Attachment I- Milliman Staff Resumes PACE

Annie Hallum
FSA, MAAA
Principal & Consulting Actuary
Primary Contact for administration and contract management

+1 206 613 8188
annie.hallum@milliman.com

Current Responsibility

Annie has experience in providing actuarial support and consulting services to state Medicaid agencies, health plans, and providers in more than 10 states.

Annie's actuarial experience includes Medicaid rate setting, health policy and waiver support, Medicare Advantage premium rate development, Medicaid Managed Care procurement support, state budget projections, legislative impact analysis, and audit support.

Recent projects include:

- Medicaid rate setting for managed care programs covering physical health, behavioral health, and dental benefits for low-income family, blind and disabled, aged, ACA adult expansion, foster care, and CHIP populations
- Development of upper payment limits and certification of Medicaid capitation rates for Programs of All-Inclusive Care for the Elderly (PACE)
- Support for 1915(b)/(c) and 1115 waiver design, application, and implementation
- Design and implementation of inpatient and outpatient Medicaid payments models using All Patients Refined Diagnosis Related Groups (APR-DRGs) inpatient payment rates and Enhanced Ambulatory Patient Groups (EAPGs)
- Medicaid Managed Care procurement support
- Upper payment limit demonstrations for nursing home, inpatient, outpatient, professional, and clinic services
- Alternative payment model design, including bundled payment rates and hospital all-payer budgets
- Actuarial modeling of healthcare variables to test their impact of proposed changes to current and projected healthcare costs
- Development and analysis of changes to provider reimbursement

Relevant Professional Experience

- **State of Washington, Aging and Long-Term Support Administration:** PACE rate and AWOP development (2010-2015; 2020 to present)
- **State of Washington, Health Care Authority:** Medicaid physical health and behavioral health rate development and ad hoc financial support including risk mitigation settlements, risk adjustment, Health Home provider rate development, and other fiscal modeling ((2010 to 2015; 2019 to Present); Provider payment assistance including calculation of tax amounts, modeling payment projections, and net fiscal impacts by hospital, provider stakeholder engagement and development of CMS demonstrations needed for federal approval (2017 to 2018)

- **State of Hawai`i, Department of Health and Human Services:** Medicaid rate development and other ad hoc support (2019 to Present)
- **State of Nevada, Department of Healthcare Financing and Policy:** Medicaid rate development, risk adjustment, and other ad hoc support (2010 to 2015)
- **State of Utah, Department of Health:** Medicaid rate development, risk adjustment, CMS waiver assistance, and other ad hoc support (2019 to Present)
- **State of Idaho, Division of Medicaid:** Provider payment rate development for long-term services and supports and Medicaid managed care capitation rate review (2017 to 2018)
- **State of Minnesota, Department of Health**: Assistance with payment rate calculations and simulation modeling of the fiscal impact of updating its Medicaid inpatient APR-DRG payment system (2018)
- **State of Nebraska, Division of Medicaid**: Assisted with payment rate calculations and simulation modeling of the fiscal impact of annual updates to its Medicaid inpatient APR-DRG based methodology and converting its outpatient payment system from a cost-based methodology to EAPGs; Performed UPL and DSH calculations (2017 to 2018; 2021 to present)

Presentations & Publications

- Key Insights into 2023 Medicare Advantage D-SNP landscape (April 2023)
- Key Insights into 202s Medicare Advantage D-SNP landscape (February 2022)
- Medicaid long-term services and supports (February 2022)
- Direct Contracting Duals Model: Medicaid MCOs managing Medicare FFS costs for dual-eligible beneficiaries (February 2021)

Education

- Bachelor of Science, Statistics Magna cum Laude

  Bachelor of Arts, Mathematics and Economics Magna cum Laude

  University of Washington

Professional Designations

- Member, American Academy of Actuaries
- Fellow, Society of Actuaries

Nick Johnson
FSA, MAAA
Principal & Consulting Actuary
Alternative Contact for administration and contract management

+1 206 504 5941
nick.johnson@milliman.com

Current Responsibility

Nick's primary expertise is in helping clients understand the financial implications of trends and changes in the healthcare delivery system, particularly in Medicare, Medicaid, and dual-eligible populations.

He has worked with a broad range of clients, including health plans, integrated delivery systems, provider groups, and the Veterans Health Administration. He has significant experience in Medicare Advantage, Medicare Part D, Medicaid, commercial, and ACA markets.

Relevant Professional Experience

Nick's primary focus areas, including examples for recent analyses, include:

Medicare Advantage / Part D

- MA bid development and certification
- Product development and feasibility analysis
- Risk score monitoring, forecasting, and optimization
- Risk-sharing contract support for health plans and providers

Managed long-term services and supports (MLTSS)

- MLTSS, FIDE SNP, and PACE capitation rate setting
- Nursing home to HCBS transition monitoring
- Forecasting and analysis of programmatic changes
- Medicaid MLTSS RFP response

Presentations & Publications

- Key Insights into 2023 Medicare Advantage D-SNP landscape; Milliman Insight (April 2023)
- Partnering on Integration: Capacity-Building for Advancing Medicare-Medicaid Integration; CHCS Medicare Academy (April 2023)
- Key Insights into 2022 Medicare Advantage D-SNP landscape; Milliman Insight (February 2022)
- Direct Contracting Duals Model: Medicaid MCOs managing Medicare FFS costs for dual-eligible beneficiaries; Milliman Insight (February 2021)
- COVID-19 and the future of HCBS; Milliman Insight (September 2020)
- Changing how Medicare and Medicaid talk to each other; Milliman Insight (March 2020)
- State strategies for leveraging D-SNPs to achieve Medicaid goals; Milliman Medicaid State Client Forum (July 2022)

Education

- Masters, Applied Statistics, Portland State University
- Bachelor of Arts, Mathematics Augustana College

Professional Designations

- Member, American Academy of Actuaries
- Fellow, Society of Actuaries

Justin Birrell
FSA, MAAA
Principal & Consulting Actuary
Subject Matter Expert for program history

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Current Responsibility

Justin has nearly 30 years of actuarial experience with a variety of health-related issues, with most of that time focused on Medicaid. This has involved work for states including Hawaii, Idaho, Nevada, Utah, Washington, and Vermont, as well as non-state clients where he has supported Medicaid populations in Kentucky, Arizona, Georgia, and Massachusetts. He has worked on a variety of projects, including medical, long-term care, behavioral health, transportation, disease management, procurement, healthcare reform, and other state-specific analyses. In addition to the development of capitation rates, Justin has worked with states to negotiate final rates and produce required CMS documentation.

Justin's experience includes:

- Working in multiple states to develop rates and an appropriate structure that integrates both the Medicare and Medicaid component of costs into a single rate for members eligible for both programs
- Developing rate structures for integrated (medical, mental health, chemical dependency, and long-term care) healthcare models for Medicaid recipients that improve healthcare and reduce expenditures, including CMS documentation of rates and rate structures
- Developing and documenting Medicaid capitation rates in multiple states for managed care services for TANF, aged, blind, disabled, and other unique Medicaid populations, including those eligible for Medicare and those only eligible for Medicaid benefits
- Documenting cost effectiveness for Medicaid programs
- Risk adjusting Medicaid capitation rates
- Developing non-emergency transportation rates for Medicaid populations
- Analyzing large claims databases and healthcare modeling
- Developing prescription drug formularies
- Conducting Medicaid disease management financial savings analyses and analyses of soundness of disease management rates
- Working with state agencies to project the impacts of benefit and enrollment changes, including the impact of PPACA legislation on state expenditures
- Designing and evaluating pay-for-performance incentives in Medicaid-managed care programs
- Assisting the State of Washington in its SIM grant proposal
- Making projections of expenditures for Medicaid expansion in Washington, Hawaii, and Idaho

Relevant Professional Experience

- **Washington Aging and Long-Term Support Administration**: Development of PACE Rates
- **State of Washington, Health Care Authority**: Development of Medicaid capitation rates for multiple populations and services including, healthy Options low-income families and children, Healthy, options blind and disabled, Medicare-Medicaid dually eligible, Apple Health adult expansion, foster care, adoption support, and alumni, acute care medical benefits, community behavioral health benefits, LTSS, dental services (2000 to Present)
- **State of Hawai`i, Department of Health Services**: Capitation Rate Setting: TANF low-income families and children, seniors and persons with disabilities, Medicare-Medicaid dually eligible, Affordable Care Act (ACA) adult expansion, special populations generally excluded from managed care, acute care medical benefits, behavioral health benefits, long-term care services and supports (LTSS), services generally excluded from managed care
- **State of Nevada, Division of Health Care Financing and Policy**: Development of Medicaid capitation rates and peer review (2002 to 2020), TANF, State Children's Health Insurance Program (SCHIP), ACA adult expansion, Medicare-Medicaid dual demonstration, Acute care medical benefits, Behavioral health benefits

Presentations & Publications

- CY 2019 Managed Care Rating and Cost Drivers (January 2019)
- Medicaid Risk Mitigation Strategies (July 2018)
- Integrating Behavioral Health and Substance Abuse in Managed Care (July 2018)

Education

- Bachelor of Science, Mathematics
  Brigham Young University

Professional Designations

- Member, American Academy of Actuaries
- Fellow, Society of Actuaries

Dan Gerber
ASA, MAAA
Associate Actuary
Project Manager

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daniel.gerber@milliman.com

Current Responsibility

Since joining Milliman's Seattle Health practice in 2017, Dan has specialized in Medicare Advantage and Medicaid, specifically in behavioral health and long-term care rate setting. Dan has been the lead analyst on several annual rate-setting projects, managed multiple teams, developed timelines, and communicated results to various stakeholders. He has developed and presented Medicaid-related training to internal and external audiences.

Relevant Professional Experience

- **State of Nevada, Medicaid Managed Care:** Trend analysis, rate development, risk adjustment, data management, rate setting (2017-2019)
- **State of Washington, PACE (Medicaid) Managed Care**: project management, trend analysis, IBNP, program changes, rate development and presentation (2018 - Present)
- **State of Washington, Apple Health (Medicaid) Managed Care**: Behavioral Health-specific: Project Management, Trend Analysis, IBNP, Program Changes, Rate Development and Presentation (2019 - Present)
- **General**: data acquisition and management, trend analysis, certification and presentation, Medicare Advantage bid development, commercial MCO arrangements, Medicaid managed care rate setting

Education

- Bachelor of Arts, Mathematics and Neuroscience

  Carthage College

Professional Designations

- Member, American Academy of Actuaries
- Associate, Society of Actuaries

Kelly Backes
FSA, MAAA
Principal & Consulting Actuary
External Peer Reviewer

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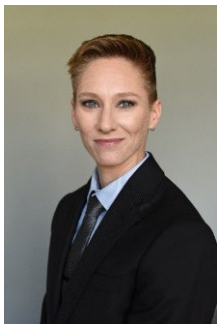

Current Responsibility

Kelly has more than 20 years of actuarial experience, working with health plans and state and Federal agencies. Kelly's deep expertise lies in the Medicare Advantage (MA) market.

They have provided MA organizations with bid pricing and preparation, strategic planning, product design, desk review, and audit services, claims processing analysis, risk sharing arrangement analysis, experience analysis, organizational start-up assistance, forecasting, Part D settlement analysis, and financial statement analysis and certification. Kelly also conducted bid desk reviews and audits on behalf of CMS for several years.

Kelly has also worked in the Medicaid and Commercial markets. They have provided pricing for new and existing Medicaid programs and for a number of different populations. Kelly also worked extensively in the pre-ACA and early ACA individual markets.

Kelly led the pricing and filing of products, managed form discontinuance and rollover support, and provided statistical analysis related to corporate retention and application placement initiatives. Kelly also provided other services, including reserving, forecasting, assisting federal and state governments with ACA compliance and initiatives, and reviewing state filings. Kelly has aided in Medicaid managed care capitation rate development and actuarial certification for programs in two states: Minnesota and Florida. These states serve a wide variety of populations and covered benefits. This work includes financial modeling, strategic assistance around program design, rate negotiations, and contracting. Kelly has also aided in Medicaid managed care rate bidding for a health plan in the state of Washington. Kelly has provided peer review support for the HCA's PACE upper payment limit development for the past several years.

Relevant Professional Experience

- **State of Florida, Agency for Healthcare Administration:** Development of Medicaid Upper Payment Limits for the PACE population (2015 to Present); Development of Medicaid capitation rates for the dual eligible population (2015 to 2018)
- **State of Minnesota, Department of Huma Services:** Development of Medicaid capitation rates for acute care services for parents, pregnant women, children, foster care children and disabled populations, as well as for acute care services for the Basic Health Program for individuals with incomes up to 200% of the Federal Poverty Limit (2016 to 2021)
- **State of Washington, Health Care Authority:** Peer review of the development of Medicaid Upper Payment Limits for the PACE population (2021 to Present)

Presentations & Publications

- Making the leap, Milliman White Paper (September 2022)
- Medicare Advantage innovation: A primer on Hospice VBID, Milliman White Paper (March 2020)

- Medicare Advantage: Strategies to increase plan revenue, Milliman White Paper (January 2020)
- Medicare Advantage: Eight critical considerations for every organization as ESRD eligibility expands in 2021, Milliman White Paper (January 2020)

Education

- Bachelor of Arts, Mathematics — Actuarial Science
- Bachelor of Arts, Economics, Honors Degree

  University of Wisconsin — Milwaukee

Professional Designations

- Member, American Academy of Actuaries
- Fellow, Society of Actuaries

Attachment II- WA PACE SFY 23-24 Rate Certification

MILLIMAN REPORT

Washington Program of All-Inclusive Care for the Elderly (PACE):

Fiscal Year 2023-2024 Rate Development

WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING & LONG-TERM SUPPORT ADMINISTRATION

April 28, 2022

Annie Hallum, FSA, MAAA
Nicholas Johnson, FSA, MAAA
Daniel Gerber, ASA, MAAA

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Executive Summary

INTRODUCTION

At your request, we have developed rates for the Washington Program of All-Inclusive Care for the Elderly (PACE) effective July 1, 2022 – June 30, 2024 (FY 2023 – 2024). Rates were developed for the following counties and PACE organizations: King County, Spokane County, and Snohomish County, administered by Providence ElderPlace (Prov); King County, administered by International Community Health Services (ICHS); and King County and Pierce County, administered by MultiCare (MC).

Table 1 shows the change between the current rates and the proposed rates by rate cell for each service area and PACE organization, not including the behavioral health component. Starting in February 2022, the Washington Aging and Long-term Supports Administration (ALTSA) contracted with Consumer Direct Washington (CD WA) to coordinate the administration of in-home individual provider services. This necessitated a rate adjustment for the final six months of the fiscal year. Both the previously approved FY 2022 rates and the submitted Jan-Jun 2022 rates are shown for reference. The rates in Table 1 are intended to cover all services other than behavioral health. PACE organizations are paid an additional amount for behavioral health services which is equivalent to the amount that would otherwise be paid to a behavioral health organization under Washington's Apple Health Integrated Managed Care program. Table 2 shows the CY 2022 behavioral health rates developed as part of Washington's Apple Health Integrated Managed Care rates by rate cell for each service area.

TABLE 1: PROPOSED FY 2023-2024 PACE RATES

FY 2023-24 PROPOSED RATE						
RATE CELL	KING (PROV)	KING (ICHS)	KING (MC)	PIERCE (MC)	SNOHOMISH (PROV)	SPOKANE (PROV)
Medicaid Only 55-64	$ 7,621.67	$ 6,679.94	$ 6,910.78	$ 6,984.88	$ 7,324.73	$ 6,584.91
Medicaid Only 65+	$ 7,621.67	$ 6,679.94	$ 6,910.78	$ 6,984.88	$ 7,324.73	$ 6,584.91
Dually Eligible 55-64	$ 5,060.65	$ 4,875.63	$ 5,024.73	$ 4,916.50	$ 5,369.93	$ 4,950.90
Dually Eligible 65+	$ 5,060.65	$ 4,875.63	$ 5,024.73	$ 4,916.50	$ 5,369.93	$ 4,950.90
Composite	**$ 5,277.35**	**$ 5,028.30**	**$ 5,184.32**	**$ 5,091.52**	**$ 5,535.34**	**$ 5,089.16**
FY 2022 APPROVED RATE						
RATE CELL	KING (PROV)	KING (ICHS)	KING (MC)	PIERCE (MC)	SNOHOMISH (PROV)	SPOKANE (PROV)
Medicaid Only 55-64	$ 7,009.80	$ 7,544.94	$ 7,368.11	$ 5,586.07	$ 7,824.84	$ 6,260.72
Medicaid Only 65+	$ 5,326.05	$ 5,649.66	$ 5,560.43	$ 4,119.97	$ 5,988.11	$ 4,561.43
Dually Eligible 55-64	$ 4,229.71	$ 4,374.69	$ 4,333.65	$ 3,786.80	$ 4,310.34	$ 3,909.03
Dually Eligible 65+	$ 4,380.40	$ 3,885.60	$ 3,844.63	$ 3,678.10	$ 4,187.03	$ 3,780.42
Composite	**$ 4,572.67**	**$ 4,207.37**	**$ 4,155.92**	**$ 3,830.04**	**$ 4,482.04**	**$ 3,979.46**
JAN-JUN 2022 SUBMITTED RATE (PRIOR TO COVID RATE ADJUSTMENT)						
RATE CELL	KING (PROV)	KING (ICHS)	KING (MC)	PIERCE (MC)	SNOHOMISH (PROV)	SPOKANE (PROV)
Medicaid Only 55-64	$ 7,242.59	$ 7,768.56	$ 7,646.53	$ 6,046.44	$ 7,961.63	$ 6,563.13
Medicaid Only 65+	$ 5,596.22	$ 5,909.17	$ 5,883.56	$ 4,616.79	$ 6,183.45	$ 4,913.79
Dually Eligible 55-64	$ 4,428.99	$ 4,806.34	$ 4,862.52	$ 4,414.55	$ 4,835.03	$ 4,343.01
Dually Eligible 65+	$ 4,558.65	$ 4,482.61	$ 4,575.23	$ 4,296.89	$ 4,786.45	$ 4,232.46
Composite	**$ 4,757.44**	**$ 4,761.62**	**$ 4,834.65**	**$ 4,436.48**	**$ 5,037.76**	**$ 4,418.16**
RATE CHANGE (FY23-24 VS JAN-JUN 2022)						
RATE CELL	KING (PROV)	KING (ICHS)	KING (MC)	PIERCE (MC)	SNOHOMISH (PROV)	SPOKANE (PROV)
Medicaid Only 55-64	5.2%	-14.0%	-9.6%	15.5%	-8.0%	0.3%
Medicaid Only 65+	36.2%	13.0%	17.5%	51.3%	18.5%	34.0%
Dually Eligible 55-64	14.3%	1.4%	3.3%	11.4%	11.1%	14.0%
Dually Eligible 65+	11.0%	8.8%	9.8%	14.4%	12.2%	17.0%
Composite	**10.9%**	**5.6%**	**7.2%**	**14.8%**	**9.9%**	**15.2%**

* Composite rates based on CY 2021 Providence & ICHS members

TABLE 2: CY 2022 BEHAVIORAL HEALTH RATES

RATE CELL	KING (PROV)	KING (ICHS)	KING (MC)	PIERCE (MC)	SNOHOMISH (PROV)	SPOKANE (PROV)
Non-Disabled Adult	$ 64.00	$ 64.00	$ 64.00	$ 30.11	$ 27.25	$ 37.47
Disabled Adult	$ 356.84	$ 356.84	$ 356.84	$ 184.39	$ 239.32	$ 207.16
Newly Eligible	$ 73.09	$ 73.09	$ 73.09	$ 70.54	$ 68.25	$ 93.43

Based on the CY 2021 current PACE program membership distribution by rate cell, the rates above (not including behavioral health) constitute an increase of 5.6% to 15.2% in aggregate for each PACE organization compared to Jan-Jun 2022 rates. The key drivers of the rate change are illustrated in Table 3, below. The CD WA change between the FY 2022 approved rates and the Jan-Jun 2022 updated rates is shown for reference. Note that the Jan-Jun 2022 rates only include 5 months with the updated CD WA hourly cost, so there is still a minor rate change associated with CD WA for the FY 2023 rates relative to the Jan-Jun 2022 rates for most PACE organizations.

TABLE 3: RATE DRIVERS

KEY DRIVER	KING (PROV)	KING (ICHS)	KING (MC)	PIERCE (MC)	SNOHOMISH (PROV)	SPOKANE (PROV)
FY 2022 Rates	**$4,630**	**$4,262**	**$4,211**	**$3,843**	**$4,475**	**$3,991**
CD WA Change (FY22 to Jan-Jun 22)	184	556	681	608	559	440
Jan-Jun 22 Rates	**$4,814**	**$4,818**	**$4,892**	**$4,451**	**$5,034**	**$4,431**
Updated Base Data	183	196	180	231	297	300
Fee Schedule Changes	329	307	273	306	307	374
CD WA Change (Jan-Jun 22 to FY23)	35	111	0	(0)	(0)	80
Transportation	(120)	(120)	(120)	(117)	(169)	(107)
COPES Living Situation Mix	147	(348)	(40)	147	13	33
NH/COPES Blend	(73)	109	43	83	60	(1)
Rate Cell Mix	26	18	19	21	20	17
FY 2023-24 Rates	**$5,341**	**$5,092**	**$5,248**	**$5,122**	**$5,563**	**$5,127**

Key changes relative to prior certifications are listed below, separated into underlying data and assumption updates and methodology changes. These changes are discussed in detail later in this letter.

Underlying base data and assumption updates include the following:

- **Updated Base Data and Trend:** Reflects the impact of using data from the July 2020 to June 2021 base period to develop projected claims costs, patient participation, and assumptions. The prior rates used CY 2018 as the base data. This also includes the impact of applying trend from the base to the projection period, which is the largest component of this driver in Table 3. Note that all COVID-specific payment increases were identified and removed from the base claims data and claims data was adjusted for the impacts of deferred or omitted care.
- **Fee Schedule Changes:** Reflects the impact of fee schedule changes for long-term services and supports (LTSS) between the base and projection period (excluding the CD WA change).

- **CD WA Change:** Change resulting from adjusting hourly payments for all Individual Provider in-home services (identified with HCPCS code T1019) to the contracted CD WA hourly cost of $29.20, to align with the new CD WA arrangement effective February 2022. Note that the fee schedule change for CD WA (to $31.80 per hour) effective July 1, 2023, is included in the preceding fee schedule section.
- **Transportation:** Reflects changes in non-emergency transportation (NEMT) unit cost and utilization assumptions based on more recent experience.
- **Community Options Program Entry System (COPES) Living Situation Mix**: For King (Prov) rates, living situation mix was updated to reflect actual 2021 membership. King (ICHS) rates were updated to blend actual 2021 membership with the King County PACE-similar population mix whereas prior rates reflected only King County PACE-similar population mix. ICHS is a relatively new PACE organization and did not have credible historical membership to use for previous rate setting. For all other rates, changes reflect updated county-specific PACE-similar population mix.
- **NH/COPES Blend:** The new PACE organizations and counties are more mature, so their rates reflect higher projected nursing home membership percentages than previous rates. King (Prov) and King (ICHS) NH percentages reflect updates to actual 2021 membership.
- **Rate Cell Mix:** The age band mix used to composite rates for visualizations was updated to use actual 2021 membership (from ICHS and Providence). This doesn't reflect actual rate changes, it is purely due to the compositing mix.

Other methodology changes, all of which had minor impacts on the overall rate change:

- **Recipient Aid Category (RAC) Exclusion:** As in prior rate certifications, the fee-for-service (FFS) similar population and eligible claims were limited to remove members with enrollment RAC codes ineligible for inclusion in PACE and claims with functional RAC codes which are non-Medicaid services or otherwise ineligible for inclusion in PACE. PACE recipients themselves are also excluded from the similar population. Effective for July 1, 2022, we updated the list of enrollment RAC codes and functional RAC codes that are used to identify ineligible members and services. See Table 6 for the list of included functional RAC codes and Table 7 for the list of included enrollment RAC codes.
- **Combining Age Bands:** Due to credibility concerns, rates for both Medicaid-Only and Dually Eligible members are developed using all similar population members instead of separating by 55-64 and 65+ age bands. COPES living situation is a better predictor of cost than age band, so we have developed rates based on living situation and blended them for the past two years. Note that no rate cell cross-subsidizes payments in any other rate cell.
- **Pharmacy Rebates:** We adjusted the PACE-similar populated reported pharmacy costs for rebate amounts retained by the Washington State Health Care Authority (HCA) for the PACE-similar members.
- **Hepatitis C Add-on Rate and Hemophilia Carve-in:** Hepatitis C drugs were removed from the base data in previous rates, as PACE organizations were previously not at risk for Hepatitis C or hemophilia prescription drugs. For this rate setting period, there is a separate rate for members who receive a Hepatitis C prescription in a given month. The rate is calculated as the sum of the member's rate, based on dual eligibility status, and a Hepatitis C load. Hemophilia drugs were previously carved out of rates, but they are now included in the base data. All Medicaid benefits are now included in the rate and amount that would otherwise have been paid (AWOP) development.

Table 4 shows the portion of the rates shown in Table 1 that are attributable to the State of Washington ALTSA. This state department funds the portion of this rate used for LTSS services, while the HCA funds the medical portion of the rates (including pharmacy and dental). The ALTSA rate component in Table 4 includes the ALTSA (primarily LTSS) claims cost, patient participation, half of the administrative load for Medicaid only members, all of the administrative load for dually eligible members, and 55% of the transportation costs. Behavioral health rate components are excluded from Table 4.

TABLE 4: PORTION OF PROPOSED FY 2023-2024 PACE RATES ATTRIBUTABLE TO ALTSA

FY 2023-24 PROPOSED RATE

RATE CELL	KING (PROV)	KING (ICHS)	KING (MC)	PIERCE (MC)	SNOHOMISH (PROV)	SPOKANE (PROV)
Medicaid Only 55-64	$ 5,377.51	$ 4,387.73	$ 4,450.94	$ 4,634.04	$ 4,875.71	$ 4,107.68
Medicaid Only 65+	$ 5,377.51	$ 4,387.73	$ 4,450.94	$ 4,634.04	$ 4,875.71	$ 4,107.68
Dually Eligible 55-64	$ 4,727.76	$ 4,569.88	$ 4,714.61	$ 4,612.13	$ 5,025.45	$ 4,681.71
Dually Eligible 65+	$ 4,727.76	$ 4,569.88	$ 4,714.61	$ 4,612.13	$ 5,025.45	$ 4,681.71
Composite	**$ 4,782.74**	**$ 4,554.47**	**$ 4,692.30**	**$ 4,613.98**	**$ 5,012.78**	**$ 4,633.14**

JAN-JUN 2022 SUBMITTED RATE (PRIOR TO COVID RATE ADJUSTMENT)

RATE CELL	KING (PROV)	KING (ICHS)	KING (MC)	PIERCE (MC)	SNOHOMISH (PROV)	SPOKANE (PROV)
Medicaid Only 55-64	$ 4,759.74	$ 5,099.72	$ 5,019.17	$ 3,647.30	$ 5,339.61	$ 4,009.42
Medicaid Only 65+	$ 4,264.62	$ 4,476.83	$ 4,427.68	$ 3,723.82	$ 4,541.89	$ 3,796.40
Dually Eligible 55-64	$ 4,066.14	$ 4,408.66	$ 4,463.74	$ 4,040.98	$ 4,396.99	$ 4,005.94
Dually Eligible 65+	$ 4,200.25	$ 4,119.67	$ 4,209.77	$ 3,944.47	$ 4,372.25	$ 3,919.80
Composite	**$ 4,232.41**	**$ 4,215.57**	**$ 4,289.14**	**$ 3,926.98**	**$ 4,446.52**	**$ 3,930.93**

RATE CHANGE (FY23-24 VS JAN-JUN 2022)

RATE CELL	KING (PROV)	KING (ICHS)	KING (MC)	PIERCE (MC)	SNOHOMISH (PROV)	SPOKANE (PROV)
Medicaid Only 55-64	13.0%	(14.0%)	(11.3%)	27.1%	(8.7%)	2.5%
Medicaid Only 65+	26.1%	(2.0%)	0.5%	24.4%	7.3%	8.2%
Dually Eligible 55-64	16.3%	3.7%	5.6%	14.1%	14.3%	16.9%
Dually Eligible 65+	12.6%	10.9%	12.0%	16.9%	14.9%	19.4%
Composite	**13.0%**	**8.0%**	**9.4%**	**17.5%**	**12.7%**	**17.9%**

* Composite rates based on CY 2021 Providence & ICHS members

CMS GUIDANCE

We have reviewed the PACE rate setting guidelines from CMS issued in December 2015. This section will explain how we comply with specific components of these guidelines. The guidance states that *42 CFR 460.182 requires that states make a prospective monthly capitation payment to a PACE organization for a Medicaid participant enrolled in PACE which:*

- *Is less than what would otherwise have been paid under the state plan if not enrolled in PACE* - State plan data is used as the basis for these rates, which are then adjusted for the expected living situation distribution specific to each PACE program. The amount otherwise paid assumes that in the absence of a PACE program, the nursing home distribution of a PACE population would be similar to that shown in the state plan data.
- *Takes into account comparative frailty of participants* – In King (Prov), the underlying state plan data is adjusted for the acuity of the PACE population as measured by its Comprehensive Assessment Reporting Evaluation (CARE) level, Medicare eligibility status, and living situation distribution. King (ICHS) is a newer program but has sufficient membership to rely on at least partially, so the underlying data is partially adjusted for living situation distribution. As the population of each PACE organization grows, we expect to transition to rely more on their actual membership distributions.

- *Is a fixed amount regardless of changes in a participant's health status* - the rate cells shown in Table 1 do not change based on a participant's health status.

Additional guidance from that document is as follows:

- *Amounts that would have otherwise been paid should be calculated for a period no longer than 12 months* – Though our projection is for 24 months, our intention is to rebase it after 12 months with updated census information and fee schedule changes.
- *Describe the method for setting rates, for example - a percentage discount off of amounts that would have otherwise been paid, actuarial approach, other* –

  Rates and amounts that would have otherwise been paid were developed in parallel using an actuarial approach for each county and PACE organization. Rates were then compared to amounts that would have otherwise been paid to ensure that they were in compliance.

  Development of rates and amounts that would have otherwise been paid followed the same general approach:
  - Review and summarize base benefit costs
  - Project benefit costs to the projection period
  - Add retention such as care management and administration

  Key differences between the rates and amounts that would otherwise be paid include the following:
  - Non-benefit expenses including administrative costs and retention
  - Nursing home percentage and mix
  - Non-emergency transportation costs

  Table 5 below compares the components of the amounts otherwise paid to the components of the rates. Other than the items specified below, description of rate development throughout this document is consistent with the development of the amounts that would have otherwise been paid.

TABLE 5: COMPARISON OF RATES TO AMOUNTS OTHERWISE PAID

RATE COMPONENT	SET RATES	AMOUNTS OTHERWISE PAID
Nursing Home Distribution	[redacted]	[redacted]
HCBS Living Situation Distribution	[redacted]	[redacted]
Transportation	Projected PMPM costs based on actual King-Prov experience (incl. trips and unit cost).	Projected PMPM costs based on FFS-reported trips and costs.
Care Management	Care management costs transferred from the State	Care management costs transferred from the State
Administrative Load	4.5% of premium for dually eligible and 5.0% of premium for Medicaid only	Administrative costs transferred from the State
Risk Margin	1.0% risk margin	None
Taxes & Fees	None (not applicable)	None

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- *Amounts that would have otherwise been paid should be rebased annually but at least every 3 years* – Given this guidance we have proposed a two-year rate. Rates will be updated after one year with a more current PACE member profile mix and any significant applicable fee schedule or programmatic changes that are not already reflected in the rates. This rebasing will also include a recalculation of the distribution of PACE members by living situation.
- *Data should not be more than 3 years old* – This is true for the rates presented in this rate report.

