North Carolina Department of Health and Human Services
Division of Medical Assistance

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Robin Gary Cummings, M.D.
Deputy Secretary for Health Services
Director, Division of Medical Assistance

October 1, 2014

SENT VIA ELECTRONIC MAIL

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 1026, Legislative Building
Raleigh, NC 27603

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 307A, Legislative Office Building
Raleigh, NC 27603-5925

The Honorable Mark Hollo, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 639, Legislative Office Building
Raleigh, NC 27603-5925

Dear Senator Hise and Representatives Burr and Hollo:

Section 12H.34.(a) of Session Law 2014-100 requires the Department of Health and Human Services, Division of Medical Assistance, to submit a report about the Program of All-Inclusive Care for the Elderly (PACE) to the Joint Legislative Oversight Committee on Health and Human Services on October 1, 2014. The report is attached.

Please direct all questions concerning this report to Melanie Bush, Assistant Director for Policy and Regulatory Affairs, Division of Medical Assistance, DHHS at 919-855-4115 or Melanie.Bush@dhhs.nc.gov.

Sincerely,

Robin Gary Cummings, M.D.

Cc:

Sarah Riser	Pat Porter
Brandon Greife	Susan Jacobs
Theresa Matula	Joyce Jones
Pam Kilpatrick	Rod Davis
Steve Owen	reports@ncleg.net

Legislative Report

S.L. 2014-100, section 12H.34.(a)

State of North Carolina
Department of Health and Human Services
Division of Medical Assistance

October 1, 2014

INITIAL REPORT

INTRODUCTION

Per Session Law 2014-100, Section 12H.34, the General Assembly requires two reports on the Program of All-Inclusive Care for the Elderly (PACE). This is the first of the two reports that the Department of Health and Human Services, Division of Medical Assistance (DMA), will provide to the Joint Legislative Oversight Committee on Health and Human Services.

> ***SECTION 12H.34.(a)*** *By October 1, 2014, the Department of Health and Human Services, Division of Medical Assistance, shall report to the Joint Legislative Oversight Committee on Health and Human Services with the following information on the Program of All-Inclusive Care for the Elderly (PACE):*
>
> *(1) The number of individuals being served in each of the PACE service areas.*
>
> *(2) A description of the program enrollment criteria and enrollment process.*
>
> *(3) Detailed figures showing how funding for the program has been spent during the past two fiscal years.*
>
> *(4) The per member per month cost of serving individuals through the PACE program compared to the cost of serving individuals in a nursing home.*
>
> *(5) An estimate of how many PACE participants would enter a nursing home if they were not enrolled with the PACE program.*

The January 1, 2015 report will include an update on the program elements discussed in this report, a comparison of North Carolina's PACE program with programs in other states, and recommended changes for the program going forward.

PROGRAM BACKGROUND

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated managed care program for frail and elderly beneficiaries enrolled in Medicaid or in both Medicaid and Medicare. As a capitated payment program, PACE funds a comprehensive service delivery system that integrates both Medicare and Medicaid financing for beneficiaries enrolled in both programs. Monthly capitation fees from the two sources are combined by a PACE organization into a common pool from which all health care expenses are paid. PACE organizations assume full financial risk for the costs of all medical care for their clients, including: nursing home (NH), long-term care services, inpatient hospital, outpatient hospital, physician services, laboratory and radiology services, pharmacy, transportation, durable medical equipment (DME), and hospice services. See Exhibit A for the complete list of beneficiary services. Because PACE organizations assume full risk for patient care at a fixed monthly cost, the cost to the State per beneficiary does not change during the year in response to changes in participants' health status or service settings (e.g., communities, nursing homes, or hospitals) as long as the beneficiary remains enrolled in the program.

CURRENT PACE ENROLLMENT

As of September 10, 2014, 1,097 Medicaid beneficiaries were enrolled in PACE organizations throughout North Carolina. The table below shows current PACE enrollment by organization and start dates of the organizations. There are nine operational PACE organizations serving ten sites,[1] with two more in development. The two organizations in development are in Asheboro (scheduled to open in December 2014) and Asheville (scheduled to open in January 2015).

