A. Readiness Review: The State will perform a Readiness Review of the applicant entity that assures the entity has fully developed its policies and procedures, obtained commitments from key staff, developed its solvency plan and has a facility that meets State and Federal requirements at the time of the application, in accordance with Section 460.12(b)(1).

B. Monitoring During Trial Period: During the trial period, the State, in cooperation with CMS, will conduct comprehensive reviews of a PACE organization to ensure compliance with State and federal requirements.

At the conclusion of the trial period, the State, in cooperation with CMS, will continue to conduct reviews of a PACE organization, as appropriate, taking into account the quality of care furnished and the organization's compliance with State and federal requirements.

C. Annual Monitoring: The State assures that at least annually it will reevaluate whether a participant meets the level of care required under the State Medicaid plan for coverage of nursing facility services. The State understands that this determination may be waived if there is no reasonable expectation of improvement or significant change in the participant's conditions because of the severity of a chronic condition or the degree of impairment of functional capacity.

D. Monitoring of Corrective Action Plans: The State assures it will monitor the effectiveness of corrective actions required to be taken by the PACE organization.

IV. Rates and Payments

A. Calculation of Medicaid Capitation Rate

The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1.___ Rates are set at a percent of fee-for-service costs
2. **X** Experience-based (contractors/State's cost experience or encounter date)(please describe)
3.___ Adjusted Community Rate (please Describe)
4.___ Other (please describe)

The Medicaid capitation rates are based upon the most recent claims data for a similar population in Florida's Aged/Disabled Adult Services and Assisted Living for the Elderly waiver populations who would be eligible for the PACE program and who spent at least 50% of their waiver claims experience in the community. Only Dual eligible, Medicare Part B only eligible,

and Medicaid only eligible experience is included for those recipients with 50% of their total monthly eligibility months occurring in the community (versus being a nursing home resident). Although the waivers used for comparable populations do not require Medicare coverage, the presence of Medicare coverage would reduce Medicaid coverage for that individual.

Step One

The data for the most recent waiver claims are summarized by service category for all covered services and trended forward using the same inflation factors approved by the Florida Legislature for use in projecting social service program budgets.

PACE UPPER PAYMENT LIMIT METHODOLOGY – STEPS

i. Summarize the most recent fee-for-service data by service category for all covered service categories by eligibility category (SSI without Medicare, Medicare B Only and Medicare A & B). Include separately both a community and an institutional population using Medicaid fee-for-service data for individuals ages 55 and over who are nursing home eligible.
ii. Trend the data to the contract period using inflation factors approved by the Florida Legislature for the covered services for both populations.
iii. Summarize the trended data from previous step by service category for all covered service categories by eligibility category and calculate a PMPM amount separately for both the community and institutional populations.
iv. Blend together the results obtained for the community and institutional populations using their respective case months.
v. Adjust for incurred but not reported (IBNR) claims and third party liability (TPL) recoveries.
vi. Add non-emergency transportation cost to reflect a capitation arrangement. The capitation amount was adjusted to reflect fee-for-service utilization differences between the base population underlying the capitation and the waiver population used for the PACE capitation rates.
vii. Rate development in this Upper Payment Limit method is compared with program rates developed through the program rate process period. The Upper Payment Limit rates and program rates are compared to verify that the Upper Payment Limit rates are higher than the actual program rates.

Step Two

Home and community based services for the PACE capitation rates are adjusted because a capitation rate based fully on the Assisted Living for the Elderly waiver and Aged/Disabled Adult waiver experience does not fully represent the same service mix as found in the PACE population. The rates are adjusted based on encounter data collected for a comparable population (see step 8). The following service categories are affected by the adjustment:

- Adult Congregate Living
- Assistive Care Services
- Home and Community Based – Aging
- Home Health Services

Step Three

Statewide Assessment Rating Factor (ARF)

A statewide assessment rating factor (ARF) was developed to address health status differences between different areas of the state. Recipients were given functional screens that gauged health status. Measurements were made of recipient's required level of assistance in activities of daily living (i.e. ADLs), instrumental activities of daily living (IADLs), presence of specific chronic conditions (diabetes, etc.) and level of cognitive impairment. Statistical techniques were employed to model the relationship of medical costs as they vary in the presence and severity of impaired health as measured by the assessments. After the model was validated, an average ARF was determined. The average represents the magnitude of the payment PMPM attributable to health status compared to a similar but healthy population.

Step Four

This step adjusts trended historical costs for health status by dividing the statewide ARF into the service categories. This step establishes the average statewide service costs for the PACE program population.