We emphasize that these proposed rates are contingent on CMS approval and CMS feedback may require adjustment to these proposed rates.

APPENDICES

The following appendices have been attached to this letter:

Appendix A:

- **Exhibit 1** presents a summary of projected FY 2023-2024 FFS costs sourced from ProviderOne (P1), the State's data warehouse, separated by rating cohort and category of claim. The "PACE Distribution" calculates risk-adjusted costs based on the acuity levels of members in PACE as of CY 2021. Rates in Exhibit 1 do not include behavioral health or transportation costs.
- **Exhibit 2** adds behavioral health, transportation, care management, and administrative costs to Exhibit 1 and blends the nursing home and HCBS rate for each rate cell. The blend is calculated based on the projected PACE nursing home population percentage for each specific PACE program. Exhibit 2 also shows the allocation of rate components to HCA and ALTSA accounting categories.
- **Exhibit 3** includes rates by budget category using the rates presented in Exhibits 1 and 2, including a comparison to current rates.
- **Exhibit 4** compares the projected PACE rates to projected FFS amounts otherwise paid if the members were not enrolled in PACE.
- **Exhibit 5** illustrates the development of the Hepatitis C add-on rate for months in which a member receives a Hepatitis C prescription.

Appendix B:

- **Exhibit 1** contains a description of the ALTSA services and administrative costs included in the rate calculations (assisted living facilities, adult family homes, individual providers, agencies and "other").
- **Exhibit 2** contains detailed fee schedule changes from the base period to the projection period for all HCBS services that have a change.

Appendix C contains Hepatitis C NDCs included in the separate Hepatitis C load development.

Methodology Overview

Rates have been developed based on FFS data for the PACE-similar population. We model the Medicaid FFS benefits for the PACE-similar population as follows:

1. Identify the appropriate base data representing historical FFS medical and LTSS costs.
2. Limit the Medicaid medical and LTSS costs to the PACE-similar population and stratify by living situation [redacted]
3. Adjust the base period benefit costs by applying pharmacy rebates, COVID add-on adjustments, and completion factors.
4. Project the medical and LTSS benefit costs by living situation, including the application of trend, fee schedule changes, and other program changes.
5. Risk adjust the rates and AWOP for each individual PACE organization by blending the projected costs by living situation.
6. Project and add NEMT costs.
7. Add non-benefit costs transferred from the State to the PACE organization.
8. Add the behavioral health (BH) capitation rates which are developed separately.

Each of these steps is described in more detail in the sections that follow.

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Base Data Identification

AVAILABLE DATA SOURCES

We use the following sources of data for rate development:

1. P1 claims information for all Medicaid enrollees from January 2019 paid through November 2021
2. Client-by-month membership information for all Medicaid enrollees from January 2019 through November 2021
3. FFS NEMT trips and costs, reported separately by ALTSA and not included in the P1 data
4. PACE organization claims and summary data reported by the PACE organizations with sufficient experience (i.e., King- Prov and King-ICHS). Note that this data was not reliably produced for all PACE organizations nor is it credible enough for use in rate setting therefore we only used it for determining reasonableness of the rates.
5. PACE organization historical membership information by living situation and month and membership projections by month.
6. Estimated administrative costs for services transferred by ALTSA to the PACE organizations.
7. CY 2020 pharmacy rebate information by NDC and quarter from HCA for the PACE-similar population.

MEDICAL AND LTSS BASE DATA

Our primary source of data was P1, Washington State's payment system identified in item 1 above. Final rate calculations were based on claims incurred in SFY 2021, paid through November 30, 2021. The P1 database provided us with detailed claim-level information for HCA services, as well as nursing home services and HCBS. We note the following about the services and costs included in the P1 data:

- Costs that are not the responsibility of the State were excluded, including those paid by Medicare and third-party liability (TPL) claims. Medicare copays and deductibles paid by the State are included in the P1 claims data and have been factored into this analysis.
- Consistent with CMS guidance, rates are gross of patient participation. For all counties, we composited patient participation costs using the same distributions as the claim-based rate components. We have presented this information separately in the report, rather than as part of the medical costs. The patient participation included in the rates is the sum of three P1 fields: room and board amount, third party resource amount, and participation amount. Participation costs are from the following sources:
    - For non-nursing home members, participation amounts are reported at a claim level in P1 data
    - Participation amounts for members in nursing homes are reported at a member month level in the Washington Medicaid enrollment files
- Medicare premiums are not included in P1 and are not included in our analysis. It is our assumption that the State will continue to pay Medicare premiums for PACE members.
- NEMT costs are not included in P1.
- Behavioral health services covered under the IMC Behavioral Health capitation rates are excluded as they are not paid FFS.
- Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) encounters are included in P1 with HCPCS T1015. We include these encounters in the rate and AWOP development. Any other payments made to FQHC / RHCs, such as settlements for RHCs not receiving prospective encounter rates, are made outside P1 and are therefore excluded from our base data.
- Graduate Medical Education (GME), Indirect Medical Education (IME), and Disproportionate Share Hospital (DSH) payments are generally made outside P1 and are therefore excluded from our base data. The one exception is the inclusion of GME and IME cost differences in the development of the inpatient and

outpatient provider payment rates. These amounts would continue to be included in the PACE rate and AWOP development as the cost would transfer from the State to the PACE organization.

- Any expense or recovery, such as post-pay recoveries not processed through P1 are excluded from our base data. Based on discussions with the State, we understand that pharmacy rebates are the only material post-pay recovery not included in P1. We have developed a separate adjustment discussed later in this report to account for rebate recoveries.
- Retrospective eligibility and costs are included in the base data. However, we only include eligibility and costs for members with a CARE assessment which limits the retrospective data that could be included. Given the CARE assessment requirement, it is our understanding that including member months and costs from retrospective enrollment does not materially impact the rates or AWOP.
- We limit the FFS claims data in P1 to reflect Medicaid covered services as defined in Washington's State Plan Amendment. Table 6 shows the functional RAC codes included in PACE rate development. These RAC codes are used to determine whether a LTSS claim is a Medicaid service and would be covered by a PACE organization.

TABLE 6: FUNCTIONAL RECIPIENT AID CATEGORY (RAC) CODES INCLUDED IN PACE-SIMILAR CLAIMS DATA

RAC	FUNCTIONAL RAC DESCRIPTION
3000-3004	COPES Waiver
3030-3035	RSW
3040	New Freedom Waiver
3050-3056	CFC (incl. Fast Track and Ancillary)
3100	HCS Roads to Community Living
3105	Community Transition or Sustainability Services
3110	Intervention Services/Independent Living Fund
3120	Washington Roads
3170-3171	Medicaid Alternative Care (MAC)
3175-3178	Tailored Supports for Older Adults (TSOA)
3200-3201	HCS MPC
3210-3211	ABP HCS PC
3214-3217	ABP CFC
3240	Private Duty Nursing
3300	HCS Chore
3310	APS Services
3320	Veterans Directed Home Services Program

OTHER DATA SOURCES

We will discuss how the other data sources were used in the subsequent sections as follows:

- Eligibility data: See the PACE Similar Population Identification & Stratification section.
- NEMT trips and costs, reported separately by ALTSA and not included in the P1 data: See the NEMT Rate Development section.

- PACE organization claims and summary data: See the NEMT Rate Development and Dental Adjustment sections.
- PACE organization historical and projected membership: See the Risk Adjustment section. Note that historical membership is also used for weighting average rates as documented underneath each table as appropriate.
- Transferred administrative costs: See the Admin Development section.
- Rebate information: See the Rebate Adjustment section.

PACE-Similar Population Identification & Stratification

PACE ELIGIBLE POPULATION

The eligible population for the PACE program is Medicaid-eligible (including dually eligible) members residing in Washington state ages 55 and older, who are aged, blind, disabled, or presumptive SSI, at a nursing home level of care.

We develop rates using FFS members as a PACE-similar population. We were provided with a comprehensive membership eligibility file for all Washington Medicaid members in force between January 1, 2019, and November 30, 2021, as well as further historical data. This file included county of residence, gender, date of birth, etc.

We identify the PACE-similar population as the Medicaid eligible population with the following exclusions:

- Members under the age of 55 were excluded.
- Dually eligible members who are not entitled to Medicaid Services (QMB-only, QDWI, SLMB-only and QI-1) were excluded. These were identified as members with dual eligibility indicators “01,” ”03,” “05,” or “06.”
- Members who were enrolled with a managed care program, including PACE, were excluded. Although many COPES members are enrolled in managed care, we did not include managed care data for the following reasons:
    - The managed care membership is Medicaid-only, while most of PACE consists of dual Medicaid and Medicare eligibles. The addition of managed care COPES members did not significantly impact the total membership of the PACE rates target population.
    - The managed care data would have to be adjusted back to FFS levels in order to be on the same basis as the rest of the data. This adjustment introduced a high level of uncertainty in the value of these data since it would be largely judgement-based.
- Members who are not in a nursing home and do not require a nursing home level of care were excluded. Determination of members in these two groups was based on claim data using the following methodology:
    - [redacted]
    - Any member not falling into one of these categories was excluded.
- Members with certain eligibility RAC codes were excluded when it was determined that those RAC codes indicated the member was inconsistent with the PACE population. The RAC codes included in the PACE-similar population are listed in Table 7.

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TABLE 7: ELIGIBILITY RECIPIENT AID CATEGORY CODES INCLUDED IN PACE-SIMILAR POPULATION

RAC	ELIGIBILITY RAC DESCRIPTION
1046-1049	Categorically Needy, ALF
1065-1073	Categorically Needy, LTC
1083, 1086	Medically Needy, LTC
1104-1111	Categorically Needy, SSI or SSI related
1122	Categorically Needy, breast/cervical cancer
1124-1126	Medically Needy, SSI related
1146-1153	Categorically Needy, HCBS waiver
1154	Medically Needy, HCBS waiver
1162-1163	Categorically Needy, LTC SSI related
1174-1175	Categorically Needy, HCBS waiver
1197-1201	Categorically Needy, MAGI
1217	Presumptive Disabled, MAGI
1218-1225	Categorically Needy, DDA waiver
1236-1243	Categorically Needy, Hospice
1244-1258	Categorically Needy, CFC
1260-1269	Categorically Needy, RCL

PACE RISK STRATIFICATION & COST MODEL DEVELOPMENT

[redacted]

Base Period Adjustments

The base period medical and LTSS costs from FY 2021 are adjusted for:

- COVID add-on cost removal from the base data
- Pharmacy costs rebates
- Completion factors for claims that have been incurred but not paid.

The adjustments above are described in the subsequent sections.

REMOVAL OF COVID ADD-ON COSTS

Starting in February 2020 and continuing throughout the PHE, Washington has authorized additional payment increases for LTSS services. These payment increases applied to members within PACE as well as the FFS PACE-similar population. While Washington may continue to make these additional payments in the future, any corresponding rate adjustments will be developed separately from the FY23-24 rates in this certification. Therefore, the add-on payments made during the base period were removed prior to the rate calculations shown here. The add-on payments were made differently depending on the type of service.

For AFH and ALF services, the add-on rates were paid using additional claim lines with specific HCPCS coding. These HCPCS codes were excluded from our base data.

For Nursing Facility, In-home, and Other LTSS services, the add-on rates were included as unit cost increases to the standard claims. In order to remove these costs, we adjusted the base data to remove an amount from each NF claim equal to the number of days multiplied by the add-on unit cost as supplied by ALTSA.

The overall impact of removing these add-on payments from included services in the base period is shown in Table 9.

TABLE 8: IMPACT OF COVID ADD-ON RATE REMOVAL

CATEGORY OF SERVICE	COMPLETION IMPACT
Nursing Facility	-3.3%
Adult Family Home	0.0%
Assisted Living Facility	0.0%
In-Home	-12.8%
Other LTSS	-0.5%
Total LTSS	**-7.5%**

PHARMACY REBATES

We used July to December 2020 rebate information from the State to estimate the rebates collected by the State from FFS PACE-similar costs included in our base data. The rebates were applied by NDC on a per unit basis to all pharmacy claims.

COMPLETION FACTORS

The P1 claims data used in final rate calculations were for services incurred between July 1, 2020, and June 30, 2021, paid through November 30, 2021. We calculated factors to adjust for any claims yet to be paid for these incurred dates. The impact of these completion factors is in Table 8.

TABLE 9: OVERALL COMPLETION IMPACT

CATEGORY OF SERVICE	COMPLETION IMPACT
ALTSA	0.1%
Inpatient Hospital	5.4%
Outpatient Hospital	0.7%
Professional	0.8%
Prescription Drug	0.0%
Total	**0.1%**

Medical and LTSS Benefit Cost Projections

The medical and LTSS SFY 2023 – SFY 2024 benefit cost projections begin with the stratified SFY 2021 cost models and include the following adjustments to the data:

- Geographic cost adjustments
- Utilization and unit cost trends
- Fee schedule and program changes

The adjustments above are described in the subsequent sections.

GEOGRAPHIC ADJUSTMENTS

The Medicaid-Only rate cells in each county have non-credible underlying membership in the PACE-similar population, based on a threshold of 650 member months for full credibility. This threshold was developed using the standard Medicare Advantage credibility threshold methodology, as set out by CMS in the guidelines released April 6, 2018. In order to increase the credibility of these rate cells, statewide data was included in the development of benefit costs. For LTSS services, unit cost factors were used to adjust the statewide data for county-specific costs. These factors are based on the unit cost relativity between each county and statewide data for a given category of service and are shown in Table 15.

TABLE 10: UNIT COST ADJUSTMENT TO STATEWIDE ALTSA DATA FOR MEDICAID-ONLY RATE CELLS

CATEGORY OF SERVICE	KING	PIERCE	SNOHOMISH	SPOKANE
Nursing Facility	1.055	1.020	1.075	0.951
Adult Family Home	1.021	0.988	1.021	0.953
Assisted Living Facility	1.057	0.997	1.051	0.980
In-Home	1.000	1.000	1.000	1.000

TREND RATES

In order to determine trend rates, we looked at several sources of data, including claims data we received from the State and trends in other state Medicaid programs. Note that the trend rates discussed in this section are intended to be net of the impacts of fee schedule changes. We applied fee schedule impacts separately, as discussed below. We applied the following annual trend rates:

TABLE 11: ANNUAL TREND RATES

	DUALLY ELIGIBLE			MEDICAID-ONLY		
CATEGORY OF SERVICE	TOTAL	UTILIZATION	UNIT COST	TOTAL	UTILIZATION	UNIT COST
ALTSA – In-home	1.0%	1.0%	0.0%	1.0%	1.0%	0.0%
ALTSA – AFH, ALF, NH	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Inpatient Hospital	5.0%	0.0%	5.0%	0.0%	0.0%	0.0%
Outpatient Hospital	2.5%	0.0%	2.5%	6.2%	6.2%	0.0%
Professional	5.3%	2.2%	3.0%	2.0%	1.0%	1.0%
Prescription Drug	1.6%	1.0%	0.6%	6.8%	3.4%	3.2%

Rates have been trended 2.5 years to June 30, 2023 – the midpoint of the projection period.

FFS dental costs were lower than those likely experienced in the PACE population because dental was temporarily removed as a covered benefit for the adult FFS population in 2011. Following the reinstatement of this benefit in 2014, fee schedules were kept level with rates that had been in effect since 2007. As a result, provider access has been limited. We believe the base data FFS unit costs are therefore understated relative to a delivery system with adequate access for members. This disparity in reimbursement results in a decrease in access and utilization for FFS adult dental benefit recipients. To assess the impact of this disparity, we compared the dental costs reported by the PACE organizations in CY19 and CY20 to the dental costs for the FFS PACE-similar population. The difference was similar across both years, so we developed a "network adequacy" factor based on the CY19 costs, which was then applied to the base period FFS dental cost. This constituted a 163% total increase to dental cost, which was annualized and included in the trend shown in the cost models but is not truly a trend assumption. A similar adjustment was applied to dental costs in the FY2021-22 rate development, though we have refined the method used to develop the factor.

Additionally, FFS dental costs were trended to account for returning services relative to the base period (in which services were deferred due to the COVID-19 public health emergency (PHE)). We assumed that dental services provided in the projection period would return to the pre-COVID levels seen in CY19 and applied a 16% annualized trend to FFS data consistently across all rate cells.

The trend assumptions shown in Table 9 were developed separately for medical, pharmacy, and ALTSA services, and will be described separately:

Medical Trends

Medical Trends were developed separately for Dually Eligible members and Medicaid-Only members.

For Dually Eligible members, trends were developed based on changes in the Medicare Part A and B deductibles for 2019-2022, as released by CMS. Inpatient trends were based on the Part A deductible, with the full trend assumed to be unit cost trend because the deductible applies to each hospitalization and recent inpatient admission utilization trends have been relatively flat. Outpatient and non-DME professional trends were developed as follows: the proportion of 2019 spending that fell below the Part B deductible received a trend based on the change in deductible, while the remaining 2019 spending was assigned a 0% trend. A composite trend was calculated based on these proportions. DME was considered separately, as it is the largest professional service category, and the vast majority of DME in the base period was non-Medicare covered. Based on historic unit cost and utilization, no trend was applied to DME.

For Medicaid-Only members, trends were developed using experience data for the PACE similar population incurred January 2019 through June 2021, paid through November 2021. Trends were developed assuming that any care deferred due to the COVID-19 PHE would be returning in full by the midpoint of the projection period, but that service levels would not rise above current levels if no deferred care was evident. Inpatient and professional service levels have already returned to their pre-COVID levels, so no trend was assumed for these categories. Outpatient services, however, still remain below the 2019 pre-COVID base, so trend was applied to return to 2019 service levels.

Pharmacy Trends

The annual pharmacy trend rates shown in Table 9 were derived from internal Milliman research on Medicare Part D trends. This research was based on a review of historical Milliman data, publicly available industry trend reports, and publicly available information on anticipated new drugs. Utilization trends are specific to a high-use population. Unit cost trends include anticipated changes in Average Wholesale Price (AWP) and expected impact of brand to generic shift related to patent loss.

LTSS Trends

Trends for LTSS services were developed based on the following data:

- LTSS trends from other states' managed LTSS rate settings were reviewed when publicly available.

- Historical trends for members and services included in the PACE-similar FFS population.

The data described above was reviewed, and trends were selected based on judgement. In particular, the PACE-similar population is characterized by a high level of utilization, especially for NH, AFH, and ALF members. It is therefore unlikely for LTSS utilization to vary significantly within these requirements. In-home members can have more flexibility in their utilization, so we have applied a small positive trend to these members The selected trends, shown in Table 9 above, were allocated entirely to utilization since unit cost increases are accounted for with our fee schedule adjustments.

LTSS trend assumptions are net of known fee schedule increases discussed in the next section.

FEE SCHEDULE & PROGRAM CHANGES

Individual Provider Contracting Change

Historically, Washington ALTSA has contracted directly with Individual Providers who provide in-home care for members in the LTSS program. Starting February 1, 2022, ALTSA will contract with CD WA, a Consumer Directed Employer, to provide these services. During FY 2023 – 2024 ALTSA and the PACE organizations will pay CD WA a set hourly rate of $31.80 for all in-home services, instead of contracting directly with individual providers at hourly rates that vary according to experience and location.

To reflect this change, benefit costs were developed by adjusting hourly payments for all Individual Provider in-home services (identified with HCPCS code T1019) to the contracted CD WA hourly cost of $31.80. The hourly cost includes the amount paid by the patient as well as by Medicaid. The impact of this adjustment on the base data is included in the "in-home" row in Table 11.

Fee Schedule Increases

The June 2021 and April 2022 legislative sessions approved several fee schedule changes to a variety of LTSS services, including adult family homes, in-home services, assisted living facilities, adult residential care, and adult day health. These rate changes were applied to the detailed claims data at the service code level.

Fee schedule increases were added independently of trend. The impact of all fee schedule increases is shown in Table 11. The adjustments shown in this table include the CDWA contracting changes, PCP fee schedule increases, and mental health provider fee schedule increases. Detailed LTSS fee schedule adjustments by HCPCS code and modifier are shown in Appendix B.

TABLE 12: IMPACT OF FEE SCHEDULE ADJUSTMENTS

CATEGORY OF SERVICE	KING	PIERCE	SNOHOMISH	SPOKANE
Nursing Facility	41.5%	44.5%	44.8%	46.5%
Adult Family Home	8.0%	9.1%	7.9%	7.5%
Assisted Living Facility	9.4%	25.7%	21.8%	19.5%
In-Home	53.3%	51.2%	53.3%	51.9%
Other LTSS	2.3%	1.7%	2.2%	0.4%
All Other	0.0%	0.0%	0.0%	0.1%
Total	**38.3%**	**36.6%**	**32.8%**	**34.9%**

Primary Care Rate Increase

Effective October 1, 2021, Section 211, proviso #35 of Engrossed Substitute Senate Bill (ESSB) 50921 requires HCA to increase physician service rates 15% for adult primary care under managed care through a uniform percentage increase pursuant to 42 CFR §438.6(c)(1)(iii)(C). Per the legislative proviso, the adjustment was calculated by applying a 15% increase to the base cost for applicable PCP services for Medicaid Only members, identified using HCPCS code and modifier.

Mental Health Provider Fee Schedule Increase

Effective October 1, 2021, the HCA has been directed by the state legislature to increase current reimbursement for certain behavioral health services provided by physicians and other non-BH-specific providers by 15%. The adjustment was implemented by applying a 15% increase to the base cost for applicable BH services, identified using HCPCS code, by 15%.

[1] http://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5092-S.SL.pdf?q=20210809224112

Risk Adjustment

[redacted]

Nursing Home Distribution

Table 14 shows the nursing home distributions calculated and used by county and PACE organization, along with the method of calculation as described below.

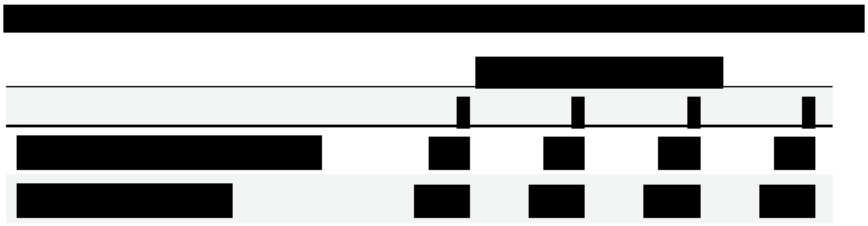
[redacted]

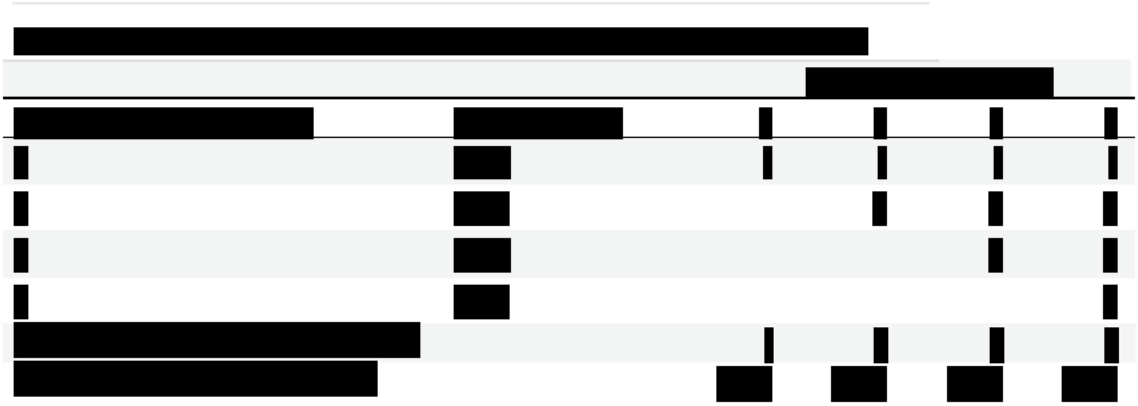
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

[redacted]

- [redacted]
  - [redacted]
  - [redacted]
- [redacted]
- [redacted]
  - [redacted]
  - [redacted]
  - [redacted] otherwise been paid).

An example of this calculation is shown in Tables 15a-c.





NEMT Rate Development

The projected transportation cost decreased compared to the FY 2022 rates for all rates. The projected FY 2023-2024 PMPMs were developed using the following methodology, as summarized in Table 17:

- Summarize Providence's King County CY 2019 transportation data, as provided by Providence. Both CY 2020 and 2021 transportation data were dampened significantly by COVID, so we chose a non-COVID year as a starting point.
- Allocate 21% of these costs to outside transportation vendors, and 79% to Providence staff, using data from Providence's January 2020 financial summary.
- Apply fee schedule changes:
    - Trend the TriMed PMPMs by 60%, consistent with the increase from $50 per trip cited by Providence in 2019 and the approximately $80 per external vendor trip supplied by Providence in 2021.
    - Trend the staff PMPMs by 71%, consistent with the FFS unit cost increase based on reports from HCA.
- Apply a reduction in trips due to COVID. In January 2020, Providence reported 8.8 trips per member, and in late 2021 they reported 4.25 trips per member. We assumed that half of these missing trips would return over the course of FY 2023, so we projected 6.5 one-way trips per member per month in FY 2023. We therefore applied a 26% reduction to the 8.8 trips per member to account for these missing trips.
- We used the same PMPM for King (ICHS) and King (MC), assuming they can contract at rates similar to Providence. For rates in other counties, we applied a geographic factor based on the relativity of the FFS unit costs.

The calculation of transportation costs in the amounts otherwise paid also changed relative to the FY 2021-2022 rates. These were previously calculated based on FFS unit cost at two round trips per week. Both Providence and HCA reported significantly fewer trips than this for each year from 2019 to 2021, so we no longer feel it is appropriate to maintain this assumption. Instead, we based the projected trips on reported trips over the three-year period, along with trips reported by Providence. The AWOP assumes eight one-way trips per member per month. The FFS unit cost based on reports provided by HCA was $60 for King County, $55 for Pierce, $70 for Snohomish, and $45 for Spokane.

TABLE 16: COMPARISON OF TRANSPORTATION METHODOLOGIES

ASSUMPTION	FY 23-24 RATES	FY 22 RATES
NEMT – Amounts otherwise paid	Use current FFS unit cost, 8 one-way trips per month.	Use current FFS unit cost, 2 round trips/week
NEMT – King Rates	Use historical King (Prov) data with unit cost increases and COVID adjustments applied	Use historical King (Prov) data with fee schedule increases applied (as % change)
NEMT – Other Rates	Use King (Prov) data with unit cost increases, COVID adjustments, and geographic adjustments applied	Use King (Prov) data with fee increases applied (as above) and geographic adjustments.

Administrative Costs

We have included retention in these rates. The retention loads are shown in Table 16 below for the rates and the amounts otherwise paid. They include care management, administration, and risk margin.

Care management costs are assumed to be the same as those transferred from the State to the PACE program. There is no duplication of care management costs or services because we have only included care management costs transferred from the State to the PACE organization in the rate and AWOP development. The State maintains the responsibility to conduct eligibility determinations but does not continue to conduct care management services for PACE members after they are enrolled in the PACE program.

Additional administration costs and risk margin are applied to both HCBS and nursing home rates as a percentage of premium, with a 5.5% load for dual eligible rates and a 6.0% for Medicaid only rates. Retention is not applied to the behavioral health rates since they already include retention.

The retention assumptions were chosen after comparison with PACE and MLTSS programs in other states as well as a review of recent high-level Providence financials. The selected assumptions result in rates lower than the amounts otherwise paid.

The amounts otherwise paid do not include the same retention load as the rates, but they do include administrative costs that are transferred from the State to the PACE organization. The care coordination component is based on the administrative cost expected to be transferred from FFS (LTSS) to PACE, as calculated by ALTSA using projected employment data. This amounts to $132.63 PMPM for HCBS members, while NH members are not expected to have any non-negligible transferred administrative cost. These costs represent state costs for administering the program, and do not include PACE administrative costs, as required by guidance from CMS. These are not the full costs expected for PACE to administer the program, nor are they the full state administration costs. These represent costs transferred to PACE and therefore are a reduction to state administration.

TABLE 17: COMPARISON OF RATES TO AMOUNTS OTHERWISE PAID

RATE COMPONENT	SET RATES	AMOUNTS OTHERWISE PAID
Care Management (HCBS Only)	$132.63 PMPM	$132.63 PMPM
Administrative Load	4.5%-5.0% of premium	None
Risk Margin	1.0% risk margin	None
Taxes & Fees	None (not applicable)	None

Behavioral Health

Substance use disorder and mental health services were covered under separate BH capitation rates in the experience period and the projection period. These rates are developed by Milliman as part of the CY 2022 Apple Health Integrated Managed Care rates. The BH rates included here are identical to those paid for members who receive their behavioral health services through a managed care organization and all other services FFS; these rates represent the cost to the State if these members remained FFS. We have added these BH rates to our final PACE rates.

Note that the behavioral health managed care rates do not include all Medicaid members as some members, such as AI/AN populations, can opt out of managed care coverage. However, the impact of including these members on the managed care rates is immaterial. Additionally, despite AI/AN opt outs, the behavioral health capitation rates are still the best representation of the AWOP for behavioral health costs for PACE members.

Hepatitis C Rate

For this rate setting period, there is a separate rate for members who receive a Hepatitis C prescription in a given month. The rate is calculated as the sum of the member's rate based on dual eligibility status as discussed through the steps above plus a Hepatitis C load. The Hepatitis C load development is shown in Exhibit 5. It is developed based on P1

prescription drug claims from Medicaid members not currently participating in managed care, incurred from July 2020 through June 2021 and paid through November 2021. Appendix C lists the NDCs for all Hepatitis C drugs considered in this load development. Their costs, less rebates received by WA Medicaid, were used to find a base PMPM for members requiring Hepatitis C drugs. The annual trend rate of 0% was derived from internal Milliman research on Medicare Part D trends, limited to Hepatitis C. This research was based on a review of historical Milliman data, publicly available industry trend reports, and publicly available information on anticipated new drugs. The monthly add-on load for a member receiving a Hepatitis C prescription drug treatment is $8,685.82.

Data Reliance and Caveats

This analysis is intended for the use of the State of Washington Aging and Long-Term Support Administration (ALTSA) in support of PACE. We understand that this information will be shared with other parties. To the extent that the information contained in this report is provided to third parties, the document should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this report prepared for ALTSA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of any managed care organization to make an independent determination as to the adequacy of the proposed capitation rates for their organization.

We relied on certain models in the preparation of these exhibits. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

Actual costs for the program will vary from our projections for many reasons. Differences between the capitation rates and actual PACE experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. Given the volatile nature of medical trends, there are a range of reasonable trend assumptions underlying the point estimates included in these rates. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. Experience should continue to be monitored on a regular basis.

This analysis has relied extensively on data provided by ALTSA, the Washington State Health Care Authority, and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis presented herein.

The terms of Milliman's contract with the Washington Aging and Long-Term Support Administration, as signed July 9, 2018, apply to this report and its use.