No.	PACE Organization	Start Date	Current Enrollment
1	LIFE Saint Joseph of the Pines (Fayetteville)	April, 2011	216
2	Pace@Home (Hickory)	January, 2012	95
3	Carolina SeniorCare (Lexington)	October, 2012	126
4	Senior Community Care of North Carolina, Inc	September, 2013	80
5	Piedmont Health Senior Care (Burlington and Pittsboro)	November, 2008	167
6	Elderhaus (Wilmington)	February 2008	130
7	PACE of Triad (Greensboro)	July, 2011	149
8	Senior Total Life Care (Gastonia)	January, 2014	56
9	PACE of Southern Piedmont (Charlotte)	July, 2013	78
Total			1,097

Note: Current enrollment figures were obtained directly from PACE providers on 9/10/2014

[1] Piedmont SeniorCare operates in two locations: Burlington and Pittsboro.

The table below shows the service area of each program by county. 42 U.S. Code § 1395eee(e)(2)(B) gives federal authorities the discretion, with State agency consultation, to prohibit overlap of PACE organization service areas to avoid duplication of services and preserve the area's capacity to serve eligible individuals.

PACE Organization Service Areas by County: September 2014

Organization Name	Service Area
1. LIFE St. Joseph of the Pines	Cumberland and Hoke Counties and portions of Harnett, Moore and Robeson Counties
2. PACE @ Home	Catawba County and portions of Lincoln, Caldwell and Alexander Counties (Newton)
3. Carolina SeniorCare	Rowan, Davidson, Davie and Iredell Counties (Lexington)
4. Senior Community Care, Inc.	Durham and Wake Counties and a portion of Granville County
5. Piedmont Health SeniorCare	Alamance, Caswell, Orange, Chatham and portion of Lee Counties (Burlington and Pittsboro)
6. Elderhaus	New Hanover County and portions of Brunswick County (Wilmington)
7. PACE of the Triad	Guilford and Rockingham Counties (Greensboro)
8. Senior Total Life Care	Gaston County and portions of Cleveland and Lincoln Counties (Gastonia)
9. PACE of the Southern Piedmont	Mecklenburg and portion of Cabarrus, Union and Stanley Counties (Charlotte)

ENROLLMENT PROCESS

Interested beneficiaries or their authorized representatives initiate contact with their local PACE organization and are screened for eligibility. An individual must be financially eligible to receive Long-term Care Medicaid Services and must meet a PACE organization's eligibility criteria imposed under its respective PACE Program Agreement. An eligible beneficiary must meet the minimum criteria set forth at 42 C.F.R. 460.150:

- Be 55 years of age or older;
- Be determined eligible to need the level of care required under the Medicaid State Plan for coverage of nursing facility services;
- Reside in the PACE organization's service area;
- Be able to live in a community setting at the time of enrollment without jeopardizing his or her safety; and
- Meet any additional criteria set forth in the program agreement.

Once deemed minimally eligible, the beneficiary undergoes a comprehensive health assessment by eight of the eleven PACE Interdisciplinary Team (IDT) team members using a discipline-specific, standardized health risk assessment form developed or adopted by the PACE organization. At the conclusion of the assessment, the IDT makes a recommendation for PACE eligibility and submits the Division of Medical Assistance (DMA) Long Term Care (FL-2) form to Computer Sciences Corporation (CSC), DMA's utilization review contractor for approval and determination of the level of care needed.

The FL-2 form documents the current and recommended levels of care needed, based on an individual's medical status and functional ability in activities of daily living (ADLs). It is reviewed by DMA staff for confirmation that eligibility criteria are met. Once DMA confirms the eligibility requirements, the PACE organization offers the beneficiary or authorized representative an enrollment agreement. The enrollment agreement contains:

- a participant's demographic data and health insurance status;
- a description of benefits;
- the effective date;
- an explanation of the premiums;
- an emergency care protocol; and
- the participant's rights and responsibilities, including conditions for enrollment and disenrollment.

