II. Rates and Payments

For services from January 1, 2010 through June 30, 2010, the net Medicaid payment will be reduced by a 10% "budget shortfall payment reduction."

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. X 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)

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.

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The PACE rate for Medicaid is established based upon services rendered to the SSI and Medically Needy populations residing in the service area. The upper payment limits (UPLs) include the aged, blind, and disabled populations that are age 55 and older. The most recent claims data is used for all services including targeted case management, with the exception of Medicare Part A and Part B premiums (Medicare buy-in). No data is used for individuals that are eligible for any current capitated managed care program. Data for persons with a living arrangement of ICF/MR, HCBS/MR, NF-MH, or state hospital are excluded. Data for persons without any identified living arrangement are also excluded. Only data for persons with a living arrangement in a NF or the PD or FE waivers are included. The costs in the base period are inflated to the present for rate setting purposes. Inflation is based on state historical costs.

Beneficiary eligibility data for the same time period as the claims data and with the same exclusions as above is used. This data was analyzed in a manner similar to that used for capitated managed care rate setting. Potential UPLs on a per member per month basis are computed by population, living arrangement, age groups, gender, and service areas. The break out of the UPL is reviewed for the possibility of unusual data, more commonly referred to as outliers, and for differences in average distributions. If no difference in average distributions is determined, a single UPL will be proposed for each eligibility category; otherwise a breakout in average distributions will be used.

An analysis of claims completion is made to determine whether a factor adjustment is needed. This factor is then negotiated with the provider.

Actual fee for service expenditures by Medicaid are used to calculate the UPL with the exceptions noted below. The claims completion factor was completed for the missing months of the last year used. The data was further adjusted for Graduate Medical Education (GME) payments not included in the historical Fee For Service (FFS) data the State provided as the capitated payment to PACE providers includes these costs. The PACE provider shall be responsible for collection of and reporting of third party liability. No adjustment is necessary to payments because claims do not reflect any receipts of third party liability by Medicaid. Adjustments to expenditures are made equal to the amount of average Medicaid pharmacy rebates received. The percentage is based upon the aggregate receipt of pharmacy rebates versus aggregate pharmacy payments as rebates cannot readily be identified to a particular population or county of residence. Co-payment, which is a reduction in actual payment, is added back into the UPLs as the provider will not be allowed to charge co-payment. Certified match expenditures are added to the UPLs. There may be instances when the provider certifies that state funds are available and the State will not pay for these funds. Medicare Part D medication drugs were deducted from the UPL.

Disproportionate share payments are not included in any claims data as they cannot be identified to a particular beneficiary, nor will they be the responsibility of the PACE provider.

For those individuals who have client participation for cost of care requirements, the net payment will be the rate less the client participation for that particular person less a 10% payment reduction. The payment reduction will be netted against the payment through an account receivable established in the payment system. The 10% payment reduction is applied to the net Medicaid paid amount after the reduction for client participation.

In order to set UPLs for a future time period, trend factors will be completed at least every 5 years. Separate trends for the following are computed using the same methodology that is used for the KHPA budget process:

- SSI Aged regular medical expenditures (all expenditures except for long term care and HCBS related),
- SSI Blind and Disabled regular medical expenditures,
- Medically Needy Aged regular medical expenditures,
- Medically Needy Blind and Disabled regular medical expenditures,
- HCBS/FE expenditures,
- HCBS/PD expenditures,
- FE targeted case management expenditures, and
- Nursing facility expenditures.