

Name and address of State Administering Agency, if different from the State Medicaid Agency.
The Ohio Department of Aging, 50 W. Broad Street, 8th Floor, Columbus, Ohio 43215

I. Eligibility

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

A. 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. The applicable groups are: 42 CFR 435.121 Aged, Blind, Disabled

(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 States'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. 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).

Regular Post Eligibility

- 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

TN No. 04-013

Supersedes

TN No. 02-011

Approval Date MAR 1 2005

Effective Date 12/1/04

(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. ___ 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): _____

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. ___ SSI Standard

2. ___ Optional State Supplement Standard

3. ___ Medically Needy Income Standard

4. ___ The following dollar amount: \$ _____

5. ___ The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.

6. ___ The amount is determined using the following formula:

7. ___ Not applicable (N/A)

(C.) Family (check one):

1. ___ AFDC need standard

2. ___ Medically needy income standard

TN No. 02-011

Approval Date 7/18/02

Effective Date 11/01/02

Supersedes

TN No. NA/New Page

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)

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

Regular Post Eligibility

2. X 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. X 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 Federal Poverty Level: _____ %
 - (e) X Other (specify): 64% of 300% of SSI standard= Community living arrangement
 - 2. X The following dollar amount: \$1,063.00
Note: If this amount changes, this item will be revised.
 - 3. X The following formula is used to determine the needs allowance:
 NF=Institutional standard with personal needs allowance of \$40.00

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.

TN No. 02-011
Supersedes
TN No. NA/New Page

Approval Date 7/18/02

Effective Date 11-01-02

(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: \$ _____
- 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: ~~\$225~~ for one, \$305 for two
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.

Spousal Post Eligibility

- 3. 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

TN No. 02-011

Approval Date 7-18-02

Effective Date 11-01-02

Supersedes

TN No. NA/New Page

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) The following standard included under the State plan (check one):

- 1. SSI
- 2. Medically Needy
- 3. 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:

Living in the community=64% of 300% of SSI payment standard

Living in a NF= \$40.00 Personal 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:

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. Rates are set at a percent of fee-for service costs
- 2. Experience-based (contractors/State's cost experience or encounter data)(please describe)
- 3. Adjusted Community Rate (please describe)
- 4. Other (please describe) Medicaid rates are developed using actuarially sound methodologies. The goal is to set capitation rates which best represent the risk characteristics of an enrolling PACE population and are acceptable to both providers and ODJFS while ensuring quality of care. The Medicaid monthly capitation payment amount is less than the amount that would otherwise have been paid under the state

TN No. 02-011

Approval Date 7-18-02

Effective Date 11-01-02

Supersedes

TN No. NA/New Page

plan if the participants were not enrolled under the PACE program.

In 1999, William M. Mercer was hired as an actuary for the state to assist in the development of rates for the PACE programs in Ohio. Because of limited PACE enrollment and encounter information, information on file from the PACE sites was not deemed credible to be used in the base for developing rates. Instead, Medicaid FPS claims experience for SFY 97 was used as a basis to develop rates. Data was collected from the eligible PACE population (for example, population at age 55 and over with nursing facility level of care, excluding the ICF-MR population and QMB only, ODWI, SLMB, OI1 and OI2)living in each service area of the two PACE sites. Data included only PACE covered services, i.e. state plan services. Data extracts reflect the service areas of the PACE site(s) (the service area represents a 30 minute drive time from each PACE site). The data was broken down by different service categories, inpatient hospital services, physician services, pharmacy and other covered services. The data was also separated by eligibility categories, like Medicaid only claims and crossover (claims for people who are eligible for Medicaid and Medicare services) claims. Dually eligible (eligible for Medicaid/Medicare services) individuals represented 94% of the total population. The experience data was summarized by category of services and eligibility type. Adjustments were made for information that was not captured in the data base, for example, pharmacy rebate. The information was further split into nursing home and waiver populations. Medicaid eligible individuals who received nursing home care were classified as the nursing home population (78.2 percent of the total population). The waiver population consisted of individuals who received home and community based services of the PASSPORT or ODJFS waiver programs. The waiver population represented 21.8 percent of the total population.

Once the base data was established, per member per month (PMPM) calculations were made by dividing claim payments by member month counts. Trend factors were applied to claim payments for each service category to project the claims forward from the midpoint of the experience period to the midpoint of the 1999 rate period. Adjustment factors were applied to account for the impact of the PACE program on service utilization. Since utilization rates for PACE participants, by category of service were unavailable, the adjustment factors were applied to overall expenditures for each of the categories. The sum of the adjusted expenditures was compared to the sum of actual expenditures to generate a managed care adjustment for each population. Mercer then used a reduction factor in nursing home care to represent expected PACE nursing home care expenses. To account for expected increases in day care activities, increases were made for home care services, transportation, and other service categories. In addition, drug, DME and physician related expense services are likely to increase as a result of PACE and adjustments were made to these categories. The application of these adjustments generated an overall managed care adjustment for each population. Because the PACE population is likely comprised of a lower cost nursing home eligible population than found in the data base, Mercer used an appropriate nursing home weight

TN No. 02-011

Supersedes

TN No. NA/New Page

Approval Date 7/18/02

Effective Date 11/01/02

factor in the rate development. The rates for nursing home and waiver populations were blended to generate the final PACE rate.

Because both PACE sites preferred just one rate for their programs Mercer created one blended rate for each site, i.e. same rate for Medicaid only and dual eligible.

The department will follow the same methodology as developed by Mercer with further refinement as required by CMS. We will update the database with the most current years' PACE eligible FFS claim experience data and create separate rates for Medicaid only and Dual eligibles by SFY 2004. All adjustments and trending will be based on historical FFS data. Capitation rates will be set in compliance with CMS's UPL requirements for federal participation. The capitation payments will be reviewed at least every two years and may be modified annually based on existing actuarial factors and experiences.

- 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.
- C. The State will submit all capitated rates to the CMS 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.

Ohio tracks enrollments/disenrollments/claims for Medicaid-eligible PACE participants through the MMIS/CRJS-E systems as well as the PACE Internal Tracking System (PACE-ITS) database. Medicare-only and private pay individuals are tracked only through the PACE-ITS database.

Ohio currently calculates a site-specific prospective Medicaid capitation rate for PACE, but does not make monthly prospective payments to the sites based on an estimated number of participants. Instead, the fee for service payment system is used, in which one unit of service equals one day of enrollment (whether or not services are actually delivered on that date), with the PACE site(s) retrospectively billing the State the appropriate per diem capitation amount for each day of each participant's enrollment. The PACE Site(s) may bill ODJFS as often as they wish, but claims must be submitted less than 365 days following the "service date" and only one claim per participant per day of enrollment may be paid. This eliminates the need for adjustment procedures. CMS has approved the continuance of this payment mechanism pursuant to the grandfathering provisions of Section 902 of BIPA 2000. Therefore, there is no need for adjustment procedures to account for the difference between the estimated and actual number of participants each month--the requirement is not applicable.

TN No. 02-011

Approval Date 7/18/02

Effective Date 11/01/02

Supersedes

TN No. NA/New Page