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 organization 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 organization 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% of the UPL. The UPL was established by utilizing all Medicaid payments for beneficiaries in the Nursing Home, Home and Community Based Services (HCBS) waiver, the Community Choices Waiver (CCW), Adult Day Health Care (ADHC) waivers, and the Long Term Personal Care Services (LT-PCS), who met the PACE enrollment criteria, including meeting nursing facility level of care requirement.

Claims data was collected for all such Individuals as was eligibility data and three rate groups were established as follows:

- Those with Medicare Part A or Medicare Parts A & B;
- Those with Medicare Part B only; and
- Those with Medicaid only.

For each rate group, the average cost per service month was initially calculated from January, 2003 to October, 2006, based on Date of Service. In order to accommodate lag time between Date of Service and Date of Payment, data was extracted in December 2006 from claims paid as of the end of October 2006. A 12- month average was calculated and multiplied by 12 to estimate annual average cost per enrollee. The amounts were multiplied by 95% to assure a 5% saving.

Under Medicaid regulation, when an individual enters a nursing facility as a permanent Medicaid nursing home 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. 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 Code of Federal Regulations (CFR) 460.164(a) (1) and state regulation, and through a federally approved PACE specific waiver under the authority of Section 903 of the Benefits and Protection Act (BIPA) of 2000, a beneficiary may be involuntarily disenrolled if the beneficiary fails to pay, or to make satisfactory arrangements to pay, any PLI due to PACE organization after a 30 day grace period.

The PACE organization must make every opportunity available for beneficiaries to pay PLI and ensure that beneficiaries are not involuntarily disenrolled without good cause. The PACE organization must 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. The state will continue to review each request for involuntary disenrollment on a case-by-case basis for approval or disapproval. The PACE organization shall document reasons for the disenrollment and all efforts to resolve the problem.

The PACE organization must 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 organization must continue to furnish all needed services.

Policies Specific to Program Rules Federal and State

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

Federal regulation 42 CFR 460.186 allows the PACE organization to accept private-pay beneficiaries and to collect a monthly premium from individuals who are Medicare-only or beneficiaries. 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, but no deductibles, coinsurance, or other type of Medicaid cost-sharing applies, 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 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 organization may not charge a premium to a participant who is eligible for both Medicare and Medicaid, or who is only eligible for Medicaid.