REIMBURSEMENT

General Provisions for Reimbursement

Program of All-Inclusive Care for the Elderly (PACE) services are financed primarily through Medicare and Medicaid capitated payments. PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. PACE providers must provide all needed services for PACE beneficiaries with the capitated funds. PACE providers assume full financial risk for the beneficiary's care without limits on amount, duration, or scope of services. The PACE provider shall be responsible for payment of the cost of the care in any setting.

The PACE capitation rate is set as a percentage of the upper payment limit (UPL) for what the State would have expected to pay under fee-for-services for enrollees. The rate shall not exceed 95 percent of the UPL. The UPL was established by utilizing all Medicaid payments for beneficiaries in the Nursing Facilities, Home and Community-Based Services (HCBS) Waiver programs: the Community Choices Waiver (CCW), Adult Day Health Care (ADHC) Waiver, and Long-Term Personal Care Services (LT-PCS), who met the PACE enrollment criteria, including meeting nursing facility level of care (NFLOC) requirement.

Claims data was collected for all such individuals, as was eligibility data. Two (2) rate groups were established as follows:

1. Medicaid only; and

2. Dual Eligible.

Under Medicaid regulation, when an individual enters a nursing facility as a permanent Medicaid nursing facility resident, a determination of the individual's required contribution towards the cost of care is based on the individual's monthly income and allowable expenses, otherwise known as a "patient liability" (PLI) amount.

The PLI amount is a shared cost between the resident and Medicaid related to nursing facility placement. PLI amounts can vary greatly.

The PLI amount is paid to the PACE provider or contracted nursing facility. The PLI paid by the beneficiary will serve to discount the contracted rate paid by PACE to the nursing facility. The Louisiana Department of Health (LDH) has the right to audit the PACE provider's PLI documentation.

If PLI is not paid by the beneficiary, the beneficiary may be involuntarily disenrolled from the PACE program. In accordance with 42 CFR 460.164(a)(1) and state regulation, a beneficiary may

be involuntarily disenrolled if the beneficiary fails to pay, or to make satisfactory arrangements to pay, any PLI due to the PACE provider after a 30 calendar day grace period.

The PACE provider must:

1. Make every opportunity available for beneficiaries to pay PLI and ensure that beneficiaries are not involuntarily disenrolled without good cause; and

2. Establish strict guidelines for the involuntary disenrollment process and follow all rules for involuntary disenrollment.

Involuntary disenrollment will occur only after all attempts at resolving the issues have been exhausted. OAAS will continue to review each request for involuntary disenrollment on a case-by-case basis for approval or disapproval.

The PACE provider must:

1. Document reasons for the disenrollment and all efforts to resolve the problem; and

2. Provide beneficiaries with reasonable advance notice of disenrollment.

During the interim period between notifying the beneficiary of an upcoming disenrollment and the effective date of the disenrollment, the PACE provider must continue to furnish all needed services.

Policies Specific to Program Rules Federal and State

In accordance with federal and state regulations, the PACE provider or its contracted nursing facility must collect PLI for beneficiaries placed permanently/long term in a nursing facility.

A PACE provider may accept private-pay beneficiaries and shall collect a monthly premium from individuals who are Medicare-only. Medicare eligible beneficiaries who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, plus the Medicare capitation rate(s), as applicable, calculated by the Centers for Medicare and Medicaid Services (CMS), but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies.

Beneficiaries may be private pay if they choose the service, but do not meet the requirements for Medicare or Medicaid eligibility.

The PACE enrollees not qualifying for Medicaid (either private pay or those covered under long term care insurance) would pay an amount equivalent to the lowest applicable Medicaid

capitated payment. A PACE provider may not charge a premium to a beneficiary who is eligible for both Medicare and Medicaid, or who is only eligible for Medicaid. PACE beneficiaries that do not meet Medicaid eligibility are still required to meet all established programmatic eligibility requirements.