



## II. Rates and Payments

A. The State assures HCFA 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.  Experience-based (contractors/State's cost experience or encounter date)(please describe)
3.  Adjusted Community Rate (please describe)
4.  Other (please describe)

The acute care portion of the UPL was based on the fee-for service claims data and the managed care encounter data. The long-term care portion of the UPL was based on fee-for-service claims data and some costs that on not in the MMIS database. Once the UPL was developed each portion was set at different percentages of the UPL. See Attachment to Supplement 2 to Attachment 3.1-A for complete description of the rate methodology.

B. The State Medicaid Agency assures that 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.

Price Waterhouse Coopers, 333 Market St, San Francisco did the work on the medical portion of the UPL and the initial work on the long-term care portion of the UPL.

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

## III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. 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.

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State of Oregon  
PACE Rate Methodology and Upper Payment Limit Calculation

The following information is organized and is consistent with the format of the document titled: PACE: Upper Payment Limit Development submitted by Price Waterhouse Coopers LLP to CMS in August, 2003. The Upper Payment Limits calculated for the PACE program were done in a manner that provided the best estimate of the per capita cost of providing comparable services to the PACE-eligible population if those eligibles were not enrolled in PACE. PACE-eligibles are persons living in Multnomah County who are age 55 and older who are Medicaid eligible (which excludes SLMB and QMB-only who are not Medicaid eligible and Medically Needy individuals) and are long term care eligible in service priority categories Levels 1- 13.

Acute Care:

The assumptions used in calculating the PACE acute care UPLs were the same as those used to develop the Oregon Health Plan per capita costs. The methods consider the mix of delivery systems used in the Oregon Health Plan (OHP), which includes capitated and non-capitated programs. These assumptions include trends, completion factors, and adjustments for data issues and programmatic changes. Where appropriate these assumptions have been modified for the PACE-eligible population and contract period.

1. A data file was created to identify the PACE-eligible population excluding PACE enrollees. This file was matched against the OHP to determine enrollment period in Fee-for-service or managed care for this population.
2. The PACE eligibility information was matched against the claim or encounter data for the PACE-eligible population.
3. The data was summarized to obtain total charges (encounter data) and total paid amounts (fee-for-service) by service category and demographic groupings.
4. The PACE eligibility information was used to develop member months of eligibility within each delivery system which were used as the denominator in the calculation of per capita costs. Appropriate adjustments were made for missing data and budget issues.
5. Trend rates were developed for various service categories, eligibility groups, and delivery systems.
6. Cost-to-charge ratios by service category were calculated and applied to encounter data for services that are paid on a capitated basis. Since the cost information for encounter data is charges not paid claims, the cost-to charge ratios were used to convert this information to a cost basis.

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7. Total projected costs per member per month were calculated for each service delivery arrangement and demographic grouping. PMPM amounts, representing unadjusted UPLs were then calculated from a blend of the managed care and FFS PMPMs. The weights used to blend the PMPMs were the PACE eligible member months in each delivery system.
8. Smoothing techniques were applied to the unadjusted UPLs to improve predictability. The smoothing process was cost-neutral in the aggregate.

Long Term Care:

The LTC component of the PACE UPL was developed in a similar manner to the acute care UPL. However, because the LTC services for the PACE-eligible population are paid on a fee-for-service basis the rate development is restricted to experience in that delivery system. Additionally, certain services appropriate for inclusion in the UPL. But not included in the MMIS system, were identified and their costs were included in the calculation. These included client contribution paid directly by the individuals to providers, including payments to nursing homes, assisted living and residential care facilities and to adult foster homes. Home-delivered meals was another category that was not in the MMIS data. These costs were allocated by demographic group based on the distribution of costs for nursing facility and HCBCs.

The general process by which the LTC UPL was calculated is as follows:

1. The data file containing identification information and dates of eligibility for PACE-eligible individuals in Multnomah County was created. PACE participants were excluded from this population.
2. This eligibility information was matched against the nursing facility and HCBC claims data to create the claims experience for the Multnomah County PACE-eligible population.
3. Claim data was summarized to obtain information on total amounts for the data period by service category and demographic grouping.
4. Non-MMIS costs were added. Since this data was available only a statewide basis, the costs were converted to a PMPM amount to allow for their inclusion in the UPL. An assumption was made that Multnomah County costs in these areas is comparable to the statewide population. These costs were allocated to the demographic groupings proportionately to the total of the nursing home and HCBC costs.
5. The PACE eligibility information was used to develop member months of eligibility. These figures were then used as the denominator in the calculation of per capita costs.
6. An adjustment was made for the relative expected cost of PACE-eligibles with survival priority scores of 1-13 relative to the total PACE-eligible population.
7. Trend rates were developed for various service categories.
8. Total projected LTC costs PMPM were calculated for each demographic grouping.

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**Final Upper Payment Limits:**

The per capita costs reflect the expected claims costs per person per month under each delivery system, plus an administrative allowance. Since PACE enrollees can come from either fee-for-service or managed care, these costs are blended based on the distribution of PACE eligible member months between the delivery systems. Smoothing techniques were applied to the UPLs to mitigate the effects of small populations in certain cohorts. The UPLs are kept separate and a percentage of each UPL is used for the LTC and acute care portion of the PACE rate. The PACE rate is currently paid by four eligibility categories; Blind & Disabled (age 55-64) with and without Medicare and Old Age Assistance (age 65+) with and without Medicare.

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