Step Five

The claims data is adjusted for incurred but not reported (IBNR) claims and third party recoveries (TPL) using the same factors used in all other Florida managed care programs for the same rate period.

Step Six

Capitated ARF Factor

For Florida's existing PACE providers, the capitated assessment rating factor (ARF) was calculated using the enrolled provider's population. For prospective PACE providers, a blending schedule was used to determine the extent the plan/county specific ARF is credible. The blending schedule was developed after reviewing the standard deviation of the ARF by provider service area (PSA) and plan. This step adjusts the PACE plan's costs to reflect the greater or lesser assessment rating factor of its beneficiaries.

Step Seven

Nursing Home Add-on Factor

The trended claims data from the Aged/Disabled Adult and Assisted Living for the Elderly waivers was limited to individuals living in the community for at least 50% of their waiver experience. Since this assumption understates the risk for nursing home placement for a PACE provider, a nursing home add-on factor was developed. The actuary conducted research on nursing home admission rates, and month to month nursing home continuance rates once a recipient enters a nursing home. The research was conducted on the Aged/Disabled Adult and Assisted Living for the Elderly waiver populations. The cost of nursing home services on a per diem basis was included to estimate per enrollee per month cost if recipients were allowed to stay in the nursing home for an unlimited amount of time.

Step Eight

Encounter Data Adjustment

The fee-for-service based capitation rates are adjusted to reflect the impact that encounter data would have. Since PACE encounter data or PACE specific financial reports are not available, the Nursing Home Diversion experience data is used instead. PACE serves a population very similar to the Nursing Home Diversion program with a very similar set of services. The fee-for-service data is adjusted in the same manner as the Nursing Home Diversion rates are adjusted for Nursing Home Diversion encounter data.

i. Develop the encounter data adjustment by dividing the Statewide Nursing Home Diversion blended rate by the Nursing Home Diversion Statewide FFS based capitation rate.
ii. Apply the encounter data adjustment factor to the FFS based PACE capitation rate.

Step Nine

Final Rate Determination

For purposes of the calculation of the UPL the capitation rate is compared to the previous year's rate. The final PACE capitation rate is the higher of the two rates so that the capitation payment does not decrease from year to year.

PACE program rates will be revised annually based upon the rate methodology set out in the previous steps.

B. The rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

C. **X** The State will submit all capitated rates to the CMS Regional Office for prior approval.

Calculation of PACE Upper Payment Limit

The PACE Upper Payment Limit is based on the most recent claims data for a population similar to Florida's Aged / Disabled Adult Services and Assisted Living for the Elderly Waiver populations and nursing home residents who would be eligible for the PACE program. Only Dual eligible, Medicare Part B only eligible, and Medicaid only eligible experience is included and recipients are separated by their care setting in any given month: living in the community or in a nursing home. Without the PACE program, the current PACE enrollees would be living in one of settings of care and the UPL needs to reflect the cost of the enrollees in the appropriate proportion to evaluate savings from the PACE program.

V. Enrollment and Disenrollment: For both State Medicaid Agencies and State Administering Agencies, the State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information 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 that month. In cases where the State Medicaid Agency is separate from the State Administering Agency, the State Medicaid Agency assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the two agencies.

A. Enrollment Process (Please describe):

For Medicare only Applicants:

1. The PACE contractor will interview the applicant to determine if the applicant is eligible for and enrolled in Medicare Part A and/or Part B.
2. If the enrolled Medicare applicant is 55 or older, and a resident of the PACE contractor's catchment area, the applicant will be referred to the local Department of Elder Affair's (DOEA) Comprehensive Assessment and Review for Long Term Care Services (CARES) office for determination of level of care.
3. If the CARES unit determines the applicant meets level of care criteria for nursing home placement, the PACE contractor will be sent a notification of the determination. When the PACE contractor receives the level of care determination from the CARES office, the PACE contractor will schedule another interview with the applicant for assessment by the multidisciplinary team and review of the PACE Enrollment Agreement.
4. After the multidisciplinary team's assessment and determination that the applicant is appropriate for care in the community setting, the PACE contractor will review the PACE Enrollment Agreement with the applicant.

The PACE Enrollment Agreement will disclose to the applicant:

a. Applicant's name, sex, date of birth and Medicare Numbers as applicable.
b. Description of PACE program benefits including all Medicaid and Medicare covered services and how services can be obtained.
c. Explanation of participant premiums and procedures for payment, if applicable.

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