Actuarial Certification

I, Annie Hallum, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by the State of Washington Aging and Long-Term Support Administration (ALTSA) to perform an actuarial certification of Program for All-inclusive Care for the Elderly (PACE) Medicaid capitation rates for July 2022 - June 2024 (FY 2023-2024) for filing with the Centers for Medicare and Medicaid Services (CMS). I reviewed the calculated capitation rates and am familiar with the Code of Federal Regulations, 42 CFR 460.182 and the CMS "Financial Review Documentation for UPL and Rate Setting" checklist.

I examined the actuarial assumptions and actuarial methods used in setting the capitation rates for FY 2023-2024. To the best of my information, knowledge and belief, for FY 2023-2024, the capitation rates offered by ALTSA are in compliance with 42 CFR 460.182(b). This actuarial report describes the Medicaid capitation rate setting methodology for the PACE program.

In my opinion, the capitation rates are actuarially sound, as defined in Actuarial Standard of Practice (ASOP) 49, were developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract.

In making my opinion, I relied upon the accuracy of the underlying records, data summaries, and calculations prepared by ALTSA and HCA. I did not audit the data and calculations, but did review them for reasonableness and consistency and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations, as I considered necessary.

Any capitated plan will need to review the rates in relation to the benefits provided. The capitated plan should compare the rates with its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with ALTSA. The capitated plan may require rates above, equal to, or below the actuarially sound capitation rates.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this certification.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted capitated plan's situation and experience

This certification assumes the reader is familiar with the Washington Medicaid program, Medicaid eligibility rules, and actuarial rating techniques. The certification is intended for the State of Washington and Centers for Medicare and Medicaid Services and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this certification, so as to properly interpret the projection results.

April 28, 2022

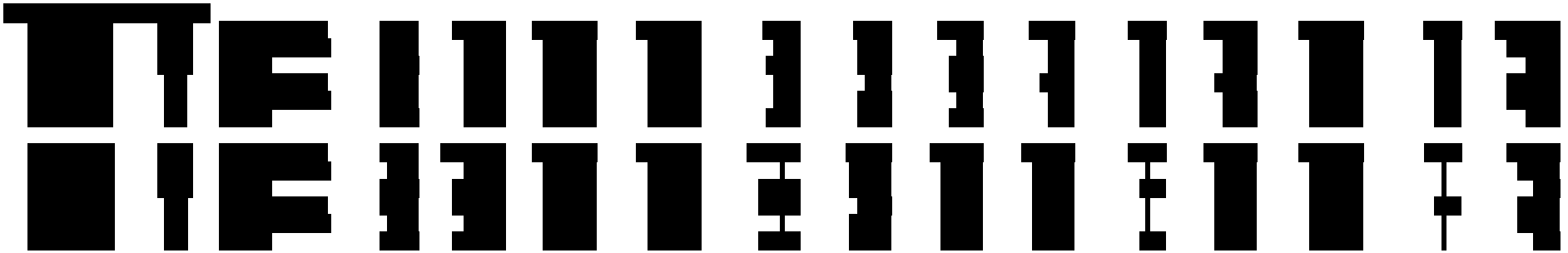
Annie Hallum, FSA, MAAA
Principal and Consulting Actuary

Date

APPENDIX A

Exhibit 1a
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Projected Providence King County PACE FFS Benefit Costs From ProviderOne

				Composite ProviderOne Benefit Costs			HCA ProviderOne Benefit Costs						ALTSA ProviderOne Benefit Costs		
Medicare Status	Age Band	Care Setting	Distribution	HCA	ALTSA	Composite[1]	Inpatient Hospital	Outpatient Hospital	Physician	Prescription Drug	Dental	Other Medical	ALTSA[2]	Nursing Home	Patient Participation
Distribution Used [3]															
Medicaid Only	55-64			$ 1,850.77	$ 4,816.32	$ 6,667.09	$ 459 86	$ 223.93	$ 286.16	$ 519.74	$ 1 66	$ 359.42	$ 4,453 57	$ 100.22	$ 262.53
Medicaid Only	65+			1,850.77	4,816.32	6,667.09	459 86	223.93	286.16	519.74	1.66	359.42	4,453.57	100 22	262 53
Dually Eligible	55-64			$ 167 60	$ 4,117.34	$ 4,284.94	$ 8.72	$ 9.77	$ 13.28	$ 11.51	$ 0.02	$ 124 30	$ 3,135.56	$ 105 68	$ 876.10
Dually Eligible	65+			167.60	4,117.34	4,284.94	8.72	9.77	13.28	11.51	0.02	124.30	3,135.56	105 68	876.10
Providence PACE Distribution [4]															
Dually Eligible	55-64	HCBS	98 8%	$ 165.71	$ 4,047.45	$ 4,213.17	$ 8 37	$ 9.74	$ 13.36	$ 11.64	$ 0 02	$ 122 59	$ 3,171 87	$ 0.66	$ 874.93
Dually Eligible	65+	HCBS	98 8%	165.71	4,047.45	4,213.17	8 37	9.74	13.36	11.64	0.02	122.59	3,171.87	0 66	874.93
King County FFS Distribution[5]															
Dually Eligible	55-64	Nursing Home	1 2%	326 09	$ 9,991.22	$ 10,317.31	37 84	12.22	7.17	1.00	0.11	267.75	83.64	8,932.79	974.79
Dually Eligible	65+	Nursing Home	1 2%	326 09	9,991.22	10,317.31	37 84	12.22	7.17	1.00	0.11	267.75	83.64	8,932.79	974.79
Medicaid Only	55-64	Nursing Home	1 2%	$ 4,423.64	$ 9,501.26	$ 13,924.90	$ 3,056 98	$ 182.79	$ 537.74	$ 173.15	$ 0 37	$ 472 61	$ 226 89	$ 8,479.60	$ 794.77
Medicaid Only	55-64	HCBS	98 8%	1,820.17	4,760.59	6,580.75	428 96	224.42	283.17	523.87	1.68	358.07	4,503.86	0 53	256 20
Medicaid Only	65+	Nursing Home	1 2%	4,423 64	9,501.26	13,924.90	3,056 98	182.79	537.74	173.15	0.37	472.61	226.89	8,479 60	794.77
Medicaid Only	65+	HCBS	98 8%	1,820.17	4,760.59	6,580.75	428 96	224.42	283.17	523.87	1.68	358.07	4,503.86	0 53	256 20



[1] Transportation and behavioral health components are not included here.
Chemical dependency services are covered under Behavioral Health rates and not shown separately.
HCA (Health Care Authority) includes inpatient, outpatient, physician, prescription drug, dental and other medical.
There has been no management discount applied to HCA services presented here.

[2] Services covered by the Aging and Long-Term Support Administration except for nursing home services which are shown separately.

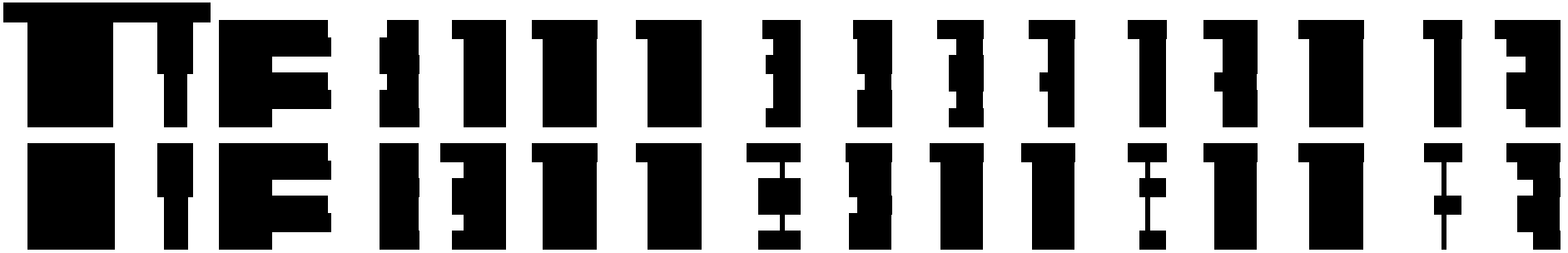
[3] Costs were summarized by Medicare status and nursing home status. Blending is done using the expected proportion of Nursing Home members.
This is to best match the appropriate FFS population to develop PACE rates.

[4] Based on the CY 2021 membership mix reported by Providence in King County

[5] Based on the entire King County distribution of similar members. This is not adjusted for risk levels experienced in the PACE population.
Partially credible rate cells are calculated with additional counties for credibility reasons.

Exhibit 1b
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Projected ICHS King County PACE FFS Benefit Costs From ProviderOne

				Composite ProviderOne Benefit Costs			HCA ProviderOne Benefit Costs						ALTSA ProviderOne Benefit Costs		
Medicare Status	Age Band	Care Setting	Distribution	HCA	ALTSA	Composite[1]	Inpatient Hospital	Outpatient Hospital	Physician	Prescription Drug	Dental	Other Medical	ALTSA[2]	Nursing Home	Patient Participation
Distribution Used [3]															
Medicaid Only	55-64			$ 1,926.97	$ 3,857.97	$ 5,784.94	$ 499.78	$ 301.00	$ 335.75	$ 412.93	$ 2.40	$ 375.11	$ 3,356 52	$ 309.58	$ 191.87
Medicaid Only	65+			1,926.97	3,857.97	5,784.94	499.78	301.00	335.75	412.93	2.40	375.11	3,356.52	309 58	191 87
Dually Eligible	55-64			$ 140.46	$ 3,972.73	$ 4,113.19	$ 12 85	$ 11.78	$ 13.15	$ 7.64	$ 0.03	$ 95 01	$ 3,236.31	$ 326 26	$ 410.16
Dually Eligible	65+			140.46	3,972.73	4,113.19	12 85	11.78	13.15	7.64	0.03	95.01	3,236.31	326 26	410.16
King County FFS Distribution [4]															
Dually Eligible	55-64	Nursing Home	3 6%	$ 326 09	$ 9,991.22	$ 10,317.31	$ 37 84	$ 12.22	$ 7.17	$ 1.00	$ 0.11	$ 267.75	$ 83 64	$ 8,932.79	$ 974.79
Dually Eligible	55-64	HCBS	96.4%	133.42	3,744.77	3,878.19	11 90	11.76	13.37	7.89	0.03	88.47	3,355.73	0 26	388.77
Dually Eligible	65+	Nursing Home	3 6%	326 09	9,991.22	10,317.31	37 84	12.22	7.17	1.00	0.11	267.75	83.64	8,932.79	974.79
Dually Eligible	65+	HCBS	96.4%	133.42	3,744.77	3,878.19	11 90	11.76	13.37	7.89	0.03	88.47	3,355.73	0 26	388.77
Medicaid Only	55-64	Nursing Home	3 6%	$ 4,423.64	$ 9,501.26	$ 13,924.90	$ 3,056 98	$ 182.79	$ 537.74	$ 173.15	$ 0 37	$ 472 61	$ 226 89	$ 8,479.60	$ 794.77
Medicaid Only	55-64	HCBS	96.4%	1,832.40	3,644.21	5,476.61	402 92	305.48	328.09	422.01	2.48	371.42	3,475.07	0.11	169.03
Medicaid Only	65+	Nursing Home	3 6%	4,423.64	9,501.26	13,924.90	3,056 98	182.79	537.74	173.15	0.37	472.61	226.89	8,479 60	794.77
Medicaid Only	65+	HCBS	96.4%	1,832.40	3,644.21	5,476.61	402 92	305.48	328.09	422.01	2.48	371.42	3,475.07	0.11	169 03



[1] Transportation and behavioral health components are not included here.
Chemical dependency services are covered under Behavioral Health rates and not shown separately.
HCA (Health Care Authority) includes inpatient, outpatient, physician, prescription drug, dental and other medical.
There has been no management discount applied to HCA services presented here.

[2] Services covered by the Aging and Long-Term Support Administration except for nursing home services which are shown separately.

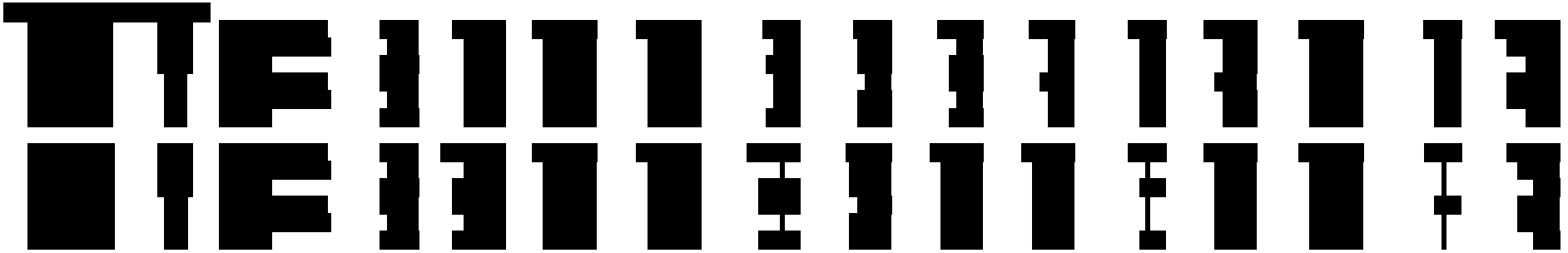
[3] Costs were summarized by Medicare status and nursing home status. Blending is done using the expected proportion of Nursing Home members.
This is to best match the appropriate FFS population to develop PACE rates.

[4] Based on the entire King County distribution of similar members. This is not adjusted for risk levels experienced in the PACE population.
Partially credible rate cells are calculated with additional counties for credibility reasons.

PROPRIETARY

Exhibit 1c
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Projected MultiCare King County PACE FFS Benefit Costs From ProviderOne

				Composite ProviderOne Benefit Costs			HCA ProviderOne Benefit Costs						ALTSA ProviderOne Benefit Costs		
Medicare Status	Age Band	Care Setting	Distribution	HCA	ALTSA	Composite[1]	Inpatient Hospital	Outpatient Hospital	Physician	Prescription Drug	Dental	Other Medical	ALTSA[2]	Nursing Home	Patient Participation
Distribution Used [3]															
Medicaid Only	55-64			$ 2,087.73	$ 3,912.48	$ 6,000.21	$ 541 97	$ 302.09	$ 360.47	$ 485.88	$ 2.71	$ 394 61	$ 3,582.75	$ 192.46	$ 137.27
Medicaid Only	65+			2,087.73	3,912.48	6,000.21	541 97	302.09	360.47	485.88	2.71	394.61	3,582.75	192.46	137 27
Dually Eligible	55-64			$ 144 83	$ 4,106.20	$ 4,251.03	$ 13 66	$ 11.27	$ 14.14	$ 8.16	$ 0.03	$ 97 57	$ 3,708.26	$ 107 84	$ 290.10
Dually Eligible	65+			144.83	4,106.20	4,251.03	13 66	11.27	14.14	8.16	0.03	97.57	3,708.26	107 84	290.10
King County FFS Distribution [4]															
Dually Eligible	55-64	Nursing Home	1 2%	$ 326 09	$ 9,991.22	$ 10,317.31	$ 37 84	$ 12.22	$ 7.17	$ 1.00	$ 0.11	$ 267.75	$ 83 64	$ 8,932.79	$ 974.79
Dually Eligible	55-64	HCBS	98 8%	142 61	4,034.47	4,177.08	13 36	11.25	14.23	8.25	0.03	95.49	3,752.43	0 29	281.75
Dually Eligible	65+	Nursing Home	1 2%	326 09	9,991.22	10,317.31	37 84	12.22	7.17	1.00	0.11	267.75	83.64	8,932.79	974.79
Dually Eligible	65+	HCBS	98 8%	142.61	4,034.47	4,177.08	13 36	11.25	14.23	8.25	0.03	95.49	3,752.43	0 29	281.75
Medicaid Only	55-64	Nursing Home	2 3%	$ 4,423.64	$ 9,501.26	$ 13,924.90	$ 3,056 98	$ 182.79	$ 537.74	$ 173.15	$ 0 37	$ 472 61	$ 226 89	$ 8,479.60	$ 794.77
Medicaid Only	55-64	HCBS	97.7%	2,033.54	3,782.84	5,816.38	483 63	304.86	356.36	493.13	2.76	392.80	3,660.59	0 23	122.02
Medicaid Only	65+	Nursing Home	2 3%	4,423.64	9,501.26	13,924.90	3,056 98	182.79	537.74	173.15	0.37	472.61	226.89	8,479 60	794.77
Medicaid Only	65+	HCBS	97.7%	2,033.54	3,782.84	5,816.38	483 63	304.86	356.36	493.13	2.76	392.80	3,660.59	0 23	122 02



[1] Transportation and behavioral health components are not included here.
Chemical dependency services are covered under Behavioral Health rates and not shown separately.
HCA (Health Care Authority) includes inpatient, outpatient, physician, prescription drug, dental and other medical.
There has been no management discount applied to HCA services presented here.

[2] Services covered by the Aging and Long-Term Support Administration except for nursing home services which are shown separately.

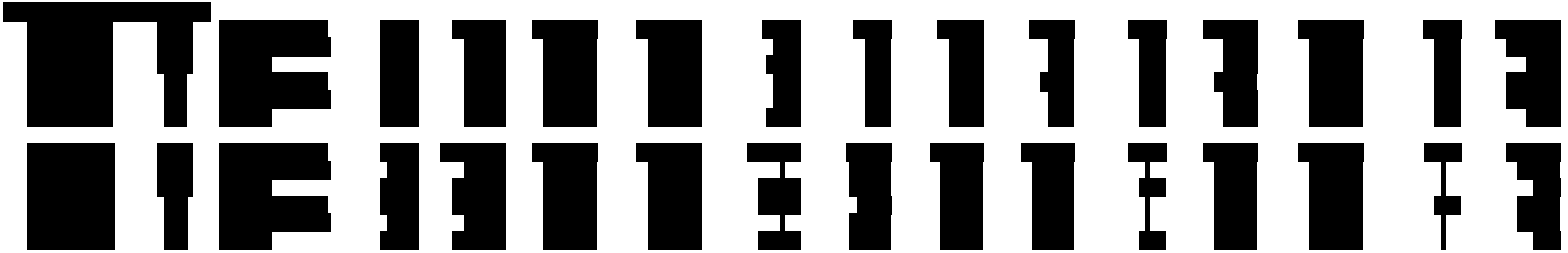
[3] Costs were summarized by Medicare status and nursing home status. Blending is done using the expected proportion of Nursing Home members.
This is to best match the appropriate FFS population to develop PACE rates.

[4] Based on the entire King County distribution of similar members. This is not adjusted for risk levels experienced in the PACE population.
Partially credible rate cells are calculated with additional counties for credibility reasons.

PROPRIETARY

Exhibit 1d
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Projected Spokane County PACE FFS Benefit Costs From ProviderOne

							HCA ProviderOne Benefit Costs						ALTSA ProviderOne Benefit Costs		
		Care		Composite ProviderOne Benefit Costs			Inpatient	Outpatient		Prescription		Other		Nursing	Patient
Medicare Status	Age Band	Setting	Distribution	HCA	ALTSA	Composite[1]	Hospital	Hospital	Physician	Drug	Dental	Medical	ALTSA[2]	Home	Participation
Distribution Used [3]															
Medicaid Only	55-64			$ 2,146.76	$ 3,618.93	$ 5,765.69	$ 573 93	$ 321.70	$ 378.36	$ 467.59	$ 2 94	$ 402 24	$ 3,254 39	$ 250.42	$ 114.12
Medicaid Only	65+			2,146.76	3,618.93	5,765.69	573 93	321.70	378.36	467.59	2.94	402.24	3,254.39	250.42	114.12
Dually Eligible	55-64			$ 134 22	$ 4,119.89	$ 4,254.11	$ 15 63	$ 4.88	$ 19.84	$ 4.54	$ 0.06	$ 89 27	$ 3,405.40	$ 257.42	$ 457.07
Dually Eligible	65+			134.22	4,119.89	4,254.11	15 63	4 88	19.84	4.54	0.06	89 27	3,405.40	257.42	457.07
Spokane County FFS Distribution [4]															
Dually Eligible	55-64	Nursing Home	3 3%	$ 226 86	$ 9,011.36	$ 9,238.22	$ 21 83	$ 6.31	$ 7.79	$ 1.17	$ 0 01	$ 189.75	$ 98.79	$ 7,872.98	$ 1,039.59
Dually Eligible	55-64	HCBS	96.7%	131.10	3,955.27	4,086.37	15.42	4 83	20.25	4.65	0.06	85.89	3,516.69	1.11	437.47
Dually Eligible	65+	Nursing Home	3 3%	226.86	9,011.36	9,238.22	21 83	6 31	7.79	1.17	0.01	189.75	98.79	7,872 98	1,039.59
Dually Eligible	65+	HCBS	96.7%	131.10	3,955.27	4,086.37	15.42	4 83	20.25	4.65	0.06	85 89	3,516.69	1.11	437.47
Medicaid Only	55-64	Nursing Home	3 3%	$ 4,423.64	$ 8,662.35	$ 13,085.99	$ 3,056 98	$ 182.79	$ 537.74	$ 173.15	$ 0 37	$ 472 61	$ 225 03	$ 7,642.55	$ 794.77
Medicaid Only	55-64	HCBS	96.7%	2,069.66	3,448.16	5,517.82	489 86	326.40	372.97	477.55	3.02	399.85	3,356.95	0.13	91.07
Medicaid Only	65+	Nursing Home	3 3%	4,423.64	8,662.35	13,085.99	3,056 98	182.79	537.74	173.15	0.37	472.61	225.03	7,642 55	794.77
Medicaid Only	65+	HCBS	96.7%	2,069.66	3,448.16	5,517.82	489 86	326.40	372.97	477.55	3.02	399.85	3,356.95	0.13	91.07



[1] Transportation and behavioral health components are not included here.
Chemical dependency services are covered under Behavioral Health rates and not shown separately.
HCA (Health Care Authority) includes inpatient, outpatient, physician, prescription drug, dental and other medical.
There has been no management discount applied to HCA services presented here.

[2] Services covered by the Aging and Long-Term Support Administration except for nursing home services which are shown separately.

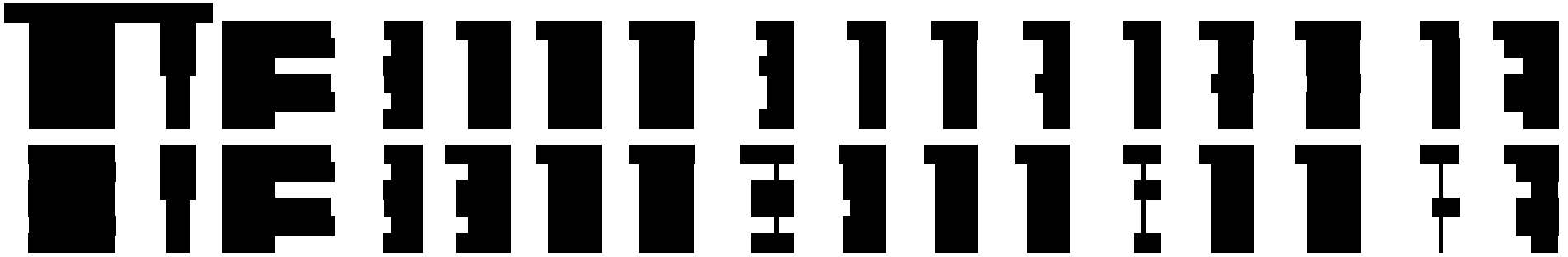
[3] Costs were summarized by Medicare status and nursing home status. Blending is done using the expected proportion of Nursing Home members.
This is to best match the appropriate FFS population to develop PACE rates.

[4] Based on the entire Spokane County distribution of similar members. This is not adjusted for risk levels experienced in the PACE population.
Partially credible rate cells are calculated with additional counties for credibility reasons.

PROPRIETARY

Exhibit 1e
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Projected Snohomish County PACE FFS Benefit Costs From ProviderOne

				Composite ProviderOne Benefit Costs			HCA ProviderOne Benefit Costs						ALTSA ProviderOne Benefit Costs		
Medicare Status	Age Band	Care Setting	Distribution	HCA	ALTSA	Composite[1]	Inpatient Hospital	Outpatient Hospital	Physician	Prescription Drug	Dental	Other Medical	ALTSA[2]	Nursing Home	Patient Participation
Distribution Used [3]															
Medicaid Only	55-64			$ 2,031.52	$ 4,283 62	$ 6,315.14	$ 519.91	$ 271 63	$ 336.92	$ 515.49	$ 2.37	$ 385 20	$ 3,974.74	$ 134.55	$ 174.33
Medicaid Only	65+			2,031 52	4,283.62	6,315.14	519.91	271 63	336.92	515.49	2.37	385 20	3,974.74	134.55	174.33
Dually Eligible	55-64			$ 146.40	$ 4,358 09	$ 4,504.49	$ 14.34	$ 6 20	$ 14.14	$ 7.74	$ 0.04	$ 103 94	$ 3,681.74	$ 144.61	$ 531.74
Dually Eligible	65+			146.40	4,358.09	4,504.49	14.34	6 20	14.14	7.74	0.04	103 94	3,681.74	144.61	531.74
Snohomish County FFS Distribution [4]															
Dually Eligible	55-64	Nursing Home	1.6%	$ 340.17	$ 10,171.14	$ 10,511.31	$ 33.03	$ 9.51	$ 12.31	$ 1.05	$ 0.03	$ 284 24	$ 103.03	$ 8,976.28	$ 1,091.83
Dually Eligible	55-64	HCBS	98.4%	143.23	4,263 29	4,406.52	14.04	6.14	14.17	7.85	0.04	101 00	3,740.09	0.59	522.60
Dually Eligible	65+	Nursing Home	1.6%	340.17	10,171.14	10,511.31	33 03	9 51	12.31	1.05	0.03	284 24	103.03	8,976.28	1,091.83
Dually Eligible	65+	HCBS	98.4%	143.23	4,263 29	4,406.52	14.04	6.14	14.17	7.85	0.04	101 00	3,740.09	0.59	522.60
Medicaid Only	55-64	Nursing Home	1.6%	$ 4,423.64	$ 9,656 32	$ 14,079.96	$ 3,056.98	$ 182.79	$ 537.74	$ 173.15	$ 0.37	$ 472 61	$ 226.78	$ 8,634.77	$ 794.77
Medicaid Only	55-64	HCBS	98.4%	1,993.76	4,198.81	6,192.57	479.86	273 03	333.75	520.90	2.40	383 82	4,033.91	0.37	164.54
Medicaid Only	65+	Nursing Home	1.6%	4,423.64	9,656.32	14,079.96	3,056.98	182.79	537.74	173.15	0.37	472 61	226.78	8,634.77	794.77
Medicaid Only	65+	HCBS	98.4%	1,993.76	4,198.81	6,192.57	479.86	273 03	333.75	520.90	2.40	383 82	4,033.91	0.37	164.54



[1] Transportation and behavioral health components are not included here.
Chemical dependency services are covered under Behavioral Health rates and not shown separately.
HCA (Health Care Authority) includes inpatient, outpatient, physician, prescription drug, dental and other medical.
There has been no management discount applied to HCA services presented here.

[2] Services covered by the Aging and Long-Term Support Administration except for nursing home services which are shown separately.

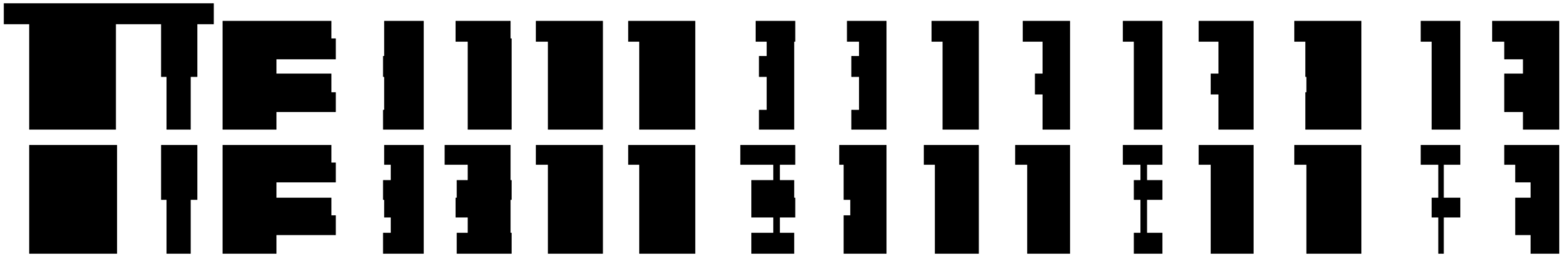
[3] Costs were summarized by Medicare status and nursing home status. Blending is done using the expected proportion of Nursing Home members.
This is to best match the appropriate FFS population to develop PACE rates.

[4] Based on the entire Snohomish County distribution of similar members. This is not adjusted for risk levels experienced in the PACE population.
Partially credible rate cells are calculated with additional counties for credibility reasons.

PROPRIETARY

Exhibit 1f
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Projected Pierce County PACE FFS Benefit Costs From ProviderOne

				Composite ProviderOne Benefit Costs			HCA ProviderOne Benefit Costs						ALTSA ProviderOne Benefit Costs		
Medicare Status	Age Band	Care Setting	Distribution	HCA	ALTSA	Composite[1]	Inpatient Hospital	Outpatient Hospital	Physician	Prescription Drug	Dental	Other Medical	ALTSA[2]	Nursing Home	Patient Participation
Distribution Used[3]															
Medicaid Only	55-64			$ 1,985.48	$ 4,101.77	$ 6,087.25	$ 482.79	$ 275 86	$ 333.64	$ 508.17	$ 2.39	$ 382 63	$ 3,894.48	$ 38.55	$ 168.74
Medicaid Only	65+			1,985.48	4,101.77	6,087.25	482.79	275 86	333.64	508.17	2.39	382 63	3,894.48	38.55	168.74
Dually Eligible	55-64			$ 147 32	$ 4,021 68	$ 4,169.00	$ 15.72	$ 10.49	$ 16.32	$ 6.90	$ 0.11	$ 97.78	$ 3,473.58	$ 148.24	$ 399.86
Dually Eligible	65+			147.32	4,021.68	4,169.00	15.72	10.49	16.32	6.90	0.11	97.78	3,473.58	148.24	399.86
Pierce County FFS Distribution[4]															
Dually Eligible	55-64	Nursing Home	1.8%	$ 399.32	$ 9,462.74	$ 9,862.06	$ 41.76	$ 4.81	$ 13.25	$ 1.09	$ 0.17	$ 338 24	$ 87.66	$ 8,298.09	$ 1,076.99
Dually Eligible	55-64	HCBS	98.2%	142.74	3,922 84	4,065.58	15.25	10 59	16.37	7.01	0.11	93.41	3,535.09	0.20	387.56
Dually Eligible	65+	Nursing Home	1.8%	399 32	9,462.74	9,862.06	41.76	4 81	13.25	1.09	0.17	338 24	87.66	8,298.09	1,076.99
Dually Eligible	65+	HCBS	98.2%	142.74	3,922.84	4,065.58	15.25	10 59	16.37	7.01	0.11	93.41	3,535.09	0.20	387.56
Medicaid Only	55-64	Nursing Home	0.5%	$ 4,423.64	$ 9,217.73	$ 13,641.37	$ 3,056.98	$ 182.79	$ 537.74	$ 173.15	$ 0.37	$ 472 61	$ 225.52	$ 8,197.44	$ 794.77
Medicaid Only	55-64	HCBS	99.5%	1,974 06	4,077.81	6,051.87	470.73	276 29	332.68	509.74	2.40	382 21	3,911.66	0.34	165.81
Medicaid Only	65+	Nursing Home	0.5%	4,423.64	9,217.73	13,641.37	3,056.98	182.79	537.74	173.15	0.37	472 61	225.52	8,197.44	794.77
Medicaid Only	65+	HCBS	99.5%	1,974 06	4,077.81	6,051.87	470.73	276 29	332.68	509.74	2.40	382 21	3,911.66	0.34	165.81



[1] Transportation and behavioral health components are not included here.
Chemical dependency services are covered under Behavioral Health rates and not shown separately.
HCA (Health Care Authority) includes inpatient, outpatient, physician, prescription drug, dental and other medical.
There has been no management discount applied to HCA services presented here.

