Medicaid Reimbursement Methodology for Programs of All-Inclusive Care for the Elderly (PACE)

This Section applies to reimbursement for Program of All-Inclusive Care for the Elderly (PACE) services described in Supplement 7 to Attachment 3.1-A, Page 6-7 and Supplement 4 to Attachment 3.1-B, Page 6-7.

Federal regulation requires that states pay PACE organizations a monthly capitated payment that:

- Is less than the amount Medicaid would otherwise have paid for PACE eligible individuals under the state plan (commonly referred to as the "amount that would otherwise have been paid" (AWOP) for PACE);
- Takes into account the comparative frailty of the PACE population; and
- Is a fixed amount regardless of participant's health status.

The District will utilize a payment methodology that fulfills the requirements set forth above. A general description of the methodology follows:

The District will obtain the most recent Medicaid claims available and calculate Medicaid costs incurred for two categories of beneficiaries: individuals residing in nursing facilities and individuals enrolled in home-and-community-based services (HCBS). To better capture the frailty of the PACE eligible population, the nursing facility population will be limited to long-term users, such as those with stays of at least three months, and the HCBS population will be limited to those in the District's 1915(c) Elderly and Physically Disabled (EPD) waiver, as these individuals must meet a nursing facility level-of-care standard to qualify. Medicaid costs for those two populations will be blended in proportions that reflect their expected enrollment in PACE.

In its analysis, the District may make the following exclusions or adjustments:

- Those enrolled in managed care plans will be excluded. Most beneficiaries who qualify as elderly or due to disability are exempted from the managed care program.
- Sub-categories of beneficiaries who are not relevant to PACE, such as Qualified Medicare Beneficiaries (QMBs), will be excluded.
- Costs that do not reflect services covered under PACE, such as patient liability or spend-down amounts, will be excluded.
- The District will account for any other factors as necessary, including, but not limited to, claims processing time lag; pharmacy rebates; programmatic changes; health care cost inflation; any irrelevant payments, such as DSH, GME, and IME; third party liability; and copayments.

The District will calculate a per-member-per-month (pmpm) payment rate based on a percentage of the PACE AWOP. Depending on cost patterns observed in the analysis above, the District may implement separate capitated rates for dual eligible and Medicaid-only PACE enrollees or other sub-groups. The final rate(s) will never be equal to or more than the PACE AWOP.