Once the enrollment agreement is signed by both parties, the PACE organization notifies the local Department of Social Services of the beneficiary's PACE enrollment.

Enrollment in the PACE program is voluntary. PACE enrollees must defer their Medicare Part A, B, and D benefits (if applicable) and the PACE becomes their sole health care insurer. A participant's enrollment in PACE is effective on the first day of the calendar month following the date the PACE organization receives a signed enrollment agreement. Enrollment in the PACE program continues until the participant's death unless the participant voluntarily disenrolls or the PACE organization involuntarily disenrolls him or her. Participants may voluntarily disenroll without cause at any time. PACE organizations may involuntarily disenroll participants for reasons allowed under 42 C.F.R. 460.164, including but not limited to disruptive or threatening behavior or no longer needing nursing facility level of care. DMA reviews all disenrollments and determines whether a PACE organization has sufficiently documented the basis for disenrollment.

PACE PROGRAM COSTS AND FUNDING

The table below summarizes total PACE-related expenditures from SFY 2012 to SFY 2014. It also displays the Federal Medical Assistance Percentage (FMAP) for each fiscal year and actual expenditures associated with them for the State and federal governments.

PACE Medicaid Expenditures ($Millions) by State Fiscal Year (SFY)

	SFY 2012	SFY 2013	SFY 2014
State Dollars	$3.61	$5.95	$11.49
Federal Dollars	$6.74	$11.28	$22.02
FMAP Rate	65.14%	65.45%	65.71%
Total Expenditures	**$10.35**	**$17.23**	**$33.50**

Note: Due to differences between North Carolina State and Federal Fiscal years, the FMAP rates are a weighted average across the months.

Total program expenditures in SFY 2014 were $33.5 million. DMA does not track individual PACE organization expenditures since payments to organizations are capitated. DMA pays PACE organizations an all-inclusive (capitated) per member per month (PMPM) rate for two distinct groups: 1) individuals who are dually eligible for Medicare and Medicaid and 2) Medicaid only. DMA contracts with Mercer Government Human Services (Mercer) to develop the capitated payment rates for both groups. The current PMPM rate paid by DMA for a Medicaid only PACE enrollee is $3,562 and for a dually-enrolled beneficiary is $3,310.

While the number of PACE organizations has grown, capitation rates have remained the same over the past three years. Growth in PACE expenditures is the result of new sites opening within the past 3 fiscal years. The table below shows expenditures by PACE site for the past three consecutive years.

PACE Expenditures ($Millions) by Organization and State Fiscal Year (SFY)

PACE Organization	SFY2012	SFY2013	SFY2014
Piedmont Health SeniorCare	$4.03	$4.68	$6.73
Elderhaus	$3.00	$4.22	$5.80
LIFE St. Joseph of the Pines	$2.10	$3.11	$2.08
PACE of Triad	$1.07	$2.84	$6.26
PACE@Home	$0.15	$1.57	$3.54
Carolina SeniorCare	N/A	$0.81	$4.28
Senior CommUnity Care	N/A	N/A	$2.01
Senior Total Life Care	N/A	N/A	$0.99
PACE of the Southern Piedmont	N/A	N/A	$1.79
Total	**$10.35**	**$17.23**	**$33.50**

Notes: All dollar amounts are in millions. N/A means that the provider was not in business at the time.

SKILLED NURSING COSTS IN PACE RATE DEVELOPMENT

A side-by-side comparison of the PACE PMPM rate to the skilled nursing PMPM rate does not fully capture the complexity of PACE rate development. DMA contracts with Mercer to develop rates for the two distinct groups for which the State pays capitated rates, the dually-enrolled and Medicaid only beneficiaries. Mercer develops separate rates based on projected claims expenditures for both institutionalized and home and community-based services (HCBS) populations. These sub-populations are blended using the population's relative mix in the fee-for-service (FFS) population to produce an Upper Payment Limit (UPL) of costs. The UPL represents the expected cost of providing services to individuals if they remain in the FFS environment. It is an estimated statewide PMPM for equivalent level services in a skilled nursing facility. PACE programs are paid approximately 80 percent of the FFS UPLs, adjusted for the populations and services covered by the PACE program.

