DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 16 Delaware Code, Section 512 (16 **Del.C.** §512)

FINAL

REGULATORY IMPLEMENTING ORDER

Program of All Inclusive Care for the Elderly (PACE)

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Delaware Title XIX Medicaid State Plan to add Medicaid coverage for *Program of All Inclusive Care for the Elderly (PACE)* as an optional service. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Del.C.** §10114 and its authority as prescribed by 31 **Del.C.** §512.

The Department published its notice of proposed regulation changes pursuant to 29 **Del.C.** §10115 in the October 2011 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by October 31, 2011 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposed amends the Delaware Title XIX Medicaid State Plan to add Medicaid coverage for *Program of All Inclusive Care for the Elderly (PACE)* as an optional service. PACE is a provider type under Medicare that allows states the option to pay for PACE services under Medicaid. The PACE program is capitated by both Medicare and Medicaid to provide all medical and long-term care services.

Statutory Authority

42 CFR Part 460, *Program of All Inclusive Care for the Elderly*

Background

Program of All-Inclusive Care for the Elderly (PACE) is a benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The PACE model was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized. Through PACE, organizations are able to deliver all services covered by PACE which participants need rather than only those services reimbursable under the Medicare and Medicaid fee-for-service systems.

The BBA establish PACE within the Medicare program and enable States to provide PACE services to Medicaid beneficiaries as a State option. In order to provide this Medicaid benefit, States must elect to cover PACE services as a State plan option and also enter into a program agreement with the PACE provider and the Secretary of the Department of Health and Human Services (DHHS). PACE providers must operate under both the Medicare and Medicaid programs. The program agreement is the contract between the PACE provider, the State, and the Federal government, and is the mechanism for receiving Federal matching funds for PACE services.

Eligibility - Participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing home care by the appropriate State agency. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.

Services - An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services) which are integrated for a seamless provision of total care. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team to improve and maintain the care of the PACE participant.

Payment - PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible Medicare and Medicaid enrollee. Medicare eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

Summary of Proposal

The intent of this rule is to implement the Program of All-Inclusive Care for the Elderly (or PACE) program as administered by the Division of Medicaid and Medical Assistance (DMMA) and to address the responsibilities of DMMA as the state administering agency under 42 CFR 460.

The proposed amendments add Medicaid coverage for PACE, as allowed under federal Medicaid regulations at 42 CFR Part 460. For a monthly capitated rate, a PACE organization provides all preventive, primary, acute, and long-term care services to persons who enroll in the program. To become a PACE organization, an entity must be approved both by the Division of Medicaid and Medical Assistance (DMMA) and by the Centers for Medicare and Medicaid Services (CMS). The organization must enter into a three-party agreement with DMMA and CMS committing to abide by state rules and federal regulations for PACE programs. The agreement must specify which areas the program will serve. The State plan amendment (SPA) must be approved before CMS can enter into a PACE program agreement.

The provisions of this SPA are subject to approval by the CMS.

Fiscal Impact Statement

Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems.

PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. Medicare eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

DMMA will assure CMS that the PACE program will be budget-neutral.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

The federal Balanced Budget Act of 1997 authorized states to adopt and implement an integrated Medicare/Medicaid program. DMMA is now adding this new "Program of All Inclusive Care for the Elderly" (PACE) to the Medicaid State Plan. Individuals enrolled in PACE will be exempt from the proposed Diamond State Health Plan Plus program. PACE will have the following features:

Eligibility: Individuals must be at least 55 years old. Applicant countable income cannot exceed 250% of the SSDI Federal Benefit (p. 441).

Services: An approved provider will be paid a capitated amount which can be derived from both Medicare and Medicaid funds to essentially provide "wrap around" services. The financial risk is borne by the provider which is responsible for "all preventive, primary, acute, and long-term care services". Services would be identified in a plan developed in collaboration with an interdisciplinary team. Available services include "all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team to improve and maintain the care of the PACE participant."

GACEC and the SCPD endorse the proposed regulation since the new program benefits individuals with disabilities.
Agency Response: Thank you for the endorsement.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the October 2011 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend Delaware Title XIX Medicaid State Plan to add Medicaid coverage for *Program of All Inclusive Care for the Elderly (PACE)* as an optional service is adopted and shall be final effective December 10, 2011.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #11-56
REVISION:

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
	42 CFR 435.217	X	4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event and existing 1915(c) is amended to cover this group(s), this option is effective on the effective date of the amendment. X PACE enrollees and will be effective on the effective date of the amendment electing PACE as an optional State plan service.

(Break in Continuity of Sections)

Citation
1905(a)(26)
and 1934

3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

_X_ Program of All Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

(Break in Continuity of Sections)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: DELAWARE

Amount, Duration, and Scope of Services OF MEDICAL AND REMEDIAL CARE
SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 2 to Attachment 3.1-A.