[2] Services covered by the Aging and Long-Term Support Administration except for nursing home services which are shown separately.

[3] Costs were summarized by Medicare status and nursing home status. Blending is done using the expected proportion of Nursing Home members.
This is to best match the appropriate FFS population to develop PACE rates.

[4] Based on the entire Pierce County distribution of similar members. This is not adjusted for risk levels experienced in the PACE population.
Partially credible rate cells are calculated with additional counties for credibility reasons.

PROPRIETARY

Exhibit 2a
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Projected King County PACE Costs - Providence

		Benefit Costs[1]					Behavioral Health Rates[2]			Total Rates[3]		
Medicare Status	Age Band	Net Admin, BH, and NEMT	Transportation	Care Management	Admin	Total Benefit Cost Net BH	Categorically Needy	Disabled	Newly Eligible	Categorically Needy	Disabled	Newly Eligible
Composite												
Medicaid Only	55-64	$ 6,667.09	$ 367.32	$ 131.07	$ 456.20	$ 7,621.67	$ 64.00	$ 356.84	$ 73.09	$ 7,685.67	$ 7,978.51	$ 7,694.76
Medicaid Only	65+	6,667.09	367.32	131.07	456 20	7,621.67	64.00	356 84	73.09	7,685.67	7,978.51	7,694.76
Dually Eligible	55-64	$ 4,284.94	$ 367.32	$ 131.07	$ 277.32	$ 5,060.65	$ 64.00	$ 356.84	$ 73.09	$ 5,124.65	$ 5,417.49	$ 5,133.74
Dually Eligible	65+	4,284.94	367.32	131.07	277 32	5,060.65	64.00	356 84	73.09	5,124.65	5,417.49	5,133.74
ALTSA												
Medicaid Only	55-64	$ 4,816.32	$ 202.03	$ 131.07	$ 228.10	$ 5,377.51						
Medicaid Only	65+	4,816.32	202.03	131 07	228.10	5,377.51						
Dually Eligible	55-64	$ 4,117.34	$ 202.03	$ 131.07	$ 277 32	$ 4,727.76						
Dually Eligible	65+	4,117.34	202.03	131 07	277.32	4,727.76						
HCA												
Medicaid Only	55-64	$ 1,850.77	$ 165.29	$ 0.00	$ 228.10	$ 2,244.16						
Medicaid Only	65+	1,850.77	165.29	-	228.10	2,244.16						
Dually Eligible	55-64	$ 167.60	$ 165.29	$ 0.00	$ 0 00	$ 332.89						
Dually Eligible	65+	167.60	165.29	-	-	332.89						

[1] Total from Exhibit 1, not including the non-emergency transportation (NEMT) or behavioral health (BH). Other counties were included for cohorts where a rate could not be calculated based on county-wide distribution for credibility reasons.

[2] Behavioral health rates are developed independently by Milliman separately for Categorically Needy, Disabled, and Newly Eligible categories of aid.

[3] Milliman is not aware of the distribution of PACE clients between Categorically Needy, Disabled, and Newly Eligible members and therefore have not blended these populations.

Exhibit 2b
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Projected King County PACE Costs - ICHS

		Benefit Costs[1]					Behavioral Health Rates[2]			Total Rates[3]		
Medicare Status	Age Band	Net Admin, BH, and NEMT	Transportation	Care Management	Admin	Total Benefit Cost Net BH	Categorically Needy	Disabled	Newly Eligible	Categorically Needy	Disabled	Newly Eligible
Composite												
Medicaid Only	55-64	$ 5,784 94	$ 367.32	$ 127.79	$ 399.89	$ 6,679.94	$ 64.00	$ 356.84	$ 73.09	$ 6,743.94	$ 7,036.78	$ 6,753.03
Medicaid Only	65+	5,784 94	367 32	127.79	399.89	6,679.94	64.00	356.84	73.09	6,743.94	7,036.78	6,753.03
Dually Eligible	55-64	$ 4,113.19	$ 367.32	$ 127.79	$ 267.33	$ 4,875.63	$ 64.00	$ 356.84	$ 73.09	$ 4,939.63	$ 5,232.47	$ 4,948.72
Dually Eligible	65+	4,113.19	367 32	127.79	267.33	4,875.63	64.00	356.84	73.09	4,939.63	5,232.47	4,948.72
ALTSA												
Medicaid Only	55-64	$ 3,857 97	$ 202.03	$ 127.79	$ 199.94	$ 4,387.73						
Medicaid Only	65+	3,857 97	202 03	127.79	199.94	4,387.73						
Dually Eligible	55-64	$ 3,972.73	$ 202.03	$ 127.79	$ 267.33	$ 4,569.88						
Dually Eligible	65+	3,972.73	202 03	127.79	267.33	4,569.88						
HCA												
Medicaid Only	55-64	$ 1,926 97	$ 165.29	$ 0.00	$ 199.94	$ 2,292.21						
Medicaid Only	65+	1,926 97	165 29	-	199.94	2,292.21						
Dually Eligible	55-64	$ 140.46	$ 165.29	$ 0.00	$ 0.00	$ 305.75						
Dually Eligible	65+	140.46	165 29	-	-	305.75						

[1] Total from Exhibit 1, not including the non-emergency transportation (NEMT) or behavioral heal h (BH). Other counties were included for cohorts where a rate could not be calculated based on county-wide distribution for credibility reasons.

[2] Behavioral health rates are developed independently by Milliman separately for Categorically Needy, Disabled, and Newly Eligible categories of aid.

[3] Milliman is not aware of the distribution of PACE clients between Categorically Needy, Disabled, and Newly Eligible members and therefore have not blended these populations.

Exhibit 2c
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Projected King County PACE Costs - MultiCare

		Benefit Costs[1]					Behavioral Health Rates[2]			Total Rates[3]		
Medicare Status	Age Band	Net Admin, BH, and NEMT	Transportation	Care Management	Admin	Total Benefit Cost Net BH	Categorically Needy	Disabled	Newly Eligible	Categorically Needy	Disabled	Newly Eligible
Composite												
Medicaid Only	55-64	$ 6,000 21	$ 367.32	$ 129.62	$ 413.63	$ 6,910.78	$ 64.00	$ 356.84	$ 73.09	$ 6,974.78	$ 7,267.62	$ 6,983.87
Medicaid Only	65+	6,000 21	367 32	129.62	413.63	6,910.78	64.00	356.84	73.09	6,974.78	7,267.62	6,983.87
Dually Eligible	55-64	$ 4,251 03	$ 367.32	$ 131.03	$ 275.35	$ 5,024.73	$ 64.00	$ 356.84	$ 73.09	$ 5,088.73	$ 5,381.57	$ 5,097.82
Dually Eligible	65+	4,251 03	367 32	131.03	275.35	5,024.73	64.00	356.84	73.09	5,088.73	5,381 57	5,097.82
ALTSA												
Medicaid Only	55-64	$ 3,912.48	$ 202.03	$ 129.62	$ 206.82	$ 4,450.94						
Medicaid Only	65+	3,912.48	202 03	129.62	206.82	4,450.94						
Dually Eligible	55-64	$ 4,106 20	$ 202.03	$ 131.03	$ 275.35	$ 4,714.61						
Dually Eligible	65+	4,106 20	202 03	131.03	275.35	4,714.61						
HCA												
Medicaid Only	55-64	$ 2,087.73	$ 165.29	$ 0.00	$ 206.82	$ 2,459.84						
Medicaid Only	65+	2,087.73	165 29	-	206.82	2,459.84						
Dually Eligible	55-64	$ 144 83	$ 165.29	$ 0.00	$ 0.00	$ 310.12						
Dually Eligible	65+	144 83	165 29	-	-	310.12						

[1] Total from Exhibit 1, not including the non-emergency transportation (NEMT) or behavioral heal h (BH). Other counties were included for cohorts where a rate could not be calculated based on county-wide distribution for credibility reasons.

[2] Behavioral health rates are developed independently by Milliman separately for Categorically Needy, Disabled, and Newly Eligible categories of aid.

[3] Milliman is not aware of the distribution of PACE clients between Categorically Needy, Disabled, and Newly Eligible members and therefore have not blended these populations.

Exhibit 2d
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Projected Spokane County PACE Costs

		Benefit Costs[1]					Behavioral Health Rates[2]			Total Rates[3]		
Medicare Status	Age Band	Net Admin, BH, and NEMT	Transportation	Care Management	Admin	Total Benefit Cost Net BH	Categorically Needy	Disabled	Newly Eligible	Categorically Needy	Disabled	Newly Eligible
Composite												
Medicaid Only	55-64	$ 5,765.69	$ 299.93	$ 128.29	$ 391.00	$ 6,584.91	$ 37.47	$ 207.16	$ 93.43	$ 6,622.38	$ 6,792.07	$ 6,678.34
Medicaid Only	65+	5,765.69	299 93	128.29	391.00	6,584.91	37.47	207.16	93.43	6,622.38	6,792 07	6,678.34
Dually Eligible	55-64	$ 4,254.11	$ 299.93	$ 128.31	$ 268.55	$ 4,950.90	$ 37.47	$ 207.16	$ 93.43	$ 4,988.37	$ 5,158.06	$ 5,044.33
Dually Eligible	65+	4,254.11	299 93	128.31	268.55	4,950.90	37.47	207.16	93.43	4,988.37	5,158 06	5,044.33
ALTSA												
Medicaid Only	55-64	$ 3,618 93	$ 164.96	$ 128.29	$ 195.50	$ 4,107.68						
Medicaid Only	65+	3,618 93	164 96	128.29	195.50	4,107.68						
Dually Eligible	55-64	$ 4,119 89	$ 164.96	$ 128.31	$ 268.55	$ 4,681.71						
Dually Eligible	65+	4,119 89	164 96	128.31	268.55	4,681.71						
HCA												
Medicaid Only	55-64	$ 2,146.76	$ 134.97	$ 0.00	$ 195.50	$ 2,477.23						
Medicaid Only	65+	2,146.76	134 97	-	195.50	2,477.23						
Dually Eligible	55-64	$ 134 22	$ 134.97	$ 0.00	$ 0.00	$ 269.19						
Dually Eligible	65+	134 22	134 97	-	-	269.19						

[1] Total from Exhibit 1, not including the non-emergency transportation (NEMT) or behavioral heal h (BH). Other counties were included for cohorts where a rate could not be calculated based on county-wide distribution for credibility reasons.

[2] Behavioral health rates are developed independently by Milliman separately for Categorically Needy, Disabled, and Newly Eligible categories of aid.

[3] Milliman is not aware of the distribution of PACE clients between Categorically Needy, Disabled, and Newly Eligible members and therefore have not blended these populations.

Exhibit 2e
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Projected Snohomish County PACE Costs

		Benefit Costs[1]					Behavioral Health Rates[2]			Total Rates[3]		
Medicare Status	Age Band	Net Admin, BH, and NEMT	Transportation	Care Management	Admin	Total Benefit Cost Net BH	Categorically Needy	Disabled	Newly Eligible	Categorically Needy	Disabled	Newly Eligible
Composite												
Medicaid Only	55-64	$ 6,315.14	$ 440.18	$ 130.57	$ 438.84	$ 7,324.73	$ 27.25	$ 239.32	$ 68.25	$ 7,351.98	$ 7,564.05	$ 7,392.98
Medicaid Only	65+	6,315.14	440.18	130.57	438.84	7,324.73	27.25	239.32	68.25	7,351.98	7,564 05	7,392.98
Dually Eligible	55-64	$ 4,504.49	$ 440.18	$ 130.50	$ 294.76	$ 5,369.93	$ 27.25	$ 239.32	$ 68.25	$ 5,397.18	$ 5,609.25	$ 5,438.18
Dually Eligible	65+	4,504.49	440.18	130.50	294.76	5,369.93	27.25	239.32	68.25	5,397.18	5,609 25	5,438.18
ALTSA												
Medicaid Only	55-64	$ 4,283.62	$ 242.10	$ 130.57	$ 219.42	$ 4,875.71						
Medicaid Only	65+	4,283.62	242.10	130.57	219.42	4,875.71						
Dually Eligible	55-64	$ 4,358 09	$ 242.10	$ 130.50	$ 294.76	$ 5,025.45						
Dually Eligible	65+	4,358 09	242.10	130.50	294.76	5,025.45						
HCA												
Medicaid Only	55-64	$ 2,031 52	$ 198.08	$ 0.00	$ 219.42	$ 2,449.02						
Medicaid Only	65+	2,031 52	198 08	-	219.42	2,449.02						
Dually Eligible	55-64	$ 146.40	$ 198.08	$ 0.00	$ 0.00	$ 344.48						
Dually Eligible	65+	146.40	198 08	-	-	344.48						

[1] Total from Exhibit 1, not including the non-emergency transportation (NEMT) or behavioral heal h (BH). Other counties were included for cohorts where a rate could not be calculated based on county-wide distribution for credibility reasons.

[2] Behavioral health rates are developed independently by Milliman separately for Categorically Needy, Disabled, and Newly Eligible categories of aid.

[3] Milliman is not aware of the distribution of PACE clients between Categorically Needy, Disabled, and Newly Eligible members and therefore have not blended these populations.

Exhibit 2f
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Projected Pierce County PACE Costs

		Benefit Costs[1]					Behavioral Health Rates[2]			Total Rates[3]		
Medicare Status	Age Band	Net Admin, BH, and NEMT	Transportation	Care Management	Admin	Total Benefit Cost Net BH	Categorically Needy	Disabled	Newly Eligible	Categorically Needy	Disabled	Newly Eligible
Composite												
Medicaid Only	55-64	$ 6,087 25	$ 348.99	$ 132.01	$ 416.63	$ 6,984.88	$ 30.11	$ 184.39	$ 70.54	$ 7,014.99	$ 7,169.27	$ 7,055.42
Medicaid Only	65+	6,087 25	348 99	132.01	416.63	6,984.88	30.11	184.39	70.54	7,014.99	7,169 27	7,055.42
Dually Eligible	55-64	$ 4,169 00	$ 348.99	$ 130.26	$ 268.25	$ 4,916.50	$ 30.11	$ 184.39	$ 70.54	$ 4,946.61	$ 5,100.89	$ 4,987.04
Dually Eligible	65+	4,169 00	348 99	130.26	268.25	4,916.50	30.11	184.39	70.54	4,946.61	5,100 89	4,987.04
ALTSA												
Medicaid Only	55-64	$ 4,101.77	$ 191.94	$ 132.01	$ 208.32	$ 4,634.04						
Medicaid Only	65+	4,101.77	191 94	132.01	208.32	4,634.04						
Dually Eligible	55-64	$ 4,021.68	$ 191.94	$ 130.26	$ 268.25	$ 4,612.13						
Dually Eligible	65+	4,021.68	191 94	130.26	268.25	4,612.13						
HCA												
Medicaid Only	55-64	$ 1,985.48	$ 157.05	$ 0.00	$ 208.32	$ 2,350.84						
Medicaid Only	65+	1,985.48	157 05	-	208.32	2,350.84						
Dually Eligible	55-64	$ 147 32	$ 157.05	$ 0.00	$ 0.00	$ 304.37						
Dually Eligible	65+	147 32	157 05	-	-	304.37						

[1] Total from Exhibit 1, not including the non-emergency transportation (NEMT) or behavioral heal h (BH). Other counties were included for cohorts where a rate could not be calculated based on county-wide distribution for credibility reasons.

[2] Behavioral health rates are developed independently by Milliman separately for Categorically Needy, Disabled, and Newly Eligible categories of aid.

[3] Milliman is not aware of the distribution of PACE clients between Categorically Needy, Disabled, and Newly Eligible members and therefore have not blended these populations.

Exhibit 3
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Change in Monthly PACE Rates from Previously Delivered FY 2022 Rates

		King ICHS			King MultiCare			King Providence			Spokane			Pierce			Snohomish		
Medicare Status	Age Band	Categorically Needy	Disabled	Newly Eligible	Categorically Needy	Disabled	Newly Eligible	Categorically Needy	Disabled	Newly Eligible	Categorically Needy	Disabled	Newly Eligible	Categorically Needy	Disabled	Newly Eligible	Categorically Needy	Disabled	Newly Eligible
Current Rates																			
Medicaid Only	55-64	$ 6,743.94	$ 7,036.78	$ 6,753.03	$ 6,974.78	$ 7,267.62	$ 6,983.87	$ 7,685.67	$ 7,978.51	$ 7,694.76	$ 6,622.38	$ 6,792.07	$ 6,678.34	$ 7,014.99	$ 7,169.27	$ 7,055.42	$ 7,351.98	$ 7,564.05	$ 7,392.98
Medicaid Only	65+	6,743.94	7,036.78	6,753.03	6,974.78	7,267.62	6,983.87	7,685.67	7,978.51	7,694.76	6,622.38	6,792.07	6,678.34	7,014.99	7,169.27	7,055.42	7,351.98	7,564.05	7,392.98
Dually Eligible	55-64	4,939.63	5,232.47	4,948.72	5,088.73	5,381.57	5,097.82	5,124.65	5,417.49	5,133.74	4,988.37	5,158.06	5,044.33	4,946.61	5,100.89	4,987.04	5,397.18	5,609.25	5,438.18
Dually Eligible	65+	4,939.63	5,232.47	4,948.72	5,088.73	5,381.57	5,097.82	5,124.65	5,417.49	5,133.74	4,988.37	5,158.06	5,044.33	4,946.61	5,100.89	4,987.04	5,397.18	5,609.25	5,438.18
FY22-23 Rates Certified 7/14/2021																			
Medicaid Only	55-64	$ 7,625.01	$ 7,905.38	$ 7,621.49	$ 7,448.18	$ 7,728.55	$ 7,444.66	$ 7,089.87	$ 7,370.24	$ 7,086.35	$ 6,290.74	$ 6,433.71	$ 6,360.28	$ 5,612.26	$ 5,773.96	$ 5,674.04	$ 7,847.09	$ 7,986.64	$ 7,899.03
Medicaid Only	65+	5,729.73	6,010.10	5,726.21	5,640.50	5,920.87	5,636.98	5,406.12	5,686.49	5,402.60	4,591.45	4,734.42	4,660.99	4,146.15	4,307.85	4,207.93	6,010.37	6,149.92	6,062.31
Dually Eligible	55-64	4,454.76	4,735.13	4,451.24	4,413.72	4,694.09	4,410.20	4,309.78	4,590.15	4,306.26	3,939.05	4,082.02	4,008.59	3,812.99	3,974.69	3,874.77	4,332.59	4,472.14	4,384.53
Dually Eligible	65+	3,965.67	4,246.04	3,962.15	3,924.70	4,205.07	3,921.18	4,460.47	4,740.84	4,456.95	3,810.44	3,953.41	3,879.98	3,704.29	3,865.99	3,766.07	4,209.28	4,348.83	4,261.22
Change from Previous Rates																			
Medicaid Only	55-64	$ (881.07)	$ (868.60)	$ (868.46)	$ (473.40)	$ (460.93)	$ (460.79)	$ 595.80	$ 608.27	$ 608.41	$ 331.64	$ 358.36	$ 318.06	$ 1,402.73	$ 1,395.31	$ 1,381.38	$ (495.11)	$ (422.59)	$ (506.05)
Medicaid Only	65+	1,014.21	1,026.68	1,026.82	1,334.28	1,346.75	1,346.89	2,279.55	2,292.02	2,292.16	2,030.93	2,057.65	2,017.35	2,868.84	2,861.42	2,847.49	1,341.61	1,414.13	1,330.67
Dually Eligible	55-64	484.87	497.34	497.48	675.01	687.48	687.62	814.87	827.34	827.48	1,049.32	1,076.04	1,035.74	1,133.62	1,126.20	1,112.27	1,064.59	1,137.11	1,053.65
Dually Eligible	65+	973.96	986.43	986.57	1,164.03	1,176.50	1,176.64	664.18	676.65	676.79	1,177.93	1,204.65	1,164.35	1,242.32	1,234.90	1,220.97	1,187.90	1,260.42	1,176.96
Percentage Change from Previous Rates																			
Medicaid Only	55-64	-11.6%	-11.0%	-11.4%	-6.4%	-6.0%	-6.2%	8.4%	8.3%	8.6%	5.3%	5.6%	5.0%	25.0%	24.2%	24.3%	-6.3%	-5.3%	-6.4%
Medicaid Only	65+	17.7%	17.1%	17.9%	23.7%	22.7%	23.9%	42.2%	40.3%	42.4%	44.2%	43.5%	43.3%	69.2%	66.4%	67.7%	22.3%	23.0%	21.9%
Dually Eligible	55-64	10.9%	10.5%	11.2%	15.3%	14.6%	15.6%	18.9%	18.0%	19.2%	26.6%	26.4%	25.8%	29.7%	28.3%	28.7%	24.6%	25.4%	24.0%
Dually Eligible	65+	24.6%	23.2%	24.9%	29.7%	28.0%	30.0%	14.9%	14.3%	15.2%	30.9%	30.5%	30.0%	33.5%	31.9%	32.4%	28.2%	29.0%	27.6%

Exhibit 4
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Proposed PACE Rates vs Projected FFS Rates Otherwise Paid

		King ICHS			King MultiCare			King Providence			Spokane			Pierce			Snohomish		
		Categorically		Newly	Categorically		Newly	Categorically		Newly	Categorically		Newly	Categorically		Newly	Categorically		Newly
Medicare Status	Age Band	Needy	Disabled	Eligible	Needy	Disabled	Eligible	Needy	Disabled	Eligible	Needy	Disabled	Eligible	Needy	Disabled	Eligible	Needy	Disabled	Eligible
Monthly PACE Rates																			
Medicaid Only	55-64	$ 6,743.94	$ 7,036.78	$ 6,753.03	$ 6,974.78	$ 7,267.62	$ 6,983.87	$ 7,685.67	$ 7,978.51	$ 7,694.76	$ 6,622.38	$ 6,792.07	$ 6,678.34	$ 7,014.99	$ 7,169.27	$ 7,055.42	$ 7,351.98	$ 7,564.05	$ 7,392.98
Medicaid Only	65+	6,743.94	7,036.78	6,753.03	6,974.78	7,267.62	6,983.87	7,685.67	7,978.51	7,694.76	6,622.38	6,792.07	6,678.34	7,014.99	7,169.27	7,055.42	7,351.98	7,564.05	7,392.98
Dually Eligible	55-64	4,939.63	5,232.47	4,948.72	5,088.73	5,381.57	5,097.82	5,124.65	5,417.49	5,133.74	4,988.37	5,158.06	5,044.33	4,946.61	5,100.89	4,987.04	5,397.18	5,609.25	5,438.18
Dually Eligible	65+	4,939.63	5,232.47	4,948.72	5,088.73	5,381.57	5,097.82	5,124.65	5,417.49	5,133.74	4,988.37	5,158.06	5,044.33	4,946.61	5,100.89	4,987.04	5,397.18	5,609.25	5,438.18
Projected FFS Amount Otherwise Paid																			
Medicaid Only	55-64	$ 6,960.78	$ 7,253.62	$ 6,969.87	$ 7,267.56	$ 7,560.40	$ 7,276.65	$ 7,957.68	$ 8,250.52	$ 7,966.77	$ 6,770.00	$ 6,939.69	$ 6,825.96	$ 7,378.74	$ 7,533.02	$ 7,419.17	$ 7,665.54	$ 7,877.61	$ 7,706.54
Medicaid Only	65+	6,960.78	7,253.62	6,969.87	7,267.56	7,560.40	7,276.65	7,957.68	8,250.52	7,966.77	6,770.00	6,939.69	6,825.96	7,378.74	7,533.02	7,419.17	7,665.54	7,877.61	7,706.54
Dually Eligible	55-64	5,054.35	5,347.19	5,063.44	5,329.58	5,622.42	5,338.67	5,362.80	5,655.64	5,371.89	5,161.89	5,331.58	5,217.85	5,197.08	5,351.36	5,237.51	5,624.29	5,836.36	5,665.29
Dually Eligible	65+	5,054.35	5,347.19	5,063.44	5,329.58	5,622.42	5,338.67	5,362.80	5,655.64	5,371.89	5,161.89	5,331.58	5,217.85	5,197.08	5,351.36	5,237.51	5,624.29	5,836.36	5,665.29

Exhibit 5
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Hepatitis C Add-on Rate

Base MMs with Hep C experience:	128
Base Hep C PMPM (pre-rebates)	$12,481
Base Hep C rebates	$3,796
Base Hep C PMPM (net rebates)	$8,686
Unit Cost Trend (annualized)	0.0%
Trend Years (1/1/2021 - 7/1/2023)	2.5
Monthly Add-on Rate (FY23-24)	$8,685.82

APPENDIX B

Appendix B-1
State of Washington
Aging and Long-Term Support Administration
FY 2023-2024 PACE Rate Development
PACE Services by HCPCS Code and Modifier

Category	HCPCS Code	Modifier	Description
Adult Family Home	S5165	UB	Environmental Adaptations Residential
Adult Family Home	T1019	U5	Medical Escort Care
Adult Family Home	T1020	TD	Personal Care Residential - PDN Inclusive
Adult Family Home	T1020	U1	Personal Care Residential AFH
Adult Family Home	T2033	U1	AFH ECS Add-on
Adult Family Home	T2033	U5	AFH Add-On for SBS
Adult Family Home	T2033	U6	AFH Meaningful Day Add-On
Assisted Living Facility	SA881		DME: Nutrition equipment and supplies
Assisted Living Facility	T1020	U2	Personal Care Residential ARC
Assisted Living Facility	T1020	U3	Personal Care Residential ARC - Enhanced
Assisted Living Facility	T1020	U4	Personal Care Residential - Specialized Dementia Care
Assisted Living Facility	T2031		Assisted Living
Assisted Living Facility	T2033	U3	EARC ECS Add-on
Other LTSS	T1020	U5	Personal Care Residential - Enhanced Service Facility
In-Home	92507		Speech/hearing therapy
In-Home	K0739		Repair/svc DME non-oxygen eq
In-Home	S5100		Adult Day Care - 15min
In-Home	S5102	HQ	Adult Day Care - Day
In-Home	S5165	UC	Environmental Adaptations SOLA
In-Home	SA295		RCL Demonstration Transition Items
In-Home	SA330	U1	Wellness Programs and Activities
In-Home	SA334	U1	NF or VDHS Budget
In-Home	SA334	U2	NF or VDHS Savings/ Adjustment
In-Home	SA390		Vehicle Modifications
In-Home	SA391		Hazard cleanup, each
In-Home	SA392		Housework and Errands
In-Home	SA392	U1	Heavy Housework
In-Home	SA539		Training; Safety/Orientation; 5 hours
In-Home	SA636		Assistive Technology, installation/maintenance
In-Home	SA876		DME: Communication devices and supplies
In-Home	SA877		DME: Diabetic equipment and supplies
In-Home	SA880		DME: Mobility aids and supplies
In-Home	SA882		DME: Orthotic equipment and supplies
In-Home	SA884		DME: Respiratory equipment and supplies
In-Home	SA887		DME: Wound care
In-Home	T1001		Nursing Assessment
In-Home	T1005	U1	Respite in a licensed setting for adults
In-Home	T1005	U3	Respite in an Adult Day setting
In-Home	T1019		Personal Care In-Home
In-Home	T1019	U1	Personal Care Addl Budget
In-Home	T1019	U2	Relief Care
In-Home	T1019	U3	Skills Acquisition Monthly Limit
In-Home	T1019	U6	Personal Care In-Home
In-Home	T2025	U2	Client Training - PEARLS

Appendix B-1
State of Washington
Aging and Long-Term Support Administration
FY 2023-2024 PACE Rate Development
PACE Services by HCPCS Code and Modifier

Category	HCPCS Code	Modifier	Description
Other LTSS	H0044		Supportive Housing, Monthly
Other LTSS	SA263	U2	Supportive Housing Specialist (Pre-Tenancy)
Other LTSS	90791		Psychiatric Evaluation
Other LTSS	92004		Ophthalmological Exam New Pt - Visit
Other LTSS	92014		Ophthalmological Exam Estab Pt - Visit
Other LTSS	92015		Ophthalmological Exam - Vision Test
Other LTSS	92506		Speech/hearing evaluation
Other LTSS	96101		Psychological Testing
Other LTSS	96118		Neuropsychological Testing
Other LTSS	97001		Physical Therapy Evaluation
Other LTSS	97003		Occupational Therapy Evaluation
Other LTSS	97124	U1	Massage Therapy For Care Receiver Only
Other LTSS	97124	U2	Massage Therapy For Caregiver Only
Other LTSS	97755		Assistive Technology Assessment
Other LTSS	99241		Level 1 Office Consultation
Other LTSS	99242		Level 2 Office Consultation
Other LTSS	99243		Level 3 Office Consultation
Other LTSS	99244		Level 4 Office Consultation
Other LTSS	99245		Level 5 Office Consultation
Other LTSS	99499	U1	Risk Assessment; Each
Other LTSS	99499	U2	Risk Assessment: sexual deviancy; hour
Other LTSS	99499	U5	Risk Assessment: Brief Evaluation, Follow up, Additional Testi
Other LTSS	99600		Skilled Nursing - Visit
Other LTSS	A4927		Non-sterile gloves-State Only
Other LTSS	D0140		Dental Consultation
Other LTSS	H0038		Independent Living Consultation
Other LTSS	H0045	U6	Respite Memory Care and Wellness Services, Day
Other LTSS	H0047		Substance Abuse Services
Other LTSS	H2010		Medication Management Consultation
Other LTSS	H2014	U1	Client Training, interview skills
Other LTSS	H2014	U2	Client Training, abuse avoidance
Other LTSS	H2014	U3	Caregiver Management
Other LTSS	H2014	U5	Nurse Delegation
Other LTSS	H2014	UC	Client Training, medical
Other LTSS	H2014	UD	Client Training, non-medical
Other LTSS	H2019		Behavior Support - Individual
Other LTSS	H2029		Sexual Deviancy Therapy
Other LTSS	H2030	HQ	Sexual Deviancy Therapy-Group
Other LTSS	H2031	HQ	Sexual Deviancy Therapy-Group
Other LTSS	H2032	HQ	Sexual Deviancy Therapy-Group
Other LTSS	H2033	HQ	Sexual Deviancy Therapy-Group
Other LTSS	H2034	HQ	Sexual Deviancy Therapy-Group
Other LTSS	S0215	U1	Transportation, mileage, related to Personal Care
Other LTSS	S0215	U3	AFH mileage, comm integration

Appendix B-1
State of Washington
Aging and Long-Term Support Administration
FY 2023-2024 PACE Rate Development
PACE Services by HCPCS Code and Modifier