See the attached Mercer report for an explanation of how PMPM rates are developed, including base data by category of service, trend and program change adjustments, and the resulting claim costs and blend percentages.

PACE AND RISK FOR INSTITUTIONALIZATION

Very few, if any, PACE program enrollees transition from an institution (e.g. skilled nursing facility) to a community setting at the time of enrollment. Estimating exactly how many PACE enrollees would have been admitted to a nursing home is dependent on a number of factors and difficult to quantify but for the opportunity to remain in a community setting by enrolling in the PACE program.

Based on current admission standards, all PACE participants are eligible for nursing home level of care and could enter a nursing home if they were not enrolled in a PACE program. In reality, this is not always true. There are a number of predictive factors that strongly correlate with whether an individual actually ends up in a skilled nursing facility. Socio-demographic factors most predictive of the need for skilled nursing facility care include age, race, living alone, and gender. Elderly, Caucasian women who live alone are most likely to be admitted to a skilled nursing facility.

There are several other factors that determine whether a beneficiary will be admitted to a skilled nursing facility. Functional independence factors include increased deficits in the individual's ability to perform activities of daily living (ADLs), cognitive impairment, multiple hospitalizations, or increased falls with injury. There is also a strong correlation with the availability of family caregivers, availability of skilled nursing beds within the community, and access to adequate community-based service alternatives.

During the next 12 months, DMA will conduct a study on the impact of PACE programs on Medicaid beneficiaries' utilization of medical services and nursing home diversion. The report will also include a comparative analysis of PACE enrollees with nursing home residents at admission and over the course of their stay, and the capacity of PACE organizations to support nursing home transition. DMA will provide additional information about this study in the January 2015 report.

Exhibit A - PACE Service Package

PACE Center

The PACE Program provides a PACE organization that includes a primary care clinic, an adult day health program, areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining that serves as the focal point for coordination and provision of most PACE services.

In-Home Care

The PACE Program provides additional services to the individual in the home, such as In-Home Personal Care Services and home health care.

Acute, Emergency Care and Long Term Care Services

The PACE organization arranges, manages, and pays for all care referred to community providers, including hospital services, nursing facility care, emergency room services, physician visits, and ancillary services.

Federal regulations require all PACE organizations to provide a comprehensive array of services that include the following:

- All Medicaid-covered services, as specified in the State's approved Medicaid plan;
- Multidisciplinary assessment and treatment planning;
- Primary care, including physician and nursing services;
- Social work services;
- Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services;
- Personal care and supportive services;
- Nutrition counseling;
- Recreational therapy;
- Transportation;
- Meals;
- Laboratory tests, x-rays, and other diagnostic procedures;
- Drugs and biologicals,
- Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items;

- Medical specialty services including, but not limited to the following:
  - Digestive Health
    - Gastroenterology
  - Ear, Nose, Throat and Hearing Health
    - Otorhinolaryngology
    - Audiology
  - Eye Health
    - Ophthalmology
  - Foot Health
    - Podiatry
  - Female Health
    - Gynecology
  - Internal Medicine
    - Cardiology
    - Nephrology
    - Oncology
    - Pulmonary Disease
    - Rheumatology
  - Mental Health
    - Psychiatry
  - Oral Health
    - Dentistry
    - Oral Surgery
  - Pharmacy
    - Pharmacy Consulting Services
  - Preventive Health
    - Radiology
  - Skin Health
    - Dermatology
  - Surgery Services
    - Anesthesiology
    - General Surgery
    - Orthopedic Surgery
    - Plastic Surgery
    - Thoracic and Vascular Surgery
  - Urinary and Male Reproductive Health
    - Urology

