates must be the same.