Category	HCPCS Code	Modifier	Description
Other LTSS	S0215	U4	AFH mileage, med appt
Other LTSS	S0516		Safety Frames - Glasses
Other LTSS	S5102	CG	Adult Day Health - Intake
Other LTSS	S5102	TG	Adult Day Health - Day
Other LTSS	S5102	U9	Adult Day Health - Trial
Other LTSS	S5115	U6	Staff/ Family Consultation & Training, medical
Other LTSS	S5160		PERS Installation
Other LTSS	S5161		PERS Service
Other LTSS	S5161	U1	PERS Add-on-Fall Detection
Other LTSS	S5161	U2	PERS Add-on-GPS
Other LTSS	S5161	U3	PERS Add-on-Medication Reminder
Other LTSS	S5165	UA	Environmental Adaptations In-Home
Other LTSS	S5170		Home Delivered Meals
Other LTSS	S5170	U1	Home Delivered Meals - Caregiver
Other LTSS	S9470		Nutritional Counseling
Other LTSS	SA038		Geriatric Assessment
Other LTSS	SA075		Assistive Technology
Other LTSS	SA075		Assistive Technology
Other LTSS	SA075	U1	Assistive Technology-CFC
Other LTSS	SA075	U2	Assistive Technology-Non-CFC
Other LTSS	SA106		Family and Provider Support
Other LTSS	SA108	U1	Caregiver Consultation
Other LTSS	SA108	U2	Legal Services
Other LTSS	SA108	U3	Long Term Care Planning
Other LTSS	SA108	U4	Dementia Consultation
Other LTSS	SA108	U5	Nurse Consultation - 1 Session
Other LTSS	SA108	U6	Dental Consultation - 1 Session
Other LTSS	SA108	U7	Occupational Therapy Consultation - 1 Session
Other LTSS	SA108	U8	Physical Therapy Consultation - 1 Session
Other LTSS	SA109	U1	Legal Consultation- 15 min
Other LTSS	SA114		Intervention Services - Care Planning
Other LTSS	SA116	U1	Care Receiver Counseling
Other LTSS	SA116	U2	Caregiver Counseling
Other LTSS	SA117	U1	Care Receiver Support Groups
Other LTSS	SA117	U2	Caregiver Support Groups
Other LTSS	SA261		RCL Transition Facilitation
Other LTSS	SA263		Community Choice Guide
Other LTSS	SA263	U1	Community Choice Guide, Employment Services
Other LTSS	SA264		Mobility Training
Other LTSS	SA265		Money Management Training
Other LTSS	SA281	U1	Caregiver Conference Registration Fee
Other LTSS	SA290		Community Transition or Sustainability Services: Items
Other LTSS	SA291		Community Transition or Sustainability: Services
Other LTSS	SA292		Specialty Transition Preparation

Appendix B-1
State of Washington
Aging and Long-Term Support Administration
FY 2023-2024 PACE Rate Development
PACE Services by HCPCS Code and Modifier

Category	HCPCS Code	Modifier	Description
Other LTSS	SA293		Housing Specialist
Other LTSS	SA294		Housing Subsidy
Other LTSS	SA296		Community Transition or Sustainability: Items-Federal Match
Other LTSS	SA297		Community Transition or Sustainability: Services-Federal Matc
Other LTSS	SA298		Emergency Rental Assistance
Other LTSS	SA300		Individual Provider Travel Time
Other LTSS	SA300	U1	Travel Time, non-IP
Other LTSS	SA301	U1	Travel Time, non-IP
Other LTSS	SA330	U2	Wellness Programs and Activities - Caregiver
Other LTSS	SA335		Financial Management Services
Other LTSS	SA336		Service Animal Services
Other LTSS	SA337	U1	Retainer-Daily-Dedicated Bed-Child
Other LTSS	SA337	U2	Retainer-Daily-Enhanced-Child
Other LTSS	SA337	U4	Retainer-Daily-Dedicated Bed-Adult
Other LTSS	SA337	U5	Retainer-Daily-Diversion
Other LTSS	SA345		Forensic accounting service
Other LTSS	SA351		Budget Adjustment
Other LTSS	SA388	U1	MCO Funded Behavioral Health Wrap-around Support In Hom
Other LTSS	SA389	U1	MCO Funded Behavioral Health Wrap-around Support Reside
Other LTSS	SA392	U2	Yardwork
Other LTSS	SA396		Bath Aide
Other LTSS	SA419		Furniture portion of lift chair
Other LTSS	SA420		Non-Medical Supplies
Other LTSS	SA421		Non-Medical Equipment & Supplies
Other LTSS	SA529		Continuing Education; 12 hours annually plus union time
Other LTSS	SA530		Nurse Delegation Core Training
Other LTSS	SA531		Nurse Delegation Core Training, diabetes
Other LTSS	SA533		Nurse Aide Train & Test
Other LTSS	SA537		IP Training
Other LTSS	SA540		Training; 30 hour Basic training; plus union time
Other LTSS	SA541		Training; 70 hour Basic training; plus union time
Other LTSS	SA604		IP Supplemental Payment
Other LTSS	SA609		ORCSP Pharmacy Service Reimbursement
Other LTSS	SA615		Residential Services and Supports Allowance
Other LTSS	SA616		Community Transition Reimbursement
Other LTSS	SA626		Installation/Maintenance of Non-Medical Equipment
Other LTSS	SA627		Train-the-Trainer Tuition Reimbursement
Other LTSS	SA628		Train-the-Trainer Per Diem Reimbursement
Other LTSS	SA635		Specialized Goods Purchase Card-Federal
Other LTSS	SA637		Specialized Goods Purchase Card-State
Other LTSS	SA638		Specialized Goods Purchase Card-RCL
Other LTSS	SA685		Bed Hold, 1-7 Days
Other LTSS	SA686		Bed Hold, 8-20 Days
Other LTSS	SA875		DME: Bathroom and toileting

Appendix B-1
State of Washington
Aging and Long-Term Support Administration
FY 2023-2024 PACE Rate Development
PACE Services by HCPCS Code and Modifier

Category	HCPCS Code	Modifier	Description
Other LTSS	SA878		DME: Hospital beds and supplies
Other LTSS	SA879		DME Miscellaneous
Other LTSS	SA883		DME: Ostomy care
Other LTSS	SA885		DME: Urinary/incontinence equipment
Other LTSS	SA886		DME: Wheelchairs and access
Other LTSS	SA888		Physical Therapy
Other LTSS	SA889		Occupational Therapy
Other LTSS	SA890		Nutritional Services
Other LTSS	SA891		PT/OT Evaluation services
Other LTSS	SA892		Speech/Hearing/Communication Evaluation
Other LTSS	SA894		Acupuncture Services
Other LTSS	SA895		Chiropractic Services
Other LTSS	SA896	U1	Massage Therapy for Care Receiver
Other LTSS	SA896	U2	Massage Therapy for Caregiver
Other LTSS	SA897	U1	Acupuncture Services for Care Receiver
Other LTSS	SA897	U2	Acupuncture Services for Caregiver
Other LTSS	T1000		Private Duty Nursing
Other LTSS	T1005		Respite
Other LTSS	T1005	U5	Respite in Adult Day Health, 15 min
Other LTSS	T1005	U7	Respite in Assisted Living, 15 min
Other LTSS	T1005	U8	Respite in Nursing Home, 15 min
Other LTSS	T1019	U4	Skills Acquisition Annual Limit
Other LTSS	T1021		Home Health Aide
Other LTSS	T1028	U1	Home Safety/Home Environment Assessment -15 min
Other LTSS	T1030		Skilled Nursing - RN
Other LTSS	T1030	CG	Skilled Nursing ETR Rate
Other LTSS	T1030	U1	Skilled Nursing Addl Visit
Other LTSS	T2025	U1	Client Training - CDSM
Other LTSS	T2025	U3	Client Training Intensive Behavior Support
Other LTSS	T2025	U4	Caregiver Training/Education
Other LTSS	T2025	U5	Caregiver Training/Education Powerful Tools
Other LTSS	T2025	U6	Caregiver Training/Education: Star-C
Other LTSS	T2025	U7	Caregiver Training/Education: Reducing Disability in Alzheime
Other LTSS	T2025	U8	Caregiver Training/Education: Falls Prevention Workshop
Other LTSS	T2025	U9	Caregiver Training/Education: Reducing Disability in Alzheime
Other LTSS	V2020		Eyeglass Frames

Appendix C
State of Washington
Aging and Long-Term Support Administration
July 2022 - June 2024 PACE Rate Development
Hepatitis C NDCs Carve Out List

00003001101	00085131601	00781204342	51927167100	61958220101	66435010599
00003021301	00085131602	00781204367	54738095016	61958220301	66435010656
00003021501	00085131801	00781517728	54738095156	61958240101	66435010699
00004008694	00085132301	16241006956	54738095256	62991207701	66435010756
00004035009	00085132302	16241006976	54738095318	62991207702	66435010799
00004035239	00085132704	16241007056	54738095342	62991207703	66435010856
00004035730	00085135105	16241007076	54738095356	63370021935	66435010899
00004036030	00085136801	16241033776	54738095370	63370021945	66435020115
00004036530	00085137001	23490014105	54738095384	63370021950	66435020195
00006307401	00085137002	38779025608	54868452100	63370021955	66435020196
00006307402	00085138507	38779025609	54868452101	64116003101	66435020199
00074006328	00085435301	42291071818	54868452102	64116003106	66435020209
00074262528	00085435401	42291071856	54868452103	64116003124	66435020295
00074262580	00085435501	42291071870	54868488700	64116003901	68084015011
00074262584	00085435601	42291071884	54868488800	64116003906	68084015065
00074308228	00093722758	49452622101	54868503500	64116003924	68084017911
00074309328	00093722763	49452622102	54868503600	65862020768	68084017965
00074319716	00093722772	49452622103	54868503601	65862029018	68382004603
00074322456	00093722777	49452622104	59676022528	65862029042	68382004610
00074323914	00093723281	49884004532	59930152301	65862029056	68382004628
00074323956	00187200601	49884007176	59930152302	65862029070	68382026004
00074327156	00187200605	49884033876	59930152303	65862029084	68382026007
00074328214	00187200702	49884034076	59930152304	66435010118	68382026009
00074328256	00187200706	49884085656	61958150101	66435010142	68382026010
00085031402	00406204616	49884085692	61958150301	66435010156	68382026012
00085119403	00406226042	49884085693	61958150401	66435010170	68382026028
00085127901	00406226056	49884085694	61958150501	66435010184	72626260101
00085129101	00406226070	51167010001	61958180101	66435010216	72626270101
00085129701	00406226084	51167010003	61958180301	66435010356	
00085129702	00781204304	51552081304	61958180401	66435010456	
00085130401	00781204316	51552081305	61958180501	66435010556	

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Attachment III- PACE UPL & Rate Checklist - All Areas

PACE Contracts
Financial Review Documentation for UPL and Ratesetting

State: Washington
Contract: _____
Type: PACE Organization (PO)

Financial Reviewer:_____
Review Date: _____
Contract Period:_____

About PACE:

Programs of All-Inclusive Care for the Elderly (PACE) is a capitated program for frail elderly authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. Monthly capitated fees are combined into a common pool from which health care expenses are paid. PACE sites assume financial risk for the costs of all medical care (including inpatient hospitalization, nursing home, adult day health, home health, rehabilitation, and physician visits) for their clients.

UPL Checklist: For RO use in reviewing Medicaid PACE rates in PACE capitated programs

Order	PACE UPL Checklist – Review Task	Methodology, Actuarial Report, or Contract Page(s)	Met (Initials)	Date
1.0	Development of the UPL -- Overview of UPL development methodology is included 42 CFR 460.182 Medicaid monthly capitation payment amounts must be less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program; take into account the comparative frailty of PACE participants and must be a fixed amount regardless of changes in the participant's health status. UPL Development or Update __ The State is developing a new UPL (Steps 2-6). __ The State is inflating an already approved UPL. (Skip to step 7)	The state is updating the upper payment limit (UPL) for State Fiscal Years 2023 - 2024. UPL is calculated for each service area and PACE organization. The proposed UPL is the estimated fee-for-service equivalent for all Medicaid funded services received by nursing home residents and home and community-based waiver recipients, age 55 and over, residing in each service area. This limit was calculated using historical expenditure data incurred in state fiscal year 2021, trended forward to reflect expected utilization and cost levels in the payment year and adjusted to reflect risk levels of PACE members. The historical data used in rate setting was the most current, complete data available.		
1.1	Dual Eligibles – Medicaid State Agency Liability for Payment under PACE* Some payment limits for Dual Medicaid-Medicare Participants are outlined in Medicaid fee-for-service law and regulation. Because the regulation specifies that the State may not pay more under PACE that the PARTICIPANT would have cost under FFS, those Medicaid payment limits must be observed. Only the following groups of Medicaid-Medicare Dual Eligibles are entitled to Medicaid Services and must have a Medicaid Services UPL calculated and applied:	Members of the following eligibility groups that are in need of nursing-home-level care are eligible for Medicaid enrollment in PACE and have been included in the UPL calculation: • QMB Plus, • Medicaid (Non QMB) • SLMB Plus Members of the following eligibility groups are not eligible for Medicaid PACE enrollment:		

Order	PACE UPL Checklist – Review Task	Methodology, Actuarial Report, or Contract Page(s)	Met (Initials)	Date
	■ QMB Plus ■ Medicaid (Non QMB)** ■ SLMB Plus Eligibles and services for beneficiaries in the other five Dual Eligibles categories (QMB only, QDWI, SLMB, QI1, and QI2) should be specifically excluded from the PACE UPL/rates calculated for the 3 Dual Eligible categories above (QMB Plus, Medicaid (Non QMB), and SLMB Plus). If Dual Eligibles beneficiaries in the following 5 categories choose to enroll in PACE, the Medicaid State Agency would continue to be liable for the same Medicare payments (e.g., Medicare premium, coinsurance, or deductible) as under FFS. The beneficiary would be liable for any PACE Medicaid payment because they are not eligible for Medicaid services (See 1.2).: ■ QMB only ■ QDWI ■ SLMB ■ QI1 ■ QI2 ***Specifically for the above the above five categories, the State Medicaid agency would be liable for the amounts listed below:*** If the following Dual Eligibles enroll in PACE, the Medicaid State Agency must continue to pay Medicare for the Medicare FFS Premiums. The State Agency must calculate a UPL equal to Medicare FFS deductibles and coinsurance to Medicare providers and pay the PACE organization a rate under that UPL. No Medicaid services or payments would be included in the UPL or payment calculated for the PACE Organization. ■ QMB only For the following Dual Eligible beneficiaries, if the beneficiary chooses to enroll in PACE, the State Medicaid Agency will not make any payments to the PACE Organization. Instead, the Medicaid State Agency must continue to pay **Medicare** for the Medicare fee-for-service premium listed: ■ QDWI [Medicare Part A fee-for-service premiums (up to $300)] ■ SLMB Only [Medicare Part B fee-for-service	• QMB Only • QDWI • SLMB • QI1 • QI2 The PACE program in Washington State serves only individuals at nursing home level of care. Persons eligible for QMB only are not in need of nursing facility services and are not appropriate for PACE. No UPL has been calculated for this group. The Medicaid agency will continue to pay QI2 amounts directly to the beneficiary.		

Order	PACE UPL Checklist – Review Task	Methodology, Actuarial Report, or Contract Page(s)	Met (Initials)	Date
	premiums ($50)] ■ QI1 [Medicare Part B fee-for-service premiums ($50)] If the following Dual Eligibles enroll in PACE, the Medicaid State Agency must continue to pay the **beneficiary** an amount equal to the Medicaid QI2 fee-for-service limit of $3.09: ■ QI2 *Please note: Medicare premiums in this section refer to the Medicare fee-for-service premiums that beneficiaries are liable for to be eligible for Medicare fee-for-service. Premiums paid to the PACE organization are addressed below in 1.2. Premiums paid to M+C organizations are not addressed in this checklist because a Medicare beneficiary cannot be simultaneously enrolled in M+C and PACE. **This also includes Medicaid Non-SLMB.			
1.2	PACE Premiums -- 42 CFR 460.186(d) limits premiums collected by PACE organizations to the following: ■ If the beneficiary is Medicare and Medicaid eligible, the PACE organization may not collect any premium. ■ If the beneficiary receives services under Medicare Part A and B, the PACE organization may collect the Medicaid capitation rate as the premium from the beneficiary. ■ If the beneficiary receives services under Medicare Part A only, the PACE organization may collect the Medicaid capitation rate and the Medicare Part B rate as the premium from the beneficiary. ■ If the beneficiary receives services under Medicare Part B only, the PACE organization may collect the Medicaid capitation rate and the Medicare Part A rate as the premium from the beneficiary. ■ If the beneficiary does not receive services under Medicare or Medicaid, CMS does not regulate the premium. For purposes of PACE premiums under 460.186(d), only the following participants are considered to be eligible for Medicaid services and not liable for the payment of any PACE premium: ■ QMB Plus ■ Medicaid (Non QMB)	The PACE provider holds members liable for premiums within the limitations specified in 42 CFR 460.186(d) as outlined in this section.		

Order	PACE UPL Checklist – Review Task	Methodology, Actuarial Report, or Contract Page(s)	Met (Initials)	Date
	■ SLMB Plus For PACE, the following Dual Eligibles do not receive Medicaid services. Beneficiaries under these categories are liable for paying the PO the Medicaid PACE premium. ■ QMB only ■ QDWI ■ SLMB ■ QI1 ■ QI2			
1.3	Spenddown – FFP is not available for expenses that are the recipient's liability for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income. 42 CFR 435.1002(b); 1903(f)(2)(A); SMM 3645 Spenddown is the amount of money that an individual with income over Medicaid eligibility limits must spend on medical expenses prior to gaining Medicaid eligibility. The spenddown amount is equal to the dollar amount the individual's income is over the Medicaid income limit. 42 CFR 435 Subpart D. States must ensure that capitation rates for individuals with spenddown (both medically needy beneficiaries and beneficiaries in 209(b) States with spenddown amounts) are calculated without including expenses that are the recipient's liability. States have two methods for calculating spenddown. Regardless of the option selected by the State, the capitated rates must be calculated without including expenses that are the recipient's liability. 1. Regular method – The individual client collects documentation verifying that a medical expense has occurred and submits to the State. 2. Pay-in method – The individual client chooses to spenddown to the medically needy eligibility level through a monthly installment payment or lump sum payment. The same income and resource standards apply as in the regular method.	Rates have been developed gross of recipient liability. The state deducts each PACE participant's liability from the rate paid to the PACE organization. The PACE organization is responsible for collecting this payment from the participant.		
2.0	The claims and eligibility extract of FFS database is defined and was reviewed by the State and is the most recent data available	Fee-for-service data incurred in state fiscal year 2021, was used to determine the upper payment limit and set the payment rates. This was the most current, complete data available at the time the rate setting process began.		
	Eligibility Categories were defined for the individual	The state agency has employed the		

Order	PACE UPL Checklist – Review Task	Methodology, Actuarial Report, or Contract Page(s)	Met (Initials)	Date
2.1	setting the UPL (Although there is no requirement that an actuary*** set PACE rates, because this is a capitated program with frail participants, CMS recommends that States employ actuaries to set PACE Medicaid rates. We have referred to the person setting the UPL and rates as actuaries throughout these documents because of that recommendation). Do the state and actuary*** have a table listing their agreement on how eligibility categories are defined on the MMIS data tape?	firm of Milliman, Inc. to support the development and certification of the rates. The state and the actuary are in agreement as to the definitions of eligibility categories.		
2.2	Medicaid beneficiaries ineligible for PACE were separated from beneficiaries eligible for PACE - Were beneficiaries specifically excluded from the existing PACE plan separated from beneficiaries included in the PACE plan? (e.g., under age 55) For example, data for HCBS populations that are not eligible for PACE are not included (i.e., mentally retarded beneficiaries under age 55). - Data for all beneficiaries eligible for PACE was included in the UPL calculation. Data in the UPL includes all eligibility categories (TANF, SSI, etc) and provider types (FFS, Managed Care, HCBS, Nursing Facility) for individuals who are eligible for PACE. The frailty and comparability of the enrolled PACE population to non-enrolled populations is taken into account to the extent possible and feasible through risk-adjustment or other techniques. For example, data for all nursing facility eligible beneficiaries over age 55 is included in the UPL, not just data for nursing facility residents.	All individuals excluded from PACE participation were also excluded from the data used to set rates. Data for all members eligible for PACE was included in the UPL calculation.		
2.3	Categories of services included in the MMIS tape were defined for the actuary***. Do the state and actuary*** have a table listing their agreement on how categories of service are defined on the MMIS data tape?	Categories of services included in the PACE rates were agreed upon by the actuary and the State.		
2.4	Non-contracted service costs were separated from contracted service costs (Note: only State Plan Approved Services may be included in the UPL. As the PACE organization may provide hospice services (end-of-life services, hospice costs may be included in the calculation of the UPL)	Non-contracted services costs were separated from contracted service costs and removed from the rates.		
2.5	Recipients enrolled in capitated Medicaid managed care programs including PACE participants and their services were excluded from the UPL. If recipients and services for capitated Medicaid enrollees were included, is the rationale and methodology sound? (e.g., the State is adding a population to the program for which no FFS experience exists. The State is forced to create a	Data on recipients enrolled in capitated managed care plans, including PACE, was excluded from the UPL calculation.		

Order	PACE UPL Checklist – Review Task	Methodology, Actuarial Report, or Contract Page(s)	Met (Initials)	Date
	UPL with managed care data because no other data exists).			
2.6	Document the residency / site of service claims used for the PACE population in the PACE organizations in the State. For example, did the State use data for individuals in Nursing Facilities and HCBS waivers? Was other data used? If so, why and what is the State's justification for using the other data? What proportion of the population were in each site of service. Provide documentation regarding the data used and its relationship to the PACE population's eligibility under the program.	The state used only service payments for nursing facility services and home- and community-based services (HCBS) provided in each specific service area to members, age 55 and older when a credible number of members were enrolled in a given risk adjustment category. When enough members were not enrolled in a specific risk category, the baseline data was expanded to include statewide data and adjusted to account for known geographic cost differentials.		
2.7	Establish Rate Category Groupings – Are similar cost categories grouped together to improve predictability ___ Age Categories are defined. If not, justification for the predictability of unified UPLs is given. ___ Gender Categories are defined. If not, justification for the predictability of unified UPLs is given. ___ Region Categories are defined. If not, justification for the predictability of unified UPLs is given. ___ Eligibility Categories are defined. If not, justification for the predictability of unified UPLs is given.	Final rates are based on Medicare eligibility status (Medicaid only or Dually Eligible). Age and gender were not used, as meaningful rate differences between age and genders after adjusting for care setting and Comprehensive Assessment Reporting Evaluation (CARE) classification were not found. Final rates were developed for each service area and PACE organization.		
2.8	Once the base year data is established in Steps 2.1 – 2.6, claims and beneficiary eligibility data tables were created for the base period. The State reviewed the Base Period Data Tables for accuracy with the actuary***. The State and actuary*** mutually researched and determined what to do with data not fitting previously assigned Categories of service, age, gender, region, and eligibility category. (This includes males receiving hysterectomies, other service costs, etc) Beneficiaries and service costs falling into all other categories are identified and appropriately assigned. A per eligible amount (can be per member per month or per member per year) is calculated based on costs and eligibility from the same population. The numerator is total costs and the denominator is total number of PACE eligibles. The resulting per capita base data should not be a "case rate", i.e., dependent upon a beneficiary actually receiving services. Instead, it should be a per capita amount that reflects average costs of all eligible	The state reviewed the Base Period Data Tables (base data) for accuracy with the actuary. The actuary reviewed the data for reasonableness. Data not fitting into eligibility categories was removed from the analysis. A per member per month amount was calculated based on costs from the same population. The numerator is the total costs and the denominator is the total number of PACE eligible member months. The resulting per capita base data reflects the weighted average costs of all eligible beneficiaries regardless of receipt of service.		

Order	PACE UPL Checklist – Review Task	Methodology, Actuarial Report, or Contract Page(s)	Met (Initials)	Date
	beneficiaries regardless of the receipt of a service.			
3.0	Claims Completion Factor Derivation ___ Data is examined to determine the claims payment lag by eligibility and/or service category which may have different lags in claims payment ___ Claims completion factors are derived reflecting nuances in eligibility and service categories. Possible distortions in the factor are discussed with the State. ___ A claims completion factor table is created showing what adjustments are needed by category. ___ Base period data is adjusted by the claims completion factors.	Claim payment patterns were examined to determine the lag by service category and incurred month. Claims completion factors are derived based on known eligibility and service nuances and possible distortions were discussed with the State. The annual completion factors by service category are presented in the rate letter. Base period data is adjusted by the claims completion factors.		
4.0	Adjusted Base Period Data -- Non-claims adjustments are made to the Base Period Data based on historical data and future predictability. (Please note: PACE administrative costs cannot be added to the UPL) Adjustments to the Base Year that may increase the Base Year: ___ Cost-sharing in FFS is not in the PACE program ___ Payments not processed through the MMIS ___ FFS program additions occurring after the extraction of the data from the MMIS are taken into account ___ FFS administrative cost calculation (This can only be the administrative costs attributed to members participating in the PO if those members had been enrolled in FFS) ___ One-time only adjustment for historically low utilization in FFS program of a State Plan Approved benefit (i.e., dental) ___ Utilization due to changes in FFS utilization between the Base Year and the waiver period. Changes in utilization of medical procedures overtime is taken into account ___ Price increase in FFS made after the claims data tape was cut ___ Programmatic and Policy change in FFS made after the claims data tape was cut ___ Certified Match provided by public providers in FFS ___ Patient liability for institutional care will be charged under this program Adjustments to the Base Year that may adjust the Base Year downward: ___ Graduate Medical Education ___ Disproportionate Share Hospital Payments	Non-claims adjustments are made to the Base Period Data based on historical data and future predictability. Base Year adjustments applied include: - Medical cost trends based on data received from the state and outside sources. - Fee schedule increases present in the projection period, which were not present, or only partially present in the base data, were added. - Price impacts due to the new Consumer Directed Washington (CD WA) contract were reflected as an adjustment to the base data costs. - Dental costs were adjusted to be in line with the level expected to be paid by the PACE organization. - When statewide data was used due to credibility concerns with data in the service area, adjustments for the cost differential for nursing home and HCBS services were applied (discussed in the accompanying rate report). Downward adjustments to the base data: - Estimated pharmacy rebates		

Order	PACE UPL Checklist – Review Task	Methodology, Actuarial Report, or Contract Page(s)	Met (Initials)	Date
	___ Indirect Medical Education Payments ___ Post-pay recoveries (TPL) if the State will not collect and allow the PO to keep TPL payments ___ Pharmacy Rebates ___ Recoupments not processed through the MMIS ___ Copayments in managed care that had been added back above ___ FFS Program deletions occurring after the extraction of the data from the MMIS are taken into account ___ Income investment Factor ___ PCCM case management Fee ___ Retrospective Eligibility costs Non-claim specific adjustments that should not be reflected in a UPL paid to a capitated entity: ___ FQHC and RHC Cost-settlement adjustment	were removed from the base data. - One-time COVID-19 add-on costs were removed from the base data. Items not present in the base data: - The FQHC and RHC Cost-settlement adjustment is not reflected in the UPL nor paid to the PACE provider. - GME, IME, and DSH payments are not present in the base data.		
5.0	Cost trending (Inflation) is based upon the State's historical fee-for-services inflation rates. The years on which the rates are based are recent and the mathematical methodology is clearly explained.	Several years of claims data by population and service type were used to address inflation. Using these trends, the costs incurred in state fiscal year 2021 were trended forward to a center date of June 30, 2023 for the SFY 2023-2024 rates.		
6.0	Smoothing the Data for Predictability – The State applied actuarial techniques to reduce variability of rates and improve average predictability -- Methodology is sound and was discussed with State ___ Pooling of Catastrophic Claims ___ Regional Factors applied to small populations ___ Other Data Smoothing Techniques	Anomalies in data from year to year were not significant enough to warrant smoothing adjustments.		
7.0	UPL Updates (For Years When the State does not Rebase the UPL) ___ Was the original UPL set in a manner that was approvable? See 2.0-6.0 ___ Were program changes in the fee-for-service program appropriately accounted for in the UPL? ___ Were program price increases in the fee-for-service program appropriately accounted for? ___ Inflation factors used are based on State FFS historical costs ___ Any structural changes in the PO program are appropriately changed in the UPLs (i.e., if a structural change such as enrollment category is added to the PO eligibility, then the member months/utilization/eligibility is modified in the UPL)	Not applicable – a full rebase of the UPL was made this year.		

***Although there is no requirement that an actuary set PACE rates, because this is a capitated program with frail participants, CMS recommends that States employ actuaries to set PACE Medicaid rates. We have referred to the person setting the UPL and rates as actuaries throughout these documents because of that recommendation).

Rate Checklist: For use in all capitated Medicaid PACE programs.

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
1.0	**<u>DOCUMENTATION</u> -- Overview of ratesetting methodology is included -- Please include a lay person's description of the general steps the State followed to set rates. Please specify the time period for which the rates will be effective. The CMS RO will not retrospectively approve rates, thus the time period specified must be a defined time period in the future. The certification should include a detailed description of the ratesetting methodology employed by the State as outlined in the applicable checklist and document explain use of generally accepted actuarial principles and practices.** 42 CFR 460.182 Medicaid monthly capitation payment amounts must be less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program; take into account the comparative frailty of PACE participants and must be a fixed amount regardless of changes in the participant's health status.	Planned rates for the FY 2023 rates were computed as follows: Actual fee-for-service data incurred in state fiscal year 2021 for a population similar to the population covered by PACE was trended as discussed above. Data was initially arrayed based on age (55-64 or 65+), Medicare eligibility (Medicaid only or dual eligibility), living situation (nursing home, assisted living facility, adult family home, or in-home/other) and service type (acute and long-term care). Only services received by persons eligible for nursing facility services or HCBS, residing in the specific service area, age 55 and over, were included in the base data (except where service area data alone was not credible). Analysis of this data by both state staff and the actuary resulted in consensus that unique payment rates for the following groups would be proposed: - Medicaid Eligible Only - Medicaid & Medicare Eligible While differences in age groupings exist, it is not sufficient to merit additional payment groupings. However, it was agreed that annually the payment rates would be weighted based on the frequency distribution of dual status and care setting within a current census of the PACE program. A comparison of total costs (acute and long-term care) for nursing facility, assisted living facility, adult family home, and in-home/other		

PROPRIETARY

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
		members shows significant differences in all categories. Rates reflect the expected distribution of members by living situation of the specific PACE organization in a specific service area. For Providence rates in King County, populations were divided into sub-cohorts by CARE assessment group and rates were based on the FFS costs by sub-cohort weighted by PACE enrolled members. Rates for other PACE organizations and service areas were not developed at this level of detail due to a lack of credible information on CARE assessment distributions.		
1.1	**PACE Program Rates Under the UPL** **To determine whether the rates are less than the payment limits in 460.182, the CMS RO should ensure that one of the following is met:** <u>Option 1:</u> ___ **Open cooperative contracting**: A budget percentage factor is applied to a correctly calculated UPL to calculate rates (Non-competitive Procurement based on UPL). The UPL was set using steps 1-7 above then the State applied a budget percentage factor to finalize rates (e.g., the UPLs calculated in steps 1-7 above are multiplied by .95 to guarantee the State 5% savings.) Final rates should be 100% or less than the UPLs calculated in steps 1-7 above. Open cooperative contracting occurs when the State signs a contract with any PO meeting the technical programmatic requirements of the State and willing to be reimbursed this State-determined rate. If the State has chosen this option, the RO should complete the UPL checklist and should mark this option. The RO does not need to complete the remainder of this rate checklist but does need to check to see that the State's rationale for choosing the specific budget percentage factor is noted. <u>Option 2:</u> ___ **Separate Rate Calculation:** Rates are calculated separately using an actuary***. The State demonstrates that the rates are less than the UPL. (Non-competitive Procurement not based on the UPL). The RO should complete the UPL checklist and mark	The state has pursued Option 2: Separate Rate Calculation. Rates have been calculated separately using an actuary. Factors in the UPL and rate calculations assure that the rate will not exceed the UPL: 1. Assuming county wide FFS data is representative of the PACE catchment area, the UPL was calculated based on the living situation distribution in the PACE similar population. The PACE rates were calculated based on the projected PACE nursing home distributions. 2. Administrative and care management cost transferred to the PACE organizations by the state was included in the UPL		

PROPRIETARY

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	this option. The RO evaluates the question** below and completes the necessary sections of the rate checklist. **To analyze the actuarial basis of the rates, the CMS RO should analyze the rates for the following: __ The State is developing new rates. If this option is chosen, the RO should complete steps 2-11. __ The State is inflating an already approved set of rates. If this option is chosen, the RO should skip to step 12. <u>Option 3:</u> ___ **Competitive Procurement:** A range of budget percentage factors are applied to the UPL determined in Steps 1-7 above or to the rates determined in Steps 2-12 below (i.e., the rates are developed using a set of assumptions about utilization that results in a range of acceptable bids). A State could also disclose a maximum or minimum acceptable payment and encourage bids below or above that amount. Note: the POs' bids should include documentation and a description of how the resulting rates are actuarially sound in sufficient detail to address this set of criteria. Final rates should be 100% or less than the UPL. Competitive procurement occurs when POs submit bids and the State negotiates rates within the range of acceptable bids. *If the State chooses this option, the RO should complete the UPL checklist and mark this option. The RO does not complete the remainder of this rate checklist for the bid range. The State should document an analysis of the accepted rates that includes aspects of this rate checklist (Steps 2-11). The RO checks to see that the State's rationale for choosing the specific bid range is noted.*			
2.0	**Base Data and Utilization assumptions are defined and relevant to the Medicaid PACE population (i.e., the data base is appropriate for setting rates for the given Medicaid population). Examples of acceptable data bases in which to base utilization assumptions are: Medicaid FFS data bases, other State PACE program data, Medicaid Managed Care Encounter data, State employees health insurance data bases, low-income health insurance program data bases. Please note:**	The base data is based on Washington's Medicaid FFS database for similar enrollees.		