- Acute inpatient care to include:
  - Ambulance,
  - Emergency room care and treatment room services;
  - Semi-private room and board,
  - General medical and nursing services,
  - Medical surgical, intensive care, and coronary care unit,
  - Laboratory tests, x-rays, and other diagnostic procedures,
  - Drugs and biologicals,
  - Blood and blood derivatives,
  - Surgical care and anesthesia,
  - Oxygen,
  - Physical, occupational, respiratory therapies, and speech language pathology services, and
  - Social services
- Nursing facility care to include:
  - Semi-private room and board;
  - Physician and skilled nursing services;
  - Custodial care;
  - Personal care and assistance;
  - Drugs and biologicals;
  - Physical, occupational, recreational therapies, and speech language pathology, if necessary;
  - Social services; and
  - Medical supplies and appliances

Other services determined necessary by the PACE organization Interdisciplinary Team to improve and maintain the participant's overall health status.

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January 6, 2014

Subject: State of North Carolina – Program of All-inclusive Care for the Elderly Upper Payment Limits for State Calendar Year 2014

Dear Wrenia:

In partnership with the State of North Carolina Division of Medical Assistance (State), Mercer Government Human Services Consulting (Mercer) developed upper payment limits (UPLs) for the Program of All-inclusive Care for the Elderly (PACE) program. The UPL development was completed for the contract year: January 1, 2014 through December 31, 2014 (CY14). This letter presents an overview of the analyses and methodology used by Mercer to develop these UPLs.

Overview of UPL Methodology

PACE UPLs were developed in accordance with the PACE UPL checklist. To develop the UPLs, Mercer utilized historical fee-for-service (FFS) data adjusted for the populations and services covered by the PACE program. The following sections describe the program, base data, and adjustments used to develop the UPLs.

PACE Program Overview

PACE Eligibility

The State's program follows a national PACE model where Medicaid recipients 55 years of age or older, who require a nursing home level of care, and live within a PACE service area are eligible for program participation. The determination of PACE eligibility will be performed by the State or its utilization review contractor.

Covered Benefits

The PACE UPL encompasses a comprehensive benefit package, including nursing home (NH), long-term care services, inpatient hospital, outpatient hospital, physician services, laboratory and x-ray services, pharmacy, transportation, durable medical equipment (DME), and hospice services. The benefits and services contained in the PACE UPL include a comprehensive list of covered benefits and coordinated access services included in the PACE State Plan Amendment. Separate UPLs were developed for the following populations:

- Dually Eligible Individuals (Medicare and Medicaid)

- Non-Dually Eligible Individuals (Medicaid only)

Base Data Source and Analysis

The State supplied Mercer with historical Medicaid FFS data which Mercer compiled from its data warehouse for January 1, 2010 through December 31, 2012, by date of service. Claims and eligibility data were gathered for both the dually eligible and the Medicaid Only populations. Claims and eligibility data for individuals under age 55 were excluded because they would not be eligible for PACE.

The Medicaid Management Information System (MMIS) data used in the analysis was verified to be, or as necessary, adjusted to be appropriate for UPL rate setting as described in the Centers for Medicare & Medicaid Services (CMS) PACE UPL checklist. In particular:

- The dual eligible population was identified using State-provided logic.
- Recipients identified as older than 65, but not dually eligible were not included in the analysis because they demonstrated unusually low medical and pharmacy costs which are not expected to be representative of the remaining non-dual PACE eligible population.
- Recipients enrolled in managed care programs, and their associated information, were not included in the analysis.
- Only services covered under the PACE program by Medicaid were included for this analysis; in particular, spend-down amounts that represent patient liability were not included in the calculations.
- Disproportionate Share Hospital (DSH) payments are not included in the MMIS data. Based on our recent discussion with the State, no cost settlement adjustment is needed for nursing facility, no GME adjustment is needed for hospital inpatient, and no payment data adjustment is needed for Third Party Recoveries (TPR) and Fraud and Abuse (F&A).
- Mercer estimated the impact of prescription drug rebates on the payments for the PACE program. MMIS data does not include collected rebates on pharmacy claims. Mercer, therefore, applied a rebate formula at the pharmacy claim level to estimate the appropriate rebate for the time period.
- Base data represented claims with paid dates through June 30, 2013 (six months of run out). Mercer conducted a completion analysis and adjusted the base data to reflect claims incurred through the end of December 2012 but not yet paid as of June 30, 2013.

Frailty Status

Mercer utilized state-wide data from two population groups to develop the PACE UPLs: individuals enrolled in home- and community-based services (HCBS) waivers, classified by the State as the Community Alternatives Program for Disabled Adults (CAP/DA), and individuals who require a nursing facility level of care. Each of these populations was analyzed separately and the results were combined to produce blended UPLs. The blend of the two frailty groups was based on their relative proportions within the FFS environment, producing a UPL that represents the expected cost to continue to serve those individuals under a FFS model.

Base Data Development

Mercer requested, and was provided, three years of state historical FFS data, January 1, 2010 - December 31, 2010 (CY10), January 1, 2011 - December 31, 2011 (CY11), and January 1, 2012 - December 31, 2012 (CY12), for the populations and services associated with the PACE program. Mercer also requested, and was provided, historical and prospective fee schedule changes by major service category. Data from CY12 reflects many program changes and rate changes that are expected to continue into the contract period CY14 and is used as the base data to develop the UPLs.

PACE UPL Development Adjustments

Once the base data was analyzed, adjusted, and determined appropriate, Mercer applied adjustments to determine the PACE UPL. The adjustments include base period interim program changes, prospective program changes, and trend.

Base Period Interim Program Changes

Due to the fact that program changes were implemented in the middle of CY12, adjustments have been calculated and applied to the base data to reflect what the base data would be if the fee schedule changes had been effective at the beginning of the CY12 to reflect true future costs. The following table describes key program changes.

Name	Description
Nursing Facility	The rates were frozen on 07/01/2012.
Inpatient	The rates were increased by 2.48% on 07/01/2012.
Outpatient	The rates were increased by 0.67% on 07/01/2012.
Pharmacy	The pharmacy reimbursement methodology changed to WAC+6% or AWP-11.67% on 01/01/2012.
Physician	The rates were increased by 0.67% on 07/01/2012.
Hospice	The rates were increased by 1.95% on 10/01/2012.
HCBS Waiver (CAP/DA Program)	The rates were increased by 0.67% on 07/01/2012.
Home Health	The rates were increased by 0.67% on 07/01/2012.
Other	The rates were increased by 0.67% on 07/01/2012.

Prospective Program Changes

To prepare the UPLs for CY14, the State provided Mercer with a list of prospective program changes by major service category. The projected UPLs for CY14 reflect these changes for the relevant service categories.

The following table describes key program changes:

Name	Description
Nursing Facility	The rates were decreased by 3.0% effective 01/01/2014.
Inpatient	The rates were decreased by 3.0% effective 01/01/2014.
Outpatient	The rates were decreased by 10.0% effective 01/01/2014.
Pharmacy	The rates were frozen effective 01/01/2014.
Physician	The rates were decreased by 3.0% effective 01/01/2014.
Hospice	The rates were increased by 1.7% on 10/01/2013.
HCBS Waiver (CAP/DA Program)	The rates were frozen effective 01/01/2014.
Home Health	The rates were frozen effective 01/01/2014.
Other (Including PCS)	The rates were decreased by 3.0% effective 01/01/2014.
Personal Care Services (PCS)	The per-unit rate was decreased from $3.47 to $3.28 effective 10/01/2013.

The 2013 North Carolina Substantive Legislation changes created an opportunity for a Medicaid recipient to obtain up to 130 hours per month of Medicaid Personal Care Services (PCS) in accordance with an assessment, care plan, and provided the recipient meets certain criteria. The

maximum number of hours allowed prior to this legislative change was 80 hours per month. In order for the State to remain within the budgeted amount of funds for PCS and fund the additional service hours, the State was directed to reduce the PCS rate. The current PCS rate was reduced from $3.47 to $3.28 per 15-minute unit increments effective October 1, 2013 and this rate change is reflected in the projected CY14 UPLs.

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the