_X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.
___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

(Break in Continuity of Sections)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: DELAWARE

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A._X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. Spousal impoverishment eligibility rules will apply. The applicable groups are:
Individuals receiving services under this program are eligible under the following eligibility groups:
• A Special Income Level equal to 250% of the SSI Federal Benefit (FBR) (42 CFR 435.236)
(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. ___ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C._X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Regular Post Eligibility

1. _X_ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.
(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.
1. Allowances for the needs of the:

(A.) Individual (check one)

1. _X_ The following standard included under the State plan (check one):
   - (a) _____SSI
   - (b) _____Medically Needy
   - (c) __X__The special income level for the institutionalized
   - (d) _____Percent of the Federal Poverty Level: _____%
   - (e) _____Other (specify):_____
2. _N/A_ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
3. _N/A_ The following formula is used to determine the needs allowance:
   _____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1. ____ SSI Standard
2. ____ Optional State Supplement Standard
3. ____ Medically Needy Income Standard
4. ____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
5. ____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6. _X_ The amount is determined using the following formula:
   150% of the FPL for two plus any amount by which actual shelter expenses exceed this standard, up to the maximum as established each January 1 by the federal government.
7. ____ Not applicable (N/A)

Regular Post Eligibility Continued

(C.) Family (check one):

1. ____ AFDC need standard
2. ____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
4. ____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5. _X_ The amount is determined using the following formula:
   One-third of 150% of the FPL for two.
6. ____ Other
7. ____ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. _____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount

remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735**--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1.___The following standard included under the State plan (check one):
(a) _____SSI
(b) _____Medically Needy
(c) _____The special income level for the institutionalized
(d) _____Percent of the Federal Poverty Level: _____%
(e) _____Other (specify):_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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2.___The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
3.___The following formula is used to determine the needs allowance:
_____
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1.____The following standard under 42 CFR 435.121:
_____
2.____The Medically needy income standard
_____
3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5.____The amount is determined using the following formula:
_____
_____
6.____Not applicable (N/A)

(C.) Family (check one):

1.____AFDC need standard
2 ____Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____The amount is determined using the following formula:
_____
_____
6.____ Other
7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Spousal Post Eligibility

3._X_ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A)._X_The following standard included under the State plan (check one):

1. _____SSI
2. _____Medically Needy
3. __X_The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

(B)._____The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

(C)_____The following formula is used to determine the needs allowance:

_____
_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____
_____
_____
_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: DELAWARE

II. Rates and Payments

A. The State assures CMS 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)

*See Pages 7 and 8 for description of rate setting 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.

Mercer Government Human Services Consulting
2325 East Camelback Road, Suite 600
Phoenix, Arizona 85016
Attention: Frederick P. Gibison, Jr.
1.602.522.6526

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

CAPITATED RATE METHODOLOGY

Base Data Source and Analysis

The PACE rates are based on the Upper Payment Limit (UPL) methodology. The historical fee for service target population data is extracted for claims and eligibility for more than one year. PACE eligible populations used to develop the PACE UPLs are individuals enrolled in home and community based waivers (HCBS) and individuals in nursing facilities. These two populations serve as the basis upon which the PACE UPLs are developed.

Claims and eligibility data are gathered for both Medicaid-only individuals receiving the aforementioned services and also those individuals fully dually eligible for Medicaid and Medicare Parts A/B/D. Historical FFS data is compiled by date of service for the applicable year from the State's MMIS and eligibility system. Data for clients in the aforementioned two groups who are not eligible to enroll in PACE (e.g. those under age 55) are excluded from the database. The PACE UPLs include payment for all covered Medicaid services as well as Medicare coinsurance and deductible payments for full dual eligible clients. The final UPLs are developed for two rating groups: Dual Eligible – Age 55+ and Medicaid-only Age 55+.

The FFS data used in the analysis is reviewed for reasonableness to be (or as necessary adjusted to be) appropriate for UPL development as described in the most current version of the CMS PACE checklist.

- Claims expenditures for the PACE-equivalent population include Medicaid paid amounts increased by applicable patient liability and co-payments paid by recipients.
- Data for partial dual eligible populations were specifically excluded from the analysis, as they are not entitled to Medicaid services. These populations are excluded from Delaware's PACE program: Qualified Medicare Beneficiaries (QMB), Qualified Disabled and Working Individuals (QDWI), Specified Low-Income Medicare Beneficiaries (SLMB) and Qualifying Individuals (QI1 and QI2).
- Claims for services that are not covered services under PACE are not included.

Adjustments to Develop the UPL

The prospective UPL is subject to the following adjustments;

- Base Data Adjustments: The historical FFS base data are adjusted to comply with the requirements in the PACE UPL checklist and to ensure that the UPLs reflect what otherwise would have been paid under the State plan if participants were not enrolled in PACE (e.g., FFS pharmacy rebates, completion factors, copayments and patient liability).

CAPITATED RATE METHODOLOGY (cont'd)

- Prospective Trend: Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the cost of health care services in a defined contract period. As part of the UPL development for the PACE program, annual per-member-per-month (PMPM) trend rates by consolidated COS are developed. The base data is trended forward to the midpoint of the contract period.
- Programmatic Changes: Programmatic changes recognize the impact of changes to benefits, eligibility or State reimbursement that take place between the base period and the projection period.
- State Administrative Costs: An estimate of the State's FFS administrative costs is included in the UPL development process.

PACE Capitation Rates

The State will ensure compliance with 42 CFR 460.182(b) by assuring that the PACE capitation rates will be a fixed percentage, of less than 100 percent, of the respective PACE UPL amounts. This percentage will consider differences between the FFS population from which the PACE UPLs were built and the expected enrollment in the PACE plans including relative acuity and the impact of better care management/care coordination.

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.

15 DE Reg. 847 (12/01/11) (Final)