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	estimates and samples of historical databases are not acceptable bases for setting rates. **The CMS RO may approve other sources not listed here based upon the reasonableness of the given data base source. Some states have implemented reporting requirements of the Pos to be used as an additional data base that would improved on some of the shortcomings of these specific data bases. The overall intent of these reporting requirements is to collect the same information that is available in the encounter data, but in a more complete and accurate reflection of the true cost of services.**			
2.1	The base data used was recent and is free from material omission. The CMS RO should determine the years collected. Incomplete data because of claims submission lags should be adjusted in 5.0. Other reasons for incomplete data should be analyzed by the RO and approved only if the data can result in reasonable and predictable rates. Estimates and samples of historical data are not acceptable. The data (including encounter data and data external to Medicaid) was validated by the State. The validation method should relate to the actual source of the data: Medicaid FFS data – *1. SURS review or equivalent Fraud and Abuse review and 2. MMIS edits process;* Medicaid encounter data – *1. Medical record audit or other encounter data audit and 2. Encounter data electronic edits process;* Private Sector data – *1. Medical record audit or other encounter data audit; 2. Encounter data electronic edits process.* The CMS RO may approve other validation methods not listed here based upon the reasonableness of the State's approach for the given data base source. The base data should be included for CMS review with a description of how the State and its actuary*** researched and determined what to do with "dirty" data not fitting previously assigned categories of service, age, gender, region, and eligibility category. (This includes males having hysterectomies, nursery costs for adults, other service costs, etc)	The base data is the most current, complete data available. Various utilization review efforts to eliminate duplication, or inappropriate provision of, services have been completed on long-term care expenditures and data. These efforts indicate little, if any, "dirty" data within the base. With the exception of non-emergency transportation, behavioral health treatment and alcohol and substance abuse treatment, P1 (Washington State's payment system) is used by the state to authorize and pay for acute and long term care services. The P1 data system determines Medicaid eligibility and captures various member demographic characteristics and pays for acute care, nursing facility services, hospice and adult day health services. Non-emergency transportation costs were provided by Providence and added as a separate component of the rates. Behavioral health payments are made under a prepaid capitated arrangement. Behavioral health claims have been removed from the base data and the behavioral health capitation rates have been added to the PACE UPL and rate group amounts consistent with the demographics of the behavioral		

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
		health rate groups. Patient participation was determined from actual FFS data on a PMPM basis, then added to the rates.		
2.2	Utilization assumptions are appropriate to the Medicaid population and the base data was reviewed by State for similarity with the covered Medicaid population (i.e., if the utilization and service cost assumptions are not derived from recent Medicaid experience, the State should explain where the assumptions came from and why they can be applied to the Medicaid population covered by these proposed rates). Service cost assumptions are appropriate for a Medicaid program and the base data was reviewed by the State for similarity with the Medicaid program's current costs. For example, individuals in the database roughly utilize services in the same amount as a Medicaid population and the costs of services are roughly similar to the State's current Medicaid service costs. A database comprised of adults under age 55 would be a suspect database for comparison to PACE enrollees.	The base data consists only of recent Medicaid cost experience. Data was modified for completion, trend, fee schedule change and other adjustments. Those assumptions are included in the Milliman rate letter.		
2.3	An explanation of the Medicaid eligibility categories was defined for the actuary***. The state and actuary*** have a table listing their agreement on how eligibility categories are defined and what population characteristics the eligibility categories have. The explanation should list the eligibility categories specifically excluded from the analysis.	The actuary is familiar with the Medicaid eligibility categories and the characteristics of these categories within the database.		
2.4	Data for individuals in the base period data who would not be eligible for managed care contract services were separated and left out of the data from contract eligibles. The State may apply an appropriate adjustment factor to the data to remove these ineligibles if sufficient documentation is presented. For example, if mentally retarded individuals are not in the PACE program, utilization, eligibility and cost data for mentally retarded eligibles should be excluded from the rates.	Data was limited to only those members that are PACE eligible and currently not enrolled in a pre-paid managed care plan.		
2.5	Categories of Medicaid services were defined for the actuary*** in a manner that will allow the actuary*** to compare services in the base data to State Plan Approved services capitated under the PACE program.	The actuary is familiar with the categories of Medicaid services included in the database and the State Plan and agrees with their inclusion in the calculations.		

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
2.6	DOCUMENTATION – Service costs that are not in the PACE Agreement were separated from State Plan Approved services capitated under the PACE Agreement. Rates are based only on State Plan Approved services. The explanation should list the service costs in the database specifically excluded from the analysis. Services provided by the PO that exceed the services covered in the Medicaid fee-for-service program (i.e., the Medicaid State Plan) may not be used to set capitated Medicaid PACE rates. As the PACE organization may provide hospice services (end-of-life services), hospice costs may be included in the calculation of the rate. Any additional services must be paid for by the PO out of capitated rate savings. Please note: Rates based upon plan bids may include non-State Plan approved services as long as the rate is below the UPL. The PACE statute specifically allows PACE organizations to combine capitation fees into a common pool from which health care expenses are paid. Sites assume financial risk for the costs of all medical care (including inpatient hospitalization, nursing home, adult day health, home health, rehabilitation, and physician visits) for their clients. States, however, are not permitted to set rates or UPLs on non-State Plan approved services. The statute only has provision for pooling of costs by PACE organizations. All rates, regardless of how set must be less than UPLs set by the State based on State Plan approved services.	No PACE-eligible long-term care services were excluded. No PACE-eligible acute care services were excluded.		
3.0	**Adjustments to the Base Period Data: The following adjustments to the Base period listed in 3.1 to 3.5 were made to construct rates to reflect populations and services covered during the contract period. These adjustments ensure that the rates are more predictable for the covered Medicaid population.**			
3.1	Base period differences between the underlying utilization data and Medicaid population assumptions are determined. These adjustments increase or decrease utilization to levels that have not been achieved in the base data, but are realistically attainable CMS program goals. An example of this adjustment is an adjustment to Medicaid FFS data for dental access problems where FFS beneficiaries have historically low dental access rates and PACE contractually requires the PO to have a higher utilization rate. Note: This adjustment can be distinguished from the utilization factor in 7.0. 7.0 is a one-time only	As discussed above, the only change for base period differences between the underlying utilization data and Medicaid population assumptions was for dental services where the base period had lower utilization than what would likely be experienced in the PACE population.		

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	non-recurring adjustment because of a unique utilization change projected to occur (or which did occur) after the base year data tape was produced. 3.1 is utilization change stemming from historic under- or over-utilization that is being corrected solely by the implementation of this program. Historic access problems in FFS Medicaid programs may be addressed through this adjustment. Documentation of assumptions and estimates is required if this adjustment is made.			
3.2	Differences in the service package for the Base Period data and the PACE service package are adjusted in the rates. New benefits under the State's FFS program that have been incorporated into the State Plan should be added through this adjustment. The value of these programmatic service changes should be documented. Services provided by the PO that exceed the services covered in the Medicaid fee-for-service program (i.e., the Medicaid State Plan) may not be used to set capitated Medicaid PACE rates.	There are no differences in the service package for the base period data and the PACE service package. The exclusions referenced in item 2.4 of the UPL checklist are removed before the base period data is used.		
3.3	Administrative cost allowance calculations -- The aggregate loading for administration and profit is appropriate for the level of medical service cost and utilization assumed for the size of the population anticipated to be enrolled by a contracting PO. The assumptions for the administrative cost allowance must be documented and submitted with the rate approval package. Regional Office guidance: The CMS RO may challenge and not approve administrative costs less than 15% if documentation and assumptions are not valid. PO contractor administrative costs (non-service cost expenditures including, but not limited to, marketing, claims processing, profit, and staff overhead) of up to 15% of the overall PMPM paid to POs may be built into the rates. Administrative costs higher than 15% (medical expenses lower than 85%) must be justified by the State and prior approved by the CMS RO. This guidance is intended for use as a "rule of thumb" only. 15% is the average amount built into capitation rates for commercial MCOs. Lower and higher administrative costs can certainly be justified for a PO with high capitation rates (lower) or high start-up costs (higher). Documentation and reasonableness should guide RO review. In order to receive Federal reimbursement for them, administrative costs at the PO level are subject to all applicable Medicaid administrative	Administration and risk margin is applied as a percentage of premium. The retention assumptions were chosen after comparison with other PACE programs and MLTSS programs. They were also selected so that the final rates were lower than the amounts otherwise paid. The amounts otherwise paid do not include the same retention load as the rates, but they do include administrative costs that are transferred directly from the state to the PACE organization. These costs are: • Care management expenses of $132.63 for HCBS members These are not the full costs expected for PACE to administer the program, nor are they full state administrative costs. These represent costs transferred to PACE and therefore are a reduction to state administration.		

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	claiming regulations and policies. Medicaid pays for the administration of Medicaid services to Medicaid beneficiaries covered under the contract. The following examples are not all inclusive. - Public POs cannot build in administrative costs to pay for non-Medicaid administration or services such as education, prisons, or roads, bridges and stadiums using the administrative cost in capitated rates. - Administration costs in contracts must be allocated to the appropriate programs (e.g. public health must pay for the administration of public health services to non-Medicaid eligibles). Medicaid pays for the administration of Medicaid services to Medicaid beneficiaries covered under the contract. - Regular Medicaid matching rules apply. See 434.74 which states that all payments under a risk contract are medical assistance costs (FMAP rate) and 434.75 which requires an allocation for non-risk contracts between service costs and administrative costs. Administrative costs under the State Plan should not be placed under a capitated contract in order for the State to draw down the FMAP (60-70%) rate rather than the administrative rate (50%). Examples of this include administrative transportation and case management costs. Separate administrative contracts including this administration can be written for capitated entities that will be matched at 50% by the federal government. - Paperwork costs, such as time spent writing up case notes, associated with face-to-face contact with an eligible member is already included in the direct service cost and should not be built into the capitated rates again. Medicaid State agencies should also not pay separately for this administration. This occurs when a PO contracts with a public entity to provide services. The public entity provides the direct services and then bills the State Medicaid agency or the PO for administration associated with the direct services. Local health Departments providing services could be an example. This could also occur if an PO builds in additional administrative costs associated with direct service that have already been built into the direct service rates to providers.			
3.4	Specific health needs adjustments are made to make the populations more comparable. The State may make this adjustment if the population has changed since the utilization data tape was produced (e.g., the FFS population has significantly more high-cost refugees) or the base population is different than the current Medicaid	Where CARE assessment data was available and plan membership sufficient, claims data was weighted to be consistent with PACE needs based on CARE assessment data.		

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	population (e.g., the State is using the State employees health insurance data). The State should use adjustments such as these to develop rates for new populations (e.g., working elderly disabled). The State should document why they believe the rates are appropriate for these particular new populations.			
3.5	Eligibility Adjustments - The Actuary*** analyses the covered months in the base period to ensure that member months are parallel to the covered months for which the POs are taking risk. Adjustments are often needed to remove from the base period covered months – and their associated claims – that are not representative of months that would be covered by a PO. For example, many newly eligibility Medicaid beneficiaries are retrospectively covered by FFS upon being determined eligible, but their enrollment in the PO will only be prospective. Because the costs in the weeks leading up to a level of care determination requiring institutionalization in a nursing facility can be very high, if retrospective eligibility periods are not removed from the base period, the State could be substantially over-estimating PO's average PMPM costs.	No eligibility adjustments were found to be necessary. In response to the example cited, only periods in which the individuals were receiving nursing facility or home and community services were included in the base period data.		
3.6	Other adjustments. Any non-claims adjustments made to the Base Period Data based on historical data and future predictability must be explained. (These adjustments may be positive and negative) For example, when the State includes pharmacy in its PACE rate and chooses to use FFS Medicaid MMIS claims data as the base year utilization data, the State must adjust the claims data for pharmacy rebates which are not included in the MMIS data base. Other changes may be legislative, policy or programmatic changes or changes due to court-ordered settlements not anticipated or reflected in the base data. Any adjustments and estimates (e.g., hospital price increases in excess of historic Medicaid fee schedules) should be documented.	No additional adjustments were made to the long-term care data or the acute care data.		
3.7	Once the base period was established using steps 1.0 through 3.6, the State reviewed the Base Period Data Tables with the actuary***. The documentation should acknowledge this review and the State's confirmation of analysis.	The base period data tables were developed by the actuary and reviewed by the department and found to be acceptable for the purposes of establishing the PACE UPL and payment rates.		
4.0	**Establish Rate Category Groupings -- The following rate category groupings listed in 4.1 to 4.5 were made to construct rates more predictable for future Medicaid populations rate setting. The number of categories should relate to the contracting method. If diagnostic**			

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	risk adjustment is used, the RO will review under 8.2.			
4.1	Are similar cost categories grouped together to improve predictability?	Similar cost categories have been grouped together to improve predictability.		
4.2	Age Categories are defined. If not, justification for the predictability of the methodology used is given. For example, women aged 55 versus aged 90 have different rates. The State should justify having a single rate encompassing these two ages.	Costs were arrayed by age group 55–64 and 65+. There was no dramatic difference in base group expenditure between age group 55–64 and 65+, after accounting for other known sources of cost variation (CARE classification and living situation). Therefore, the state and the actuary agreed that separate rates for age group 55–64 and 65+ was not warranted.		
4.3	Gender Categories are defined. If not, justification for the predictability of the methodology used is given. For example, women age 55 and men age 55 may have different costs, but women and men over age 90 may not have different costs. The State should explain any combined gender rate cells.	Costs were not arrayed by the gender of individuals in the base population. Meaningful differences between genders after adjusting for care setting and CARE classification were not found. Additionally with the relatively small size of the program, the complexity of analysis required by including this additional variable is not warranted.		
4.4	Region Categories are defined. If not, justification for the predictability of the methodology used is given. For example, urban and rural areas (and different PACE service areas) should have separate rates based upon the differences in utilization in the different areas unless the costs are similar.	The base data for each set of rates are specific to the area in which the rates will be effective, unless that data required credibility adjustments.		
4.5	Eligibility Categories are defined. If not, justification for the predictability of the methodology used is given. For example, TANF populations have different costs than Aged and Disabled populations.	Only the aged and disabled eligibility categories are included in the state's PACE program.		
5.0	**Claims Completion Factor Derivation – When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use DOS data which is recent, "completion factors" must be used, which increase the reported totals to an estimate of their ultimate value after all claims have been reported. Such factors are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors.**			

PROPRIETARY

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments related to services performed in various former periods.			
5.1	Claims completion factors are derived reflecting nuances in rate categories. Possible distortions in the factor are discussed with the State. Claims payment lag factors can be determined by rate cell or service category, the State should explain how they created the lag factors and what the lag factors are.	Claim payment patterns were examined to determine the lag by service category and incurred month. Claims completion factors are derived based on known eligibility and service nuances and were discussed with the State.		
5.2	A claims completion factor table is created showing what adjustments are needed by category of service or eligibility category. A State with a high percentage of FFS claims filed electronically should have a very low claims completion factor. A State with a low percentage of FFS claims filed electronically may have a higher claims completion factor depending upon how recent the base year data is. This adjustment will vary widely across health plans based on several factors: the number of months used for claim runout, the types of services paid on a FFS basis, the staffing level for claims processing, etc. Time frames for FFS claims submission may affect the claims completion factor. Anomalies in claims payment patterns have been discussed between the State and the Actuary***. For example, the Actuary*** understands how adjustment claims are handled in the MMIS system.	The annual completion factors by service category are presented in the rate letter. Claims were generally quite complete, which is as expected given the high percentage of FFS claims filed electronically and the number of months of runout used.		
5.3	Base period data is adjusted by the claims completion factors.	Base period data is adjusted by the claims completion factors.		
6.0	**Cost trending (Inflation) Inflation factors used is based on historical State-specific costs. If not, justification for the predictability of the inflation rates is given. Differentiation of trend rates is documented (i.e., differences in the trend by service categories, eligibility category, etc). All trend factors and assumptions are explained and documented.**	Several years of claims data were used to address inflation. Using these trends, the costs incurred in state fiscal year 2021 were trended forward to a center date of June 30, 2023 for the SFY 2023-2024 rates. Additionally, FFS unit cost increases were added to the base data where applicable. There were several service categories that will experience FFS cost increases in the projection period that are not reflected in the raw base data.		
7.0	**Utilization trending -- Changes in utilization of medical procedures over time is taken into account. The State should document** 1. The assumptions made for the change in utilization. 2.	Utilization trend varies by service category. More detail is provided in the rate letter.		

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	How it came to the precise adjustment size. 3. That the adjustment is a unique one-time change that could not be reflected in the utilization database because it occurred after the base year utilization data tape was cut. Examples may include: 1) outreach programs began after the base year ended; 2) major technological advances (e.g., new high cost services) that cannot be predicted in base year data (protease inhibitors would be acceptable, a new type of aspirin would not be acceptable); 3) historically underutilized services that are now being closely monitored in this program (mental health and substance abuse in the elderly). Note: This adjustment can be distinguished from the utilization factor in 3.1. 7.0 is a one-time only non-recurring adjustment because of a unique utilization change projected to occur (or which did occur) after the base year data tape was produced. 3.1 is utilization change stemming from historic under- or over-utilization that is being corrected solely by the implementation of this program. Historic access problems in FFS Medicaid programs may be addressed through this adjustment. Documentation is required if this adjustment is made.			
8.0	**Smoothing the Data for Predictability including consideration and adjustments for special populations – The State has taken into account individuals with special health care needs and catastrophic claims. These individuals/populations should only be included if they are an eligible and covered population under the contract. Claim costs and utilization for high cost individuals in the PACE program are included in the rates. The State has examined the data for any distortions.** Distortions are primarily the result of small populations, special needs individuals, access problems in certain areas of the State, or extremely high-cost catastrophic claims. Costs in rate cells are smoothed through a cost-neutral process to reduce distortions across cells and adjust rates toward the statewide average rate. The State must supply an explanation of the smoothing adjustment, an understanding of what was being accomplished by the adjustment, and demonstrate that, in total, the total dollars accounted for among all the geographic areas after smoothing is basically the same as before the smoothing.	No ineligible individuals were included in the database. The state examined the data for distortions and no distortions were noted.		
8.1	Assessment of the Data for Distortions – Because the rates are based on actual utilization in a population, the State must assess the degree to	See 8.0.		

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	which a small number of catastrophic claims might be distorting the per capita costs. The RO should verify that this assessment occurred and that distortions found were addressed in 8.2.			
8.2	Cost-neutral data smoothing adjustment -- If the State determines that a small number of catastrophic claims are distorting the per capita costs then at least one of the following **cost-neutral** data smoothing techniques must be made. The RO should verify that the data smoothing was cost-neutral. ___ Catastrophic Claims Adjustment – The State must identify that there are outlier cases and explain how the costs associated with those outlier cases were separated from the rate cells and then redistributed across capitation payment cells in a cost-neutral, yet predictive manner. ___ Small population or small rate cell adjustment – The State has used one of two methods: 1) The actuary*** has collapsed rate cells together because they are so small or 2) the actuary*** has calculated a statewide per member per month for each individual cell and multiplied regional cost factors to that statewide PMPM in a cost-neutral manner. ___ Mathematical smoothing – The actuary*** develops a mathematical formula looking at claims over a historical period (e.g., 3 to 5 years) that identifies outlier cost averages and corrects for skewed distributions in claims history. The smoothing should account for cost averages that are higher and lower than normal in order to maintain cost-neutrality. ___ Risk-adjustment based upon enrollees' health status or diagnosis. The State has chosen to employ statistical methodologies to calculate diagnosis-based risk adjusters using accepted diagnosis groupers. The State explains the risk assessment methodology chosen, documents how payments will be adjusted to reflect the expected costs of the disabled population, and demonstrates how the particular methodology used is cost-neutral. The State has outlined periodic monitoring and/or rebasing to ensure that the overall payment rates do not artificially increase, due to providers finding more creative ways to classify individuals with more severe diagnoses (also called upcoding or diagnosis creep). Risk-adjustment must be cost-neutral. ***The RO should solicit assistance from CO in the review of risk-adjustment*	Not applicable for long term care. No data smoothing was found necessary for the acute care costs.		

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	techniques. ___ Provision of stoploss or reinsurance (See 10.0) ___ Applying other actuarial techniques to reduce variability of rates and improve average predictability -- If the State chooses to use a method other than the catastrophic claims adjustment or a small population or small rate cell adjustment, the State explains the methodology. The actuary*** assisted with the development of the methodology, the approach is reasonable, the methodology was discussed with State, and an explanation and documentation is provided to CMS.			
9.0	**DOCUMENTATION -- Calculation of Capitation Rates (See 1.1 for acceptable calculation techniques) Capitation rates cannot exceed 100% of the amount actuarially calculated to provide** State Plan approved services. The State must include a projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.	The proposed capitated rates do not exceed 100% of the amount actuarially calculated to provide State Plan approved services.		
10.0	**DOCUMENTATION IF THE STATE HAS ANY STOPLOSS or REINSURANCE ARRANGEMENTS** **Calculation of stop loss rates (State Optional Policy) –** Explanation of state's reinsurance or stoploss program. Please mark 10.1 or 10.2. 10.1 or 10.2 are mutually exclusive. **Capitation rates are based upon the probability of a population costing a certain rate. Even if the PO's premium rates are sufficient to cover the probable average costs for the population to be served, the PO is always at risk for the improbable – two open heart surgery patients and one trauma victim in its first 100 members, or an extraordinarily high rate of inpatient hospitalizations. A new PO, with a small enrollment to spread the risk across, could be destroyed by one or two adverse occurrences if it were obliged to accept the full liability.** FFP is not available to fund stop loss or reinsurance arrangements on the provision of non-	The state has no stop loss or reinsurance arrangements.		

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	State Plan services.			
10.1	Commercial Reinsurance is purchased by the PO – The State has required the PO to purchase commercial reinsurance. The State should demonstrate that it has ensured that the coverage is adequate for the size and age of the PO.	The State has not required that the PO purchase commercial reinsurance.		
10.2	Simple stop loss program -- The State will provide stop-loss protection by writing into the contract limits on the PO's liability for costs incurred by an individual enrollee over the course of a year (either total costs or for a specific service such as inpatient care). Costs beyond the limits are either entirely or partially assumed by the State. The PO's capitation rates are reduced to reflect the fact that the State is assuming a portion ofthe risk for enrollees. ■ The State has documented the creation of a claims frequency distribution (claims tail lag triangle). --The State creates a frequency distribution of claims for the individuals who exceeded the reinsurance limit (or counts the number and costs of the individuals above the limit). Using the frequency distribution , the State calculates the percent of the population whose costs are above the desired stop-loss limit and calculates the PMPM rate withhold that it would cost the State to assume the risk for those individuals. ■ The State has included in its documentation to CMS the expected cost to the State of assuming the risk for the high cost individuals at the chosen reinsurance limit (also called stop loss attachment point). ■ The State has included an explanation of state's stop loss program including the amount /percent of risk for which the State versus PO will be liable. ■ In some contracts, the PO is liable up to a specified limit and partially liable for costs between that limit and some higher number. The State is wholly liable for charges above the higher limit. If there is shared risk rather than either the State or the PO entirely assuming the risk at a certain point, the PO and State determine whether the services will be reimbursed at Medicaid rates, at the POs' rates, or on some other basis. ■ The State has deducted a withhold equal to the cost to the State of assuming the risk for high cost individuals. The State pays out money based on actual claims which exceed the stop loss limit (i.e., above the attachment	The state does not intend to provide stop loss protection by writing into the contract PACE organization liability limits.		

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	point). ■ The State has documented whether premiums will be developed by rate cell or on a more aggregated basis.			
11.0	**DOCUMENTATION IF THE STATE HAS ANY INCENTIVE ARRANGEMENTS** **Inclusion of Bonus Payments (State Optional Policy) –** Explanation of state's incentive program. In general, the capitated rates were developed based upon the provision of Medicaid FFS services (i.e., State Plan approved services). Any additional incentives must be actuarially sound and based upon the provision of Medicaid State Plan approved services in a higher utilization than the utilization in the underlying base data. The incentives must be affected by the PO's actual performance or non-performance of the contract and must vary based upon the cost of providing Medicaid services to Medicaid enrollees. Total payments to contractors cannot include payments for non-State Plan approved services. Incentives cannot be renewed automatically and must be for a fixed time period. The incentive must be conditioned upon a specified activity to occur or a target to be met. Incentives must be available to all contractors (both public and private) and cannot be conditioned upon intergovernmental transfer agreements. Total payments to the PO must be less than the UPL. No federal match is available for incentive payments for bonuses for agreeing to enter into risk contracts that meet the following criteria regardless of the waiver or State plan authority: 1. A reward for signing a valid and binding contact and not affected by the PO's actual performance or non-performance or any aspect of the contract itself (i.e., the incentives are not actuarially sound). 2. The amount of the payment does not vary based upon the cost of providing services in the area served by the PO. 3. The payment is made to any PO that signs or renews a risk contract with the State as an incentive to do so.	The state has included no incentive arrangements in its PACE contract.		
12.0	**Post-Eligibility Treatment of Income.** If the SPA requires that the State consider post-eligibility treatment of income, the State pays the PACE rate for that member less the client participation amount. The State should calculate the client	The state pays the PACE rate, less patient participation. Patient participation is calculated individually for each member.		

Order	PACE Rate Checklist – Review Task	Methodology, Actuarial Report or Contract Page(s)	Met (Initials)	Date
	participation amount specifically for each member using the FFS methodology.			
13.0	**Rate Updates. This section is for use when a State does not rebase the rates in a contract extension on a new actuarial technique or different utilization data base than the one that was used previously. States should rebase the rates at least every 5 years. Simple trended updates (using criteria 12.1 to 12.4) may be performed annually otherwise.** DOCUMENTATION -- The State must include a projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.	Not applicable.		
13.1	Were the rates in the original contract period set in an actuarially acceptable manner in which CMS approved the methodology using a checklist similar to this for Steps 1.0 to 11.0?	Rates in the original/prior contract were approved by CMS through the use of a checklist similar to the one currently employed.		
13.2	Were program changes appropriately accounted for?	There were no pertinent program changes.		
13.3	Were program price increases appropriately accounted for?	Yes, program price increases were appropriately accounted for. These included: • inflation factors and • known fee schedule increases occurring after the experience period, and before or during the projection period.		
13.4	Inflation factors used are based on State historical costs. If not, justification for the predictability of the inflation rates is given.	See 6.0.		

MEDICARE/MEDICAID
DUAL ELIGIBLE CATEGORIES

(EACH MEDICAID CATEGORY IS ENTITLED TO MEDICARE)

Eligibility Category	Medicaid Benefits	Cost Limit to Medicaid (if any)	Provider	Medicaid Liability for Services
QMB only	Medicare premiums, deductibles, and coinsurance No Medicaid services	Full Medicare	Medicare	QMB rates for Medicare deductibles and coinsurance
QMB PLUS (QMB + Medicaid)	Medicare premiums, deductibles, and coinsurance Medicaid services	Full Medicare + Medicaid	Medicare Medicaid	QMB rates for Medicare deductibles and coinsurance Medicaid rates for Medicaid only services
MEDICAID (Non QMB)	Medicare Part B premiums (optional for medically needy) Medicaid services	$54 + Medicaid	Medicare Medicaid	No liability for Medicare deductibles and coinsurance Difference between Medicare payment and Medicaid rates for Medicaid services
SLMB only	Medicare Part B premiums No Medicaid services	$54	Medicare	No liability for Medicare deductibles and coinsurance
SLMB PLUS (SLMB + Medicaid)	Medicare Part B premiums Medicaid services	$54 + Medicaid	Medicare Medicaid	No liability for Medicare deductibles and coinsurance Difference between Medicare payment and Medicaid rates for Medicaid services
QDWI (Not otherwise eligible for Medicaid)	Medicare Part A premiums	$319	Medicare	No liability for Medicare deductibles and coinsurance
QI (Not otherwise eligible for Medicaid)	All or part of Medicare Part B premiums	Q1 – $54 Q2 - $3.91 in 2002	Medicare	No liability for Medicare deductibles and coinsurance

http://www.medicare.gov/Basics/Amounts2002.asp

Attachment IV - WA PACE Round 3 Responses

Washington PACE Certification Missing Information

7/21/2022 Milliman general response:

Per our meeting with CMS and the reviewing actuary on 7/1/2022, some of the questions below have been adjusted or removed. We plan to make changes to future PACE certifications to address some of the concerns expressed during the July 1st meeting and in these questions. We have included a workbook containing three exhibits referenced in our responses, titled "CMS Response Exhibits 20220721.xlsx"

The following information was missing or requires clarification in the certification for the SFY 2023-2024 Washington PACE Amount that Would Otherwise have been Paid (AWOP).

A. General Information

1. As a clarification note, many of the tables are mis-referenced within the Rate Certification. For example, the bottom of page 14 notes that the completion factors impact is in Table 8, but the completion factor impact is shown in Table 9 on top of page 15. Similarly, page 17 notes trend assumptions shown in Table 9 numerous times, but the annual trend rates are shown in Table 11. These are just a few examples, but this holds true for many of the table references. Please make sure to correct / update table references in future certifications.

7/21/2022 Milliman response:

Some of the table references did not get refreshed. We will update in future certifications.

Response: Thank you. We have no further questions on this matter at this time.

2. Please clarify if the CD WA Jan - Jun 22 rate updates were previously reviewed and approved by CMS.

7/21/2022 Milliman response:

They are still under review.

Response: Thank you. We have no further questions on this matter at this time.

3. Please provide an additional exhibit mapping the Jan-Jun 22 rates shown in Table 1 to those shown in table 3 for all counties and PACE Organizations (POs).

7/21/2022 Milliman response:

The differences between the two tables are compositing mix and inclusion of BH rates. In lieu of an additional exhibit, please see this example for King (Prov.):

Table 1 Jan-Jun 22 rate (a)	$ 4,757.44
Table 2 Non-disabled adult BH rate (b)	$ 64.00
Rate compositing mix difference*	($ 7)
Table 3 Jan-Jun 22 rate (a + b + c)	$ 4,814

* Rates in Table 1 are composited using CY 2021 Providence and ICHS membership by age band and dual eligibility status. Rates in Table 3 are composited using CY 2020 Providence and ICHS membership.

Response: Thank you. Please explain why the same calendar year's membership, by age band and dual eligibility status, was not used for both tables.

8/24/2022 Milliman response:

Table 3 is intended to be used to identify the major drivers of changes in the rates from the January to June 2022 rates to the SFY 2023 rates. Because January to June 2022 composite rates relied on the CY 2020 membership, it wouldn't be appropriate to update the membership used in compositing without identifying this change separately. In lieu of illustrating the composite change separately, we decided to compare all rates using the CY 2020 membership. We did not re-composite the Jan-Jun 22 rate using updated membership because the difference was small and the table was purely for illustration.

Response: Thank you. We have no further questions on this matter at this time.

4. Regarding the behavioral health capitation rate development,
    i. Please describe any extent to which the BH program and the PACE programs behavioral health coverages dis-align, outside of the eligibility dis-alignment noted in the certification.
    ii. Please explain why there was no adjustment to the BH rates to account for the dis-alignment noted in response to a. above.
    iii. Please provide the Washington Apple Health MC documents that demonstrate the behavioral health rate developed for each of the counties and POs.

7/21/2022 Milliman response:

The BH program includes PACE-similar members as well as members who are not similar to the PACE population or eligible for PACE services. However, if a PACE-eligible member wasn't enrolled in PACE, their behavioral health services would be covered under managed care (with very limited exceptions). Therefore, the AWOP for behavioral health services would be the managed care BH capitation rate. Note that the inclusion or exclusion of PACE-eligible participants in the development of the managed care capitation rates would not have a significant impact on the final rates, as the number of PACE members is extremely small compared to the full managed care population. We have included the Apple Health IMC certification that documents the development of the behavioral health rates, titled "CY22 IMC Capitation Rate Certification 2021218.pdf"

Response: Thank you. We have no further questions on this matter at this time.

5. Please provide a comparison of the PACE rates and AWOP for the past three years, including how these values compare with the actual PACE costs.

7/21/2022 Milliman response:

We are working with PACE providers to provide improved financial information in the future, but they do not currently provide costs separately for Medicaid and Medicare services so we are unable to provide actual PACE costs at a granularity that would allow for comparison to individual rates.

Please see Exhibit A-5 in the included spreadsheet for a summary of PACE rates and AWOP over the past three years.

Response: Thank you. We have no further questions on this matter at this time.

6. Per page 9 of the Rate Certification, please indicate how Medicare cost sharing paid by the state has been factored into the analysis.

7/21/2022 Milliman response:

Payments made by the state and reported to ProviderOne, including Medicare cost sharing, are included in rate setting base data.

Response: Thank you. We have no further questions on this matter at this time.

7. We note the rate for Medicaid Only 55-64 for King (ICHS), King (MC), and Snohomish (Prov) are experiencing a decrease from the Jan-Jun 2022 rates. Please clarify if the State is receiving additional funding through ARP and how the decline in rates complies with the MOE requirements to receive the additional federal funding under ARP.

7/21/2022 Milliman response:

This rate decreased compared to the Jan-Jun 2022 rates due to significant volatility in the small rate cells and because we did not set different rates for each age band during this period, due to credibility concerns. At a composite level, the Medicaid Only rates increased.

Response: Thank you. Please provide exhibit 3 of the certification (the Change in Monthly PACE Rates from Previously Delivered Rates) showing the composite rates and

a. confirm that each of the composite rates are not decreasing from the rates in place as of April 1, 2021.
b. confirm that the composite rates are what is paid to the PACE Organizations by the State.

8/24/2022 Milliman response:

Exhibit 3 of the certification is not available at a rate-cell level and would require significant additional time to develop. Additionally, King (MC), Pierce, and Snohomish only started accepting members in early 2022, so we do not have any membership experience for them and therefore any composites for these rates are speculative.

a. The King (ICHS) rate is the only one of those mentioned in the original question that was actually paid out in April 2021, as the other PACE organizations were not operational in those counties at that time. Using the reported Medicaid Only distribution for ICHS from Jan-Oct 2021 (consistent with the enrollment period reported in the rate development), we confirm that the Medicaid Only composite rate is higher in the proposed FY 2023 rates than it was as of April 1, 2021.

April 2021 King (ICHS) rates (prior to COVID adjustment)		
	Rate	**2021 MMs**
Medicaid Only 55-64	$7,358.12	10
Medicaid Only 65+	$5,512.53	10
Medicaid Only Composite	**$6,435.33**	**20**
Proposed FY 2023 King (ICHS) rates		
	Rate	**2021 MMs**
Medicaid Only 55-64	$6,679.94	10
Medicaid Only 65+	$6,679.94	10
Medicaid Only Composite	**$6,679.94**	**20**

b. The state pays out the age-band and dual status specific rates to the PACE organizations. Starting in FY 2023, that rate will be the same for each Medicaid Only age band because we have set the rates using combined base data due to credibility

concerns.

Response: The American Rescue Plan Act of 2021 (ARP), Section 9817, provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). PACE is included as an eligible HCBS expenditure. Consistent with the guidance in the State Medicaid Director (SMD) letter #21-003 titled Implementation of American Rescue Plan Act of 2021 Section 9817, to demonstrate compliance with the requirement not to supplant existing state funds expended for Medicaid HCBS, states are required to maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.

Per your response, Medicaid Only 55-64 for King (ICHS) has decreased from the April 2021 rate. Please demonstrate how this is compliant with the ARPA requirement respective to International Community Health Services (ICHS) administered PACE organization(s) within King County.

9/19/2022 Milliman response:

SMD letter #21-003 indicates that the state must "Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021" and that "States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021." It further states in Appendix C that "An increase to the PACE Medicaid capitation rate can be implemented as part of the state's regular annual rate update or on a temporary basis as an interim rate increase, but must comply with existing submission, review, and approval requirements." We have addressed these requirements by maintaining PACE rates that in aggregate are higher than what would have been effective in April 2021. As shown above and in our original rate certification, total payments made to ICHS (King) are significantly higher than those that would have been paid as of April 1, 2021 for a fixed membership distribution. Additionally, total payments for Medicaid Only individuals are higher than they would have been as of April 1, 2021 for a fixed membership distribution.

The decrease in the Medicaid Only 55-64 rate is due to a credibility methodology change that combines the two Medicaid Only cells into a single rate cell. Previously there were separate Medicaid Only rate cells for ages 55-64 and 65+. The updated rates are not reducing the total payment amounts for the PACE provider's full population (or even the Medicaid Only population that is impacted by the methodology change). Rather, the updated methodology smooths rates across the Medicaid Only population and then the rate update increases the combined Medicaid Only rate by approximately $245 PMPM as shown in the table included in our 8/24 response. Additionally, we have complied with the existing submission, review, and approval requirements. We have strengthened the PACE rates by making them higher in aggregate than they were in April 2021.

B. Base Period Data

1. Regarding the limited review of the data done, as described on page 27 of the Rate Certification,
    i. Did the actuary compare the claims data to the record of payments actually made to providers?
    ii. Please clarify if only claims that were actually paid are included in the analysis to

create a historical per-member-per-month rate.

iii. Describe any other validation processes in place to ensure that the base data used was appropriate for the population.

iv. Please describe if the reasonableness checks include any analysis of claims outliers (e.g., catastrophic claims).

v. Provide the magnitude of the claims removed from the base data as a result of these validations.

7/21/2022 Milliman response:

i. The claims data is FFS data paid by the state. It is a record of the payments actually made to providers.

ii. Adjustments are made to the base data to account for denied and reversed claims. Only claims that are actually paid are used in the base data.

iii. We have described our population validation processes in detail in the "Base Data Identification" section of the rate certification.

iv. Reasonableness checks review for outliers caused by data errors, such as misplaced decimal points, but do not make adjustments for reasonable catastrophic claims.

v. Please see exhibit B-1 in the included spreadsheet for a summary of excluded claims.

Response: Thank you. We have no further questions on this matter at this time.

2. Please confirm that the AWOP is calculated without including spenddown expenses that are the recipient's liability.

7/21/2022 Milliman response:

The AWOP and rates include patient participation payments, as described in the rate cert. Other spenddown expenses are not included.

Response: Thank you. We have no further questions on this matter at this time.

3. Please detail the development of the GME and IME cost differences that were included in the AWOP development, as noted on the bottom of page 9 and top of page 10 of the certification.

7/21/2022 Milliman response:

These cost differences are inherent in the provider payment rates and are therefore included in the base data. We do not expect there to be meaningful differences in the payments made by PACE organizations. As discussed during the meeting on July 1st, we will not detail the development of these provider rates and there are no other GME or IME payments included in the PACE rate or AWOP development.

Response: Thank you. We have no further questions on this matter at this time.

4. Please confirm that there were no payments or recoupments processed outside the P1 database that would need to be incorporated in the AWOP development, other than the BH and NEMT payments and rebate recoupments described in the Rate Certification.

7/21/2022 Milliman response:

Confirmed.

Response: Thank you. We have no further questions on this matter at this time.

5. Please explain how the threshold of at least 8 days of in-home care was determined to be representative of the PACE eligible population.

7/21/2022 Milliman response:

The 8-day threshold is not the main criterion in determining whether a member is included in the PACE-eligible population. The majority of non-PACE-eligible members are excluded based on RAC code and CARE assessment availability. Instead, this criteria is intended to exclude otherwise eligible members based on data integrity concerns or non-utilization. A person receiving in-home care can reasonably be expected to receive at least two services per week, so if we are not seeing this in the data then we would assume that the patient was only receiving service for a partial month, didn't have utilization characteristic of a PACE member, or has missing data.

Response: Thank you. We have no further questions on this matter at this time.

6. Please clarify if the population of "Members not fulfilling any of the previous requirements, with at least 8 days of in-home care per month" noted on page 12 of the Rate Certification is representative of the Waiver population.

7/21/2022 Milliman response:

See response B-5. The majority of population exclusions are based on RAC code and CARE assessment availability. Within this population, we do not differentiate among different RAC code inclusion reasons. This population is intended to represent those members with included RAC codes, CARE assessments, no significant services in other care settings, and enough in-home services to indicate that the data quality is sufficient for use in rate-setting.

Response: Thank you. We have no further questions on this matter at this time.

7. Please provide the patient participation amounts described on page 9 of the Rate Certification.

7/21/2022 Milliman response:

These are included in Appendix A, Exhibit 1 of the certification for each population.

Response: Thank you. We have no further questions on this matter at this time.

8. Please further explain the credibility concerns that led to combining the age bands

7/21/2022 Milliman response:

For the Medicaid-Only population, the 65+ age band has very few MMs. For the dual population, the under 65 population has less than 200 MMs in some categories (ex: Snohomish ALF has 155). Most importantly, care location and dual status have far more impact on cost than age.

Response: Thank you. Please provide the amount of member months included in each of the pre-65 and post-65 rates cells.

8/24/2022 Milliman response:

Please see the included Exhibit B-8 for the number of PACE-similar member months split out by rate cell and care location.

Response: Thank you. We have no further questions on this matter at this time.

9. Regarding the retrospective eligibility, please expand on the limitations imposed from only including eligibility and costs for members with a CARE assessment requirement. Additionally, please further explain how this limitation does not lead to material impacts to the PACE rates or AWOP.

7/21/2022 Milliman response:

All PACE members must receive a CARE assessment periodically, so the population of members with a CARE assessment more closely matches the modeled population.

Additionally, a CARE assessment is required for the risk stratification of the HCBS population for Providence King rates.

Response: Thank you. Please further explain the analysis done to determine that the retrospective enrollment would not materially impact the rates or AWOP.

8/24/2022 Milliman response:

If a CARE assessment has not been performed prior to or during the month of eligibility, we do not include the member month in our base data. In order for a retrospective member month to be included, the member would need to have received a CARE assessment during the retrospective period, which based on conversations with ALTSA is unlikely. With this understanding, we assumed that the impact of any retrospective enrollment would be negligible and did not require further analysis.

Response: Thank you. We have no further questions on this matter at this time.

C. Data Adjustments and Projections

1. Regarding the exclusion of the Managed Care Program data for Medicaid-only participants as noted on page 12 of the Rate Certification,
    i. Please clarify if this program is voluntary.
    ii. Please further explain the eligibility criteria of this program.
    iii. Please provide the proportion of Medicaid-Only members that are in Managed Care versus Fee for Service.

7/21/2022 Milliman response:

Per the July 1st call, we addressed these concerns with our responses to the program questions and a general discussion of the IMC program. As discussed, the IMC program is generally a mandatory enrollment program. However, physical health services for the populations that are most similar to the PACE population are generally covered FFS.

Response: Thank you. Please provide the proportion of Medicaid-Only members in the PACE comparable population that are in Managed Care versus Fee for Service. If the proportion in Managed Care is significant, please further explain why it was reasonable to exclude the Medicaid-only managed care participant data within the AWOP development.

8/24/2022 Milliman response:

The COPES population is the managed care population that is most similar to the population enrolled in the PACE program. Limiting to the 35+ age band for COPES, we see that the

majority (approximately 88%) of members in COPES have physical health services provided through managed care. We do not have the necessary claims and CARE information to run our full PACE-similar population logic on these members, but we expect that this proportion will decrease dramatically when limited to fully PACE-similar members.

Regardless of the proportion, we do compare the physical health component of our final PACE rates to the COPES rates developed for the Apple Health managed care program, keeping in mind that there are some differences between the two programs. The medical and pharmacy benefit costs for the COPES population range from $1,550 - $2,170 PMPM (depending on region) in the Apple Health rates effective July-December 2022, while the portion of the SFY 2023 – SFY 2024 benefit cost for each PACE provider (reported in Exhibit 1) attributable to HCA ranges from $1,850 - $2,150 PMPM, so we are confident that the overall costs between the two programs are not drastically different. Since the overall costs are similar but the Managed Care data would require additional adjustments and further data requests, we feel that excluding the managed care data is justified.

Response: Thank you. We have no further questions on this matter at this time.

2. Regarding the removal of COVID Add-On Costs, please clarify what the unit cost increase amounts were for each nursing facility claim and provide quantitative support for how those amounts were used to calculate the impacts shown in Table 8 on page 14 of the Rate Certification.

7/21/2022 Milliman response:

The following COVID daily add-on amounts were removed from each nursing home day:

Effective Date	Final Date	Daily COVID Add-on rate
7/1/2020	7/31/2020	$13.00
8/1/2020	9/30/2020	$5.00
10/1/2020	12/31/2020	$7.50
1/1/2021	3/31/2021	$8.30
4/1/2021	6/30/2021	$8.33

Additionally, for HCPCS codes T1005 (respite) and T1019 (in-home personal care), we removed $0.64 per unit for individual provider claims and $1.12 per unit for agency provider claims. For HCPCS code S5170 (home-delivered meals) we removed $1.70 per unit.

For all other services, COVID add-ons were coded in separate claim lines, so we simply did not include the add-on codes when we limited to PACE-eligible services.

Response: Thank you. We have no further questions on this matter at this time.

3. Regarding the completion factors as noted in Table 9 of the Rate Certification:
    i. Please detail the assumptions and methodologies used to develop the claims completion factors as described on page 14 and 15 of the Rate Certification.
    ii. Please explain why the completion impact for inpatient hospital is significantly higher than the other categories of service.

7/21/2022 Milliman response:

i. We develop lag triangles based on the FFS data provided, separated into broad claim categories. We use these lag triangles to analyze the typical lag and completion patterns for each category, then project these patterns to assess the

expected cost of claims not yet reported.

ii. Inpatient hospital claims complete slower than professional claims for almost every population, and the PACE population is no exception.

Response: Thank you. We have no further questions on this matter at this time.

4. Regarding the pharmacy rebate,
   i. Please provide the quantitative development for, and show the final impact of, the pharmacy rebate adjustments as noted on page 14 of the Rate Certification.
   ii. Please explain why rebate information was only for a portion of the base period (July to December 2020) per page 14 of the FY 2023-2024 Rate Certification.

7/21/2022 Milliman response:

i. We received contracted rebates per unit at an NDC level from the state for July-December 2020. We also have pharmacy claim data for the full July 2020-June 2021 period, with NDCs and units available. For each claim, if the NDC appeared on the state rebate dataset, we calculated the total rebate based on the reported units and the rebate per unit. We then removed the rebate amount from the total paid that was used to develop the capitation rates. The total statewide impact on the base data is shown in the following table:

PACE-similar MMs:	499,942
Pharmacy paid (prior to rebates):	$4,440,239
Estimated rebates:	$1,057,966
Pharmacy paid (net of rebates):	$3,382,273

ii. We did not receive rebate amounts for Jan-June 2021 from the state, and the July-December 2020 data indicates the "unit cost" rebate for each NDC. We do not expect material differences in rebates per unit for the two time periods, so we used the most recent rebate per unit to develop the Jan-June 2021 adjustments.

Response: Thank you. We have no further questions on this matter at this time.

5. If the AWOP is developed using FFS data from ProviderOne (P1), please explain why the Primary Care Rate Increase would be applied within the AWOP development.

7/21/2022 Milliman response:

The Primary Care rate increase impacts the projected FFS costs and therefore the AWOP.

Response: Thank you. We have no further questions on this matter at this time.

D. Development of Projected Benefit Cost and Trend development

General Milliman trend response:

Several of the questions below refer to development of trend assumptions that were used solely for acute medical services for Medicaid Only populations. Acute services account for less than 40% of the Medicaid Only rate, and the Medicaid Only population is approximately 8% of the total PACE population. Additionally, the PACE similar population is very small, limiting the ability to perform robust trend analyses or other projections. Given the small portion of the total cost this applies to, and the difficulty in accounting for the impacts of COVID when using long periods of historic data, it was often not practical or possible to perform a more traditional historical trend analysis. In these cases, we made assumptions

that reflect our best estimate of the impact of trends over time on these populations.

1. Please confirm that all PACE covered services are included in the base FFS data or are adjusted for within the AWOP development.

7/21/2022 Milliman response:

Confirmed

Response: Thank you. We have no further questions on this matter at this time.

2. Regarding dental costs,
    i. Please provide the full quantitative development of the 163% total increase to dental costs described on page 17 of the Rate Certification.
    ii. Please justify the 16% annualized trend to FFS data for dental services returning to pre-COVID levels narratively and quantitatively.

7/21/2022 Milliman response:

i. PACE Organization Providence provided total dental costs for 2019 and 2020 as part of their financial reporting. We compared their PMPM costs for both years to the Provider One-reported dental FFS costs, as shown in the table below:

	PACE Prov. Dental PMPM	P1 FFS Dental PMPM	Network Factor
2019	$28.83	$10.96	163%
2020	$19.28	$6.62	185%

Since both factors were similar, we used the 2019 factor to avoid any potential COVID complications. Please note that the costs reported above are spread between the “Dental” column and “Other” column in Appendix A, Exhibit 1.

ii. Many dental services are more deferrable than other physical health services, which has been demonstrated during the PHE with a significant drop in dental utilization in most markets. Comparing the P1 FFS dental costs from 2019 to 2020 and 2021 indicates that the base data used in our rate development had significantly lower dental costs than the pre-PHE period.

In developing our dental trend, we assumed that dental services would return to their pre-PHE baseline but would not increase beyond that. We also found that the unit costs in the dental data were inconsistent across the time periods, indicating either a change in service mix or a potential issue with the reported utilization. Thus, we used PMPM costs to measure the difference instead of utilization. The CY 2019 baseline for FFS dental services was $10.96 PMPM, and the SFY 2021 FFS dental PMPM in our base data period was $7.52, an increase over CY 2020 but still below the pre-PHE baseline. $10.96 / $7.52 = 1.46, which annualizes to a 16.3% increase (2.5 years of trend applied).

Response: Thank you. We have no further questions on this matter at this time.

3. Please explain which State’s Medicaid programs were analyzed and how Milliman used the trend data from other State Medicaid programs to determine the final trends.

7/21/2022 Milliman response:

We used publicly available LTSS trends from managed LTSS programs in Arizona and Oregon as a general reference. We did not directly use trends from other states in the final trend assumptions.

Response: Thank you. We have no further questions on this matter at this time.

4. For the adjustments for the impacts of deferred or omitted care due to COVID,
    i. Please provide quantitative support for the development of Dental and Outpatient COVID deferred care adjustments.
    ii. Please explain how it was determined that no other categories of service required adjustments for COVID deferral of care.
    iii. Please explain any analysis done to determine the impact of telehealth visits on COVID period utilizations.

    7/21/2022 Milliman response:

    Note that these assumptions were applied to the Medicaid Only population (see general response to trend questions).

    i. For the dental adjustment, see response D-2. The outpatient adjustment was developed in a similar way, though limited to utilization. In 2019, the Medicaid-only population incurred 15,481 Utils/1,000. In SFY 2021 (our base period), they incurred 13,316 Utils/1,000. Assuming a full recovery to pre-PHE levels, that indicates a 16.3% increase over 2.5 years, which annualizes to 6.2%.
    ii. Other categories of service had higher utilization in SFY 2021 than in the pre-PHE period, so we determined that their utilization levels had either not been impacted by the pandemic or had already returned to standard levels during our base period.
    iii. Telehealth services are included in the base data, but we did not do any further analysis to determine their impact on COVID period utilization. The two broad categories of service (dental and outpatient) for which we made omitted care adjustments are not likely to be significantly impacted by telehealth.

    Response: Thank you. We have no further questions on this matter at this time.

5. Regarding the medical trend adjustments,
    i. Please explain why the Part A and B 2019-2022 deductible levels as released by CMS were chosen as the best sources for the Dually Eligible medical trend development.
    ii. Please further explain the analysis done to determine that no trend should be applied to DME.
    iii. For the Medicaid-only population, it appears that the only medical trend analyses done was to try to return service levels to their pre-COVID levels. Please explain if any other trend analysis was done for this population.

    7/21/2022 Milliman response:

    i. For dual-eligible members, Washington Medicaid is generally responsible for the deductible, but due to lesser of policies doesn't pay for much beyond the deductible. Most members hit the deductible, so the change in deductible is a reasonable proxy for the cost to PACE.
    ii. The vast majority of PACE DME expenses are for diapers. The diaper fee

schedule didn't change, and we didn't see any historical evidence of significant utilization changes.

iii. No further analyses were done. See the general response at the beginning of the trend section.

Response: Thank you. At the start of this section responses, it was noted that for this population "…it was often not practical or possible to perform a more traditional historical trend analysis. In these cases, we made assumptions that reflect our best estimate of the impact of trends over time on these populations." In follow-up to the response to 5.iii. above, please further explain how it was determined that no further analysis or trend impacts were necessary to best reflect the expected impact of trends for this Medicaid-Only population.

8/24/2022 Milliman response:

Based on our actuarial judgment and deep knowledge of Washington's Medicaid programs and other state Medicaid programs, we feel comfortable certifying simplified trend assumptions for this population. A more detailed trend analysis would not be credible on the limited Medicaid Only population nor do we think it is necessary given our experience with Medicaid Only populations more broadly.

Response: Thank you. We have no further questions on this matter at this time.

6. Regarding the LTSS trend adjustments,
   i. Please describe the years of data analyzed and the specific results of that analysis.
   ii. Please further explain why the NH, AFH, and ALF members already having a high level of utilization would lead to no trend being applied to these populations.

7/21/2022 Milliman response:

i. The historical period used to inform the LTSS trend assumptions was Jan. 2019 through June 2021. Monthly changes in utilization were observed in Power BI for each county, living situation, and CARE level. Unit cost changes were not observed, because these are accounted for separately based on fee schedule changes. For almost all populations, the level of utilization was consistent by month, because significant changes in LTSS utilization in a member are generally correlated with a change in living situation or CARE assessment. Since we develop rates for each living situation separately, and account for CARE mix changes for large PACE populations, a flat utilization trend is reasonable. The one exception is for in-home services, where we observed a minimal increase in utilization even within CARE levels.

ii. NH, AFH, and ALF members are already receiving a per diem service every day. We do not apply any additional trend because no change in monthly utilization is expected.

Response: Thank you. We have no further questions on this matter at this time.

7. Regarding the fee schedule and program changes as noted on pages 18 and 19 of the Rate Certification,
   i. Please break out Table 12 of the Rate Certification to show the impact of each individual fee schedule and program change noted in the Rate Certification on each category of service for each region.
   ii. Using the In-Home COS as an example, please show how the individual fee

schedule changes shown in Appendix B-2, along with the fee schedule and program change noted in the Rate Certification, tie back to the 50%+ In-Home adjustments shown in Table 12 on page 18 of the certification.

7/21/2022 Milliman response:

Per the July 1st call, the information provided in Appendix B-2 of the certification is sufficient for this question.

Response: Thank you. We have no further questions on this matter at this time.

8. Regarding the HCBS and Nursing Home distributions,
    i. Please provide exhibits demonstrating how the care setting distributions in Table 13 were developed.
    ii. We note both King (Prov) and King (ICHS) are developed based on the actual Providence King County PACE enrollment as of CY 2021. Please explain why King (ICHS) contains more than twice the amount of NH percentage in the distribution compared to King (Prov).
    iii. Please provide a numeric exhibit for the development of the NH percentages shown in Table 14.
    iv. Please clarify why Spokane (Prov) is represented to have the second highest NH distribution, at 3.3%, when there is a lack of data to support it.

7/21/2022 Milliman response:

i. For King MC, Pierce, Snohomish, and Spokane, these distributions are the distributions observed in the PACE-similar population. Using Pierce as an example:
There are 56,757 non-nursing home MMs in the base period PACE-similar population. Of these, 8,051 are in an adult family home, so the AFH percentage is 8,051/56,757 = 14.2%.

For King Providence, we perform the same calculation using actual PACE Providence MMs from the base period. For King ICHS, the percentage is a 50/50 blend of the two methods.

ii. They aren't, this is a typo in the certification. NH percentage for King (Prov) is based on Providence King County enrollment, NH percentage for King (ICHS) is based on King (ICHS) enrollment.

iii. Using King (Prov) as an example of a plan using plan membership, there are 9,271 total MMs in the base period PACE population as reported by Providence. Of these, 109 are in a nursing home. So the NH percentage is 109/9,271 = 1.2%. As an example of a calculated percentage, we have included the calculation for the Snohomish population in a new Exhibit D-8. The final percentage is shown in cell V80.

iv. There are two main factors in the nursing home distribution: 1) time and 2) PACE-similar population nursing home percentages. It takes some time for members to transition to nursing homes, and members have been hesitant to move to nursing homes recently due to COVID. This is expected to change as COVID becomes less of a concern, so we treated the existing Providence Spokane membership as if they were new members when calculating their expected membership percentage. Additionally, the Spokane PACE-similar population has a higher percentage of members who transition from non-NH care situations to NH. County-specific nursing home distribution percentages in the PACE-similar population data reflect provider availability and cultural differences between counties.

Response: Thank you. We have no further questions on this matter at this time.

9. Regarding transportation costs, please explain why actual King Prov experience was used and explain why it is applicable to the other cohorts.

7/21/2022 Milliman response:

Since the other PACE organizations are fairly new, we do not have consistent data from any of them. Specifically, we don't have data from prior to the public health emergency from other PACE organizations. We also know that the transportation requirements for a PACE organization are significantly different from those for FFS members, so we prefer not to use the state FFS data to develop the rates. We rely on some assumptions on unit cost change over time from the state FFS data, but the King Prov experience is the most complete data source we have for transportation utilization and overall unit cost.

Response: Thank you. We have no further questions on this matter at this time.

10. Please provide narrative and quantitative support for the geographic factors used to determine rates for King, Pierce, and Snohomish, as shown in Table 10. Please also explain why they appear to have changed significantly from the prior certification.

7/21/2022 Milliman response:

Most of these factors are very similar to the FY 2022 recalibration factors. None of them have changed by more than 3%, and most are within 1% of the previous value. The underlying utilization mix has been updated to use the most recent data, and the fee schedules have been updated, so this doesn't seem like an unreasonable difference.

Nursing Home factors are developed based on a bed-weighted average of the FFS NH facility-level fee schedule. The county bed cost is then divided by the statewide bed cost to get the geographic adjustment factor to be applied when using statewide data. The following table shows bed cost average by county for FY 2023, with the final factors:

	King	Pierce	Snohomish	Spokane	Statewide
FY2023 Bed Cost	$329	$318	$335	$297	$311
Geo. Factor	1.055	1.020	1.075	0.951	1.000

Adult family home and assisted living facility factors are developed using FY 2023 FFS fee schedules, with unit costs composited for each county using historical utilization by CARE assessment level. A mix-adjusted statewide unit cost is calculated using the CARE assessment distribution of the county. The following table shows the mix-adjusted unit costs and geographic factors for ALF and AFH services:

	King	Pierce	Snohomish	Spokane
FY2023 ALF Unit Cost	$83.63	$85.40	$94.75	$83.93
FY2023 ALF Mix-adj Statewide Unit Cost	$79.12	$85.69	$90.13	$85.67
ALF Geo. Factor	**1.057**	**0.997**	**1.051**	**0.980**
FY2023 AFH Unit Cost	$291.28	$259.06	$284.90	$236.55
FY2023 AFH Mix-adj Statewide Unit Cost	$285.24	$262.14	$278.96	$248.14
ALF Geo. Factor	**1.021**	**0.988**	**1.021**	**0.953**

Response: Thank you. We have no further questions on this matter at this time.

E. Projected Non-Benefit Costs (Administrative Costs)

1. It was clarified during the last full certification cycle that there are other non-negligible administrative costs that would impact the PACE-eligible members if they are enrolled in FFS. However, the State was not able to estimate those other components easily, so they are not included in the AWOP.
    i. Please further describe, separately for institutional and non-institutional members, all the administrative costs that the PACE eligible members would be expected to have if enrolled in FFS.
    ii. Please explain, for each of these cost categories, why they were not able to be estimated for AWOP development purposes.
    iii. Please explain if anything is being done to ensure that all non-negligible administrative costs expected to be incurred for the PACE eligible population if they are not enrolled in PACE will be included within the AWOP development.

7/21/2022 Milliman response:

The state is still not able to estimate the separate components easily. To determine the administrative costs to the state that are being assumed by the PACE organizations for non-NH locations of care, we calculated the expected cost of the additional full-time

administrative employees the state estimates would be required if PACE did not exist. For institutional members, we assume that there are no administrative costs transferred from the state to the PACE organizations.

While we have estimated these amounts based on the best information available, it is possible additional administrative costs are being transferred to the PACE organizations. Any additional unreported admin costs would only increase the AWOP.

Response: Thank you. We have no further questions on this matter at this time.

2. Regarding the additional administrative load and risk margin applied to both the HCBS and nursing home PACE rates:
    i. Please further describe the analysis of PACE and MLTSS programs in other states and the review of recent high-level Providence financials included in the development of these rates and how the final rates were determined.
    ii. Considering that these loads are the same as they were for the previous SFY 2020-2021 Rate Certification, please explain how often this analysis is updated to ensure that the most recent administrative cost information is being applied within the rate development.
    iii. Please provide a numeric exhibit demonstrating how the 5.5% and 6.0% loads were determined for dual eligible and Medicaid only, respectively.
    iv. Please clarify why nursing home members are expected to not have any substantial administrative costs transferred to PACE.
    v. We note Table 17 states care management is $132.63 PMPM; however, each rate for care management in Exhibits 2a-2f does not show care management at $132.63. Please explain why these rates differ.

7/21/2022 Milliman response:

As discussed in the meeting on July 1, the administrative load and risk margin load were selected based on a review of data and while considering how the rates relate to the AWOP. We believe the assumptions are reasonable for the PACE organizations and support rates that are lower than the AWOP for all rate cells and PACE organizations.

i. When developing the SFY 2020 – SFY 2021 certification, we performed a review of publicly and privately available PACE and MLTSS certifications across multiple states to understand general administrative loads and margin assumptions. No detailed analysis is available.
ii. Since the SFY 2020-2021 certification, we regularly review and discuss with other certifying actuaries whether admin and margin assumptions have materially changed since the prior certification. Based on our discussions, we did not feel that a change is warranted.
iii. Please refer to question i above.
iv. The State did not identify any administrative services performed by state personnel that do not exist because of members being enrolled in PACE. Therefore, we have not included an administrative load for NH members in the AWOP.
v. The $132.63 PMPM is the cost for non-institutional members. The rates in exhibits 2a-2f are blended for all members, including those in nursing homes, so they are slightly lower.

Response: Thank you. Our understanding is that the administrative costs included in the calculation of the AWOP should reflect state administrative costs for PACE comparable participants absent the PACE program, While this sounds like it would equal administrative costs that would transfer to PACE, it doesn't seem to make sense that the State would have no administrative costs for nursing home members absent of PACE simply because costs that would transfer to PACE could not be identified for this population. Considering this assumption for the nursing home population, please further explain how it was determined that the

administrative costs that would transfer to PACE are reflective of the administrative costs for PACE comparable participants absent the PACE program.

8/24/2022 Milliman response:

It is our understanding that the state's administrative costs for members in a nursing home are fixed, regardless of whether the member is enrolled in PACE or in FFS, and that provider payment rates for nursing home providers include consideration for some administration performed by the provider as opposed the state. Given the State would not hire any additional staff or incur any additional expenses for PACE members in a nursing home, we felt it was more appropriate to assume zero transferred costs for these members in the AWOP.

Response: Thank you. We have no further questions on this matter at this time.

F. Certification Exhibits and Development of AWOPs

1. Regarding the Care Setting Distribution Developments,
    i. Please describe the historical data used to develop the 2.5% member lapse rate.
    ii. Considering that this lapse rate is the same as for the previous SFY 2020-2021 Rate Certification, please explain how often this analysis is updated to ensure that the most recent lapse data is being applied within the rate development.

    7/21/2022 Milliman response:

    This is a typo in the certification – the true lapse rate used was 2.3%, which was calculated by analyzing the duration of the PACE-similar population. Specifically, we calculated the number of members with membership in the PACE-similar population of at least 4 months in a thirty-month period (Jan. 2019 – Jun. 2021). We then determined the number of these members who had at least 16 months in the PACE-similar population to get the annual lapse rate. We then calculated a monthly lapse rate from this. Other durations separated by 12 months showed similar lapse rates.

    Response: Thank you. We have no further questions on this matter at this time.

2. Considering that July 2020 through June 2021 data was used to develop the Hepatitis C rate adjustment, please explain if COVID may have impacted this hepatitis utilization and cost data and how this may have been accounted for within the Hepatitis C Rate development.

7/21/2022 Milliman response:

Only unit cost is relevant to the Hepatitis C rate add-on; utilization patterns across the population were not analyzed because they do not impact the development of the rate. An individual with Hepatitis C receiving appropriate treatment will not require any more or fewer doses in a COVID environment. Additionally, the unit cost is driven by the state's rate and is not subject to change from COVID.

Response: Thank you. We have no further questions on this matter at this time.

3. Please expand Exhibit 4 of Appendix A to separately show the actual dollar impacts of each of the rate components in Table 5 of the certification when transitioning from the PACE rates to the AWOP.

7/21/2022 Milliman response:

We are unable to expand this exhibit. We do not develop components of the PACE rates that are different from the AWOP calculations in isolation, as there is some interaction between them and we develop the AWOP and the rates using separate buildups.

Response: Thank you. We have no further questions on this matter at this time.

Attachment V- PACE FY 23 Methodology

FY 2023 PACE Rate Development - DRAFT

DRAFT Methodology and Results

Annie Hallum, FSA, MAAA

Dan Gerber, ASA, MAAA

Nick Johnson, FSA, MAAA

APRIL 1, 2022

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Topics

- Goals and Requirements
- Base data
- Adjustments to data
- Other Considerations

Goals and Requirements

Goals of PACE Rate Development

Develop appropriate/actuarially sound rates

Meet federal requirements

Allow for program sustainability

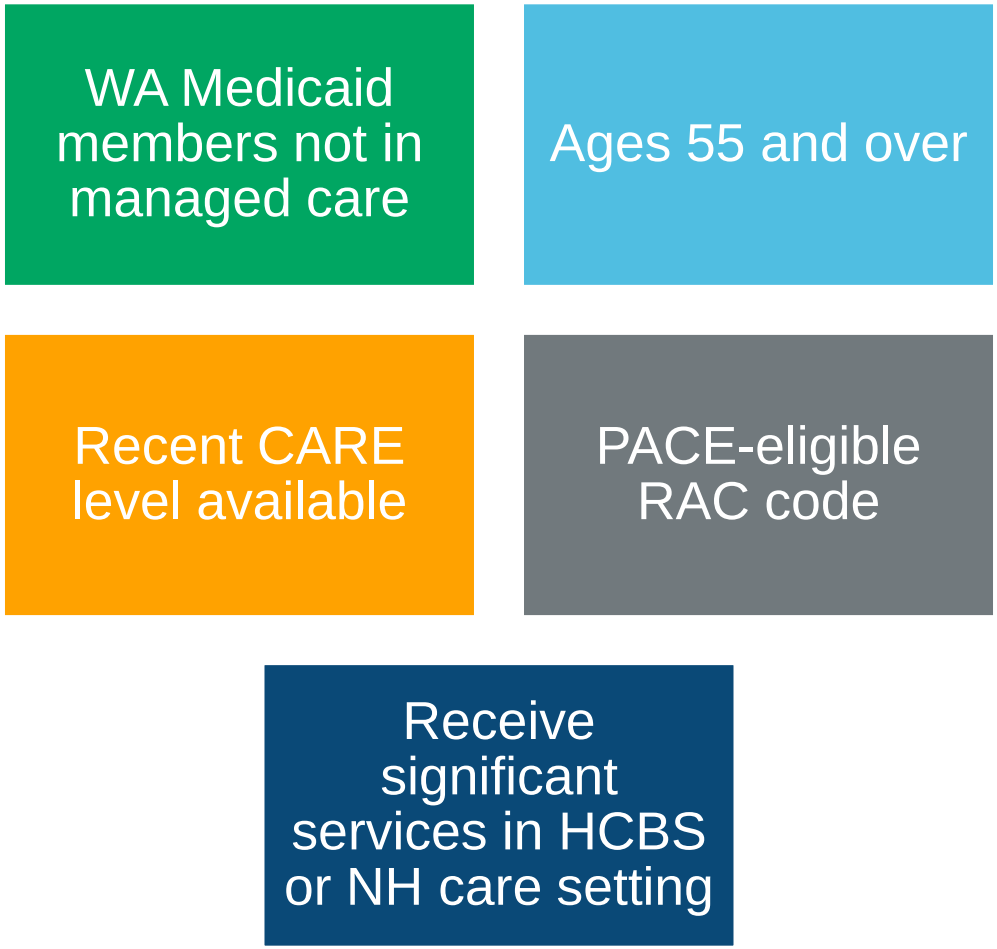
CMS Requirements

- 42 CFR 460.182 - Medicaid payment
  - The monthly capitation payment amount is negotiated between the PACE organization and the State administering agency, and specified in the PACE program agreement. The amount represents the following:
    - (1) **Is less than the amount that would otherwise have been paid under the State plan** if the participants were not enrolled under the PACE program.
    - (2) Takes into account the comparative frailty of PACE participants.
    - (3) Is a fixed amount regardless of changes in the participant's health status.
    - (4) Can be renegotiated on an annual basis.

What is the Amount that Would Otherwise have been Paid (AWOP)?

- The amount the state would pay to cover state plan services for a PACE-similar population
  - Uses fee-for-service (FFS) claims from the state's ProviderOne data warehouse, along with other costs for the same members
- Adjusted to PACE risk level (comparative frailty)
  - Using Comprehensive Assessment Reporting Evaluation (CARE) level and/or living situation mix
- Adjusted for PACE-similar population nursing home percentage

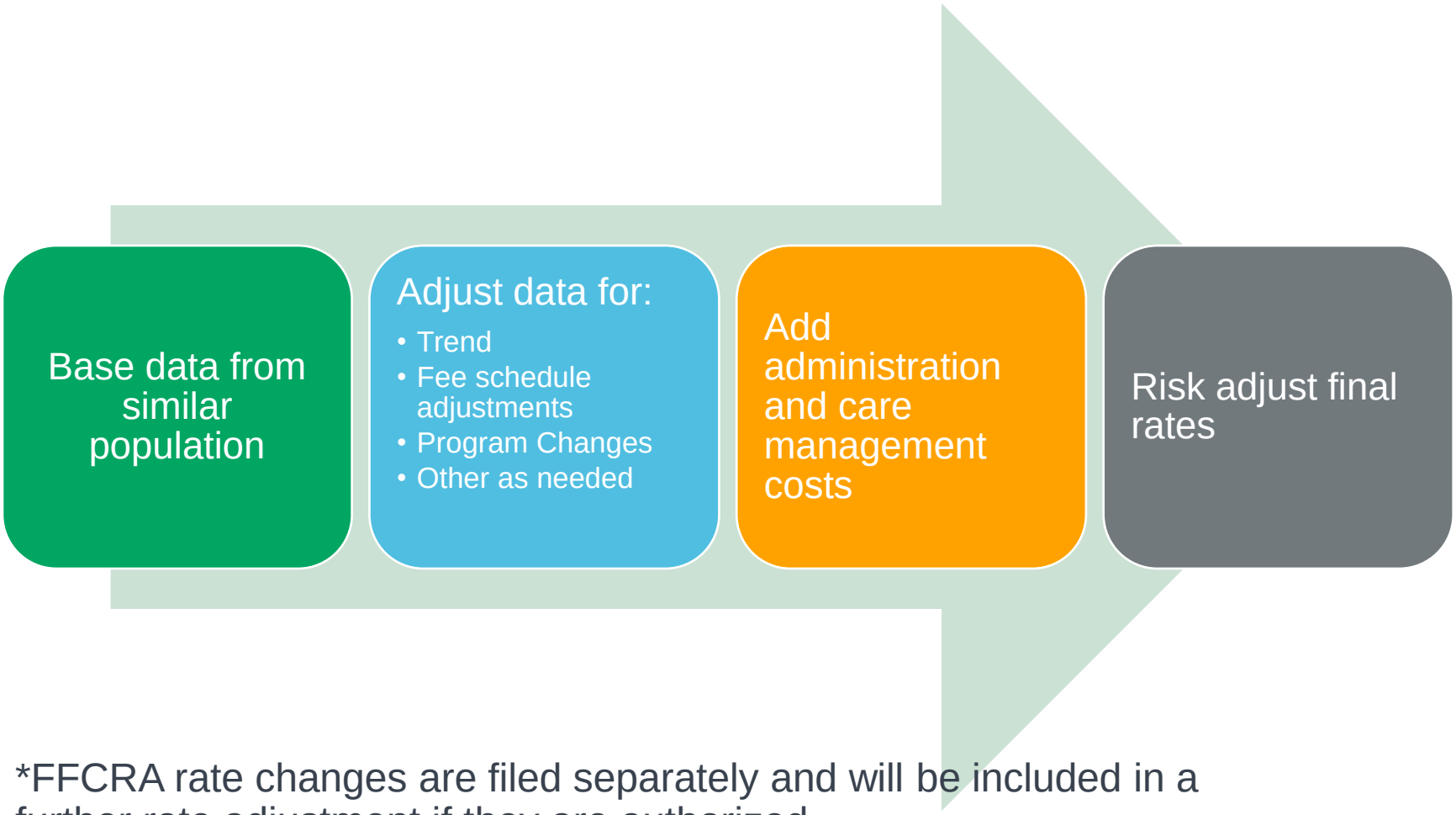
What is a PACE-Similar Population?



Why do we use a PACE-Similar Population?

- Credible population to use for developing rates
- Claim-level utilization data is available
- Note: Individual components for PACE-similar population may be different from actual PACE experience

Typical Managed Care Rate Development



*FFCRA rate changes are filed separately and will be included in a further rate adjustment if they are authorized.

Base Data

Claims and Enrollment Data

FFS claims, eligibility, and patient participation from ProviderOne data warehouse, limited to PACE-similar population

Experience period: July 2020 through June 2021 incurred, paid through November 2021

Excludes Hepatitis C drugs, NEMT, and behavioral health

- Hepatitis C drugs are used to develop a separate add-on rate
- BH services are added through a separately developed rate
- NEMT costs are developed separately

Other Data

From PACE Organizations

- Historical and projected enrollment
- Transportation trips and costs
- Detailed claims data
- PACE financials

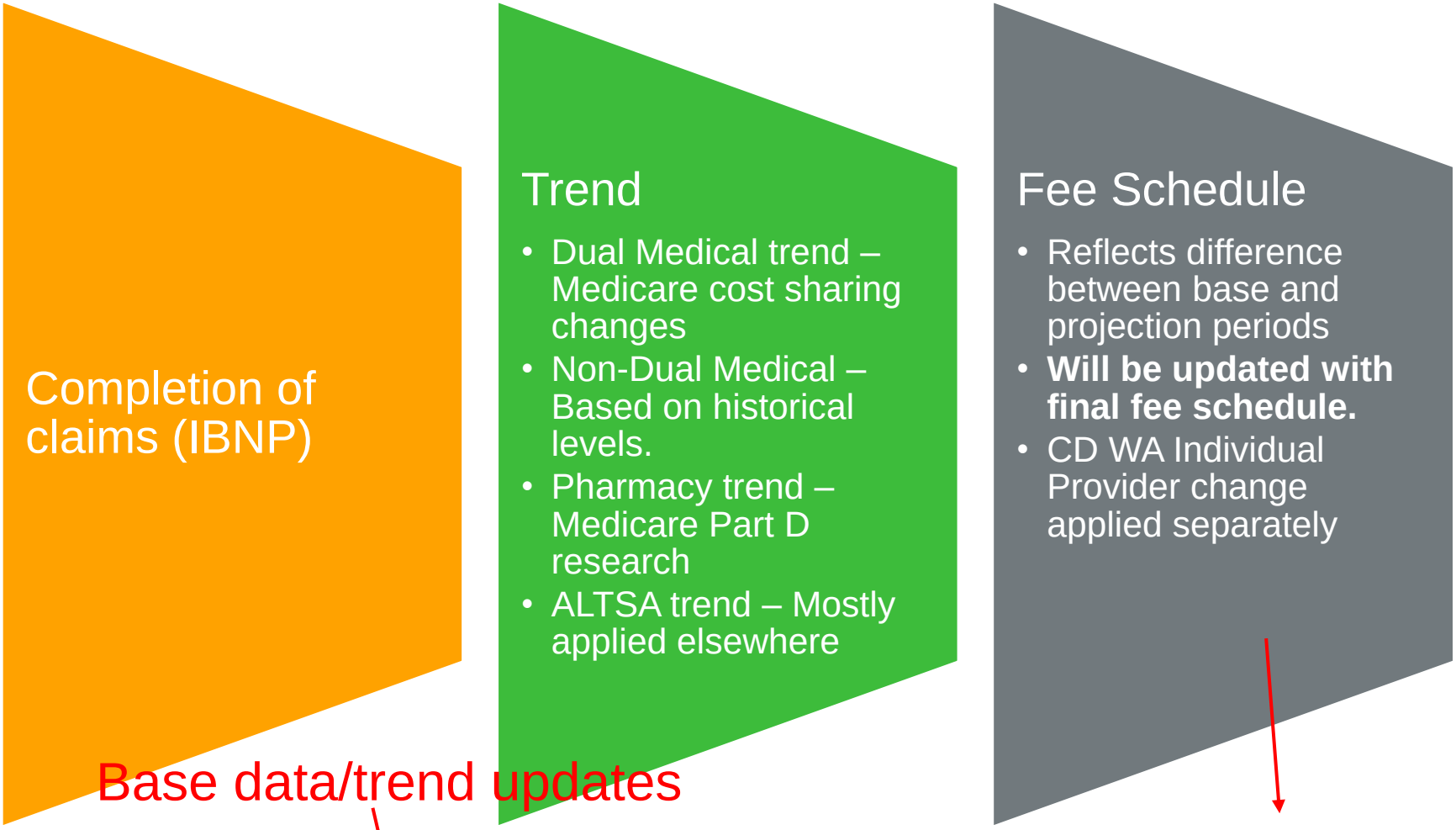
From ALTSA/HCA

- BH rate component – Apple Health BHSO rates, developed separately
- Transportation utilization assumptions and costs
- Care management and transferred admin costs
- Caseload forecasts
- Fee schedule* and other program changes
- CD WA individual provider contracting change

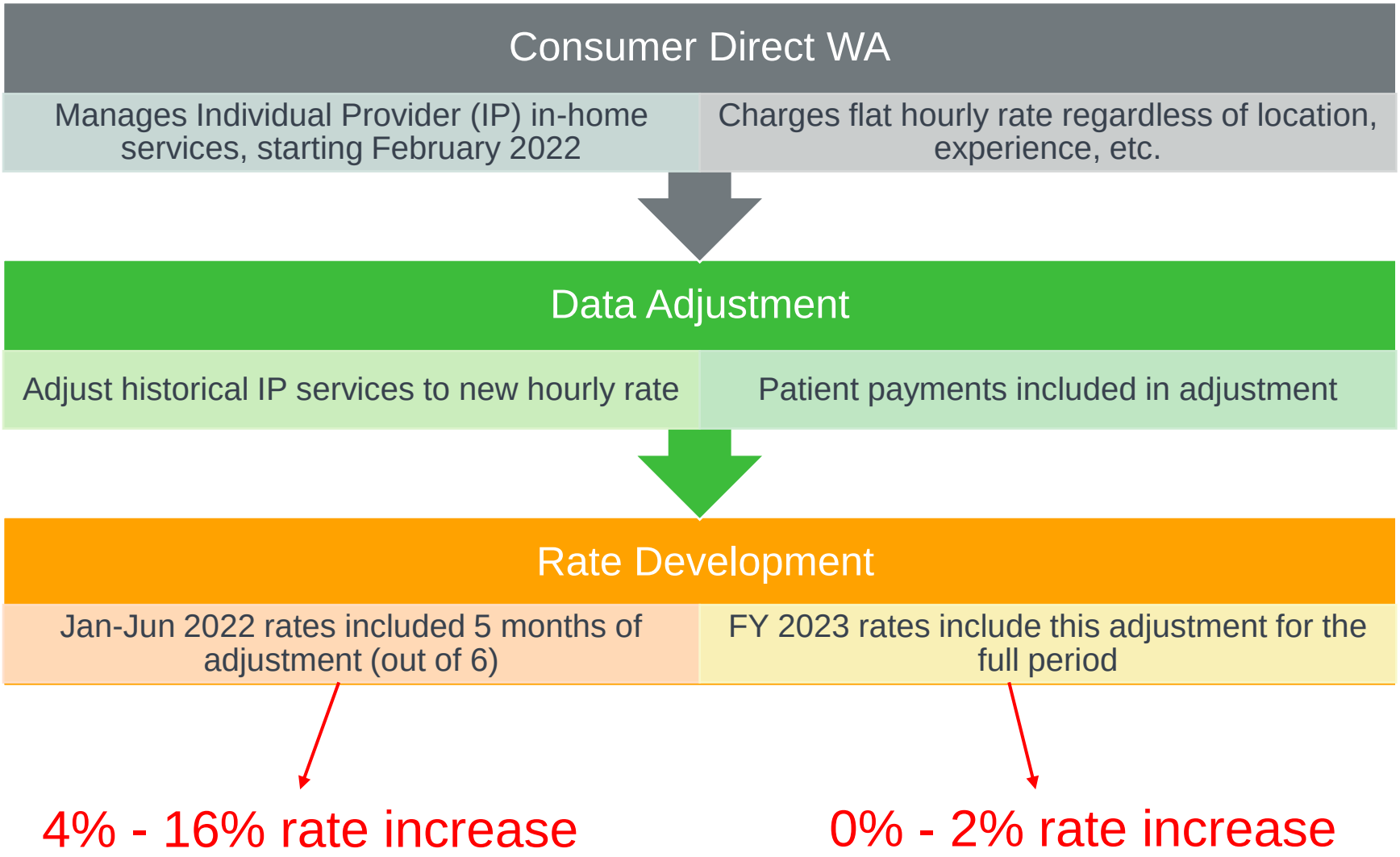
Adjustments to Data

Impacts are DRAFT and subject to adjustment

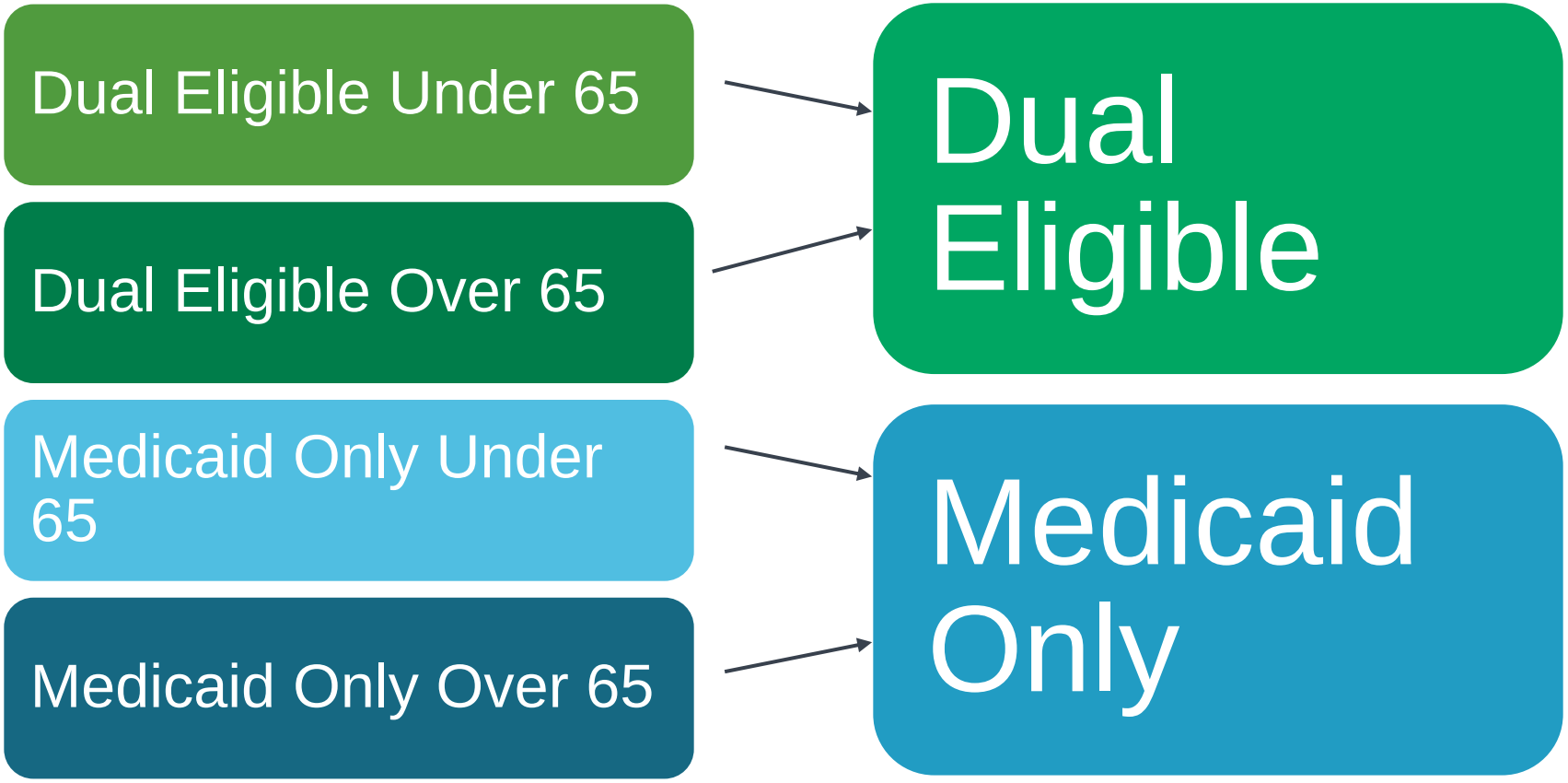
Standard Adjustments



CD WA Individual Provider Adjustment



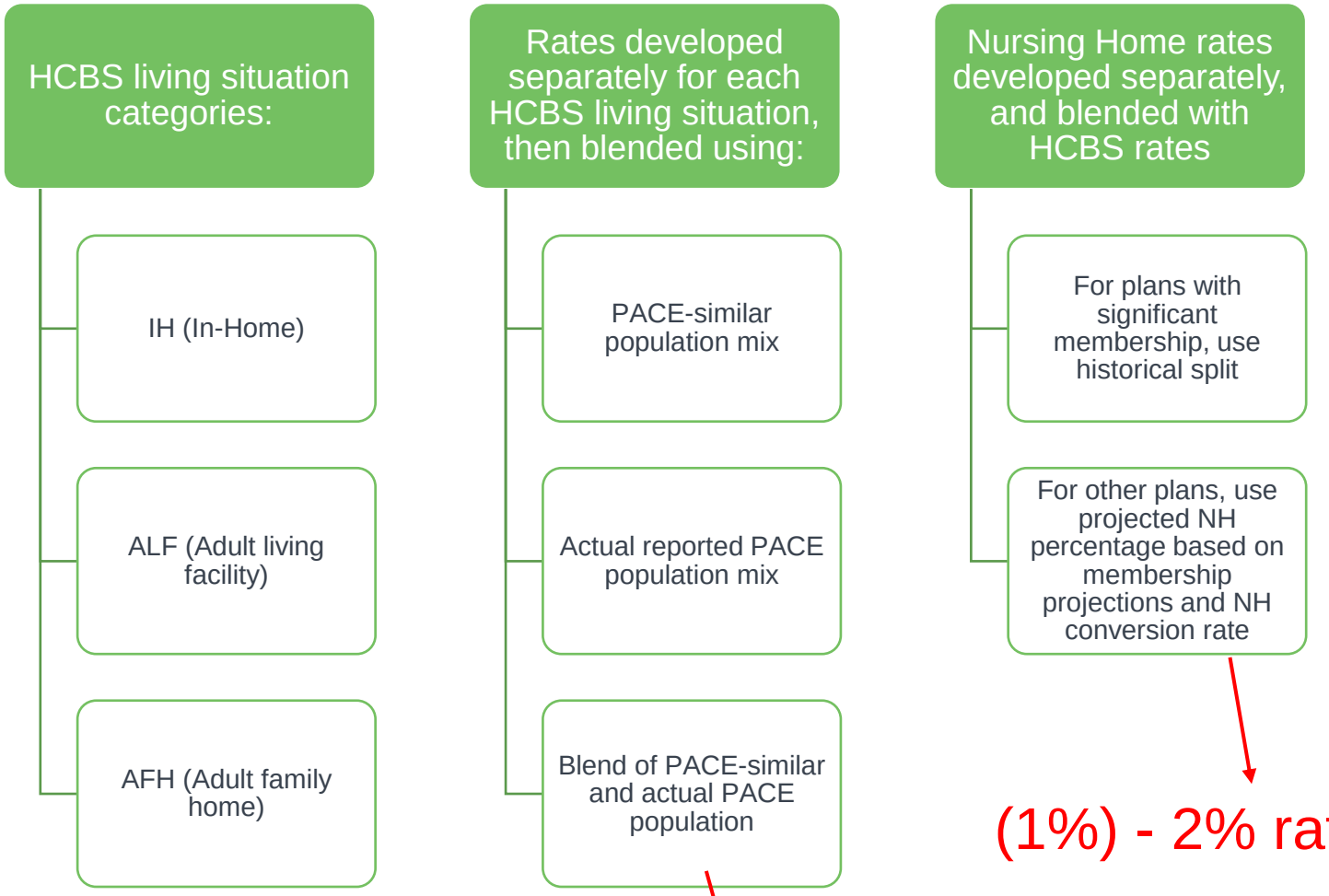
Rate Cells Combined



Risk Adjustment – CARE Level

- **Only used for plans and rate cells with credible historical enrollment**
- Base medical costs calculated based on CARE level, then blended using historical enrollment
- CARE categories:
  - Physical (High – Low)
  - Behavioral (High – Low)
  - Clinically complex (High – Low)
  - Cognitively impaired (High – Low)
  - Exceptional care (High – Low)

Risk Adjustment – Living Situation



(1%) - 2% rate impact

(7%) - 3% rate impact

PROPRIETARY

Nursing Home Distribution - Example

	MONTH OF OPERATION			
DATA AND ASSUMPTIONS	1	2	3	4
ENROLLMENT PROJECTION - TOTAL	100	200	300	400
MONTHLY LAPSE RATE	2.5%	2.5%	2.5%	2.5%

	MONTH OF OPERATION			
DURATION OF MEMBERSHIP	1	2	3	4
1	100	103	106	109
2		97	100	103
3			94	97
4				91

		MONTH OF OPERATION			
DURATION OF MEMBERSHIP	NH TRANSITION	1	2	3	4
1	0.0%	-	-	-	-
2	1.0%		1	1	1
3	2.0%			2	2
4	2.0%				2
TOTAL NURSING HOME MEMBERS		-	1	3	5
NURSING HOME PERCENTAGE		0.0%	0.5%	1.0%	1.2%

Other Considerations

Further Rate Adjustments

Credibility Adjustments

- Medicaid-only rate cells aren't credible at a county level
- Statewide data is used, with LTSS service cost adjustments

Non-Emergency Transportation

- Based on reported expenditures and costs from ALTSA and PACE organizations
- Area adjusted based on ALTSA-reported unit costs
- Assume that PACE organizations have higher utilization than FFS members

Behavioral Health

- Rates developed separately under Apple Health
- Paid based on individual member's BH rate category

Administrative Load

Care Management (HCBS Only)

- Transferred admin from HCA to PACE for providing care for members
- The admin amount HCA would otherwise be paying if the HCBS costs were paid FFS

Percent of Premium Admin

- 5.5% DE and 6.0% MO for FY23-24 rates
- Based on analysis of PACE programs in several other states, and WA PACE organization financials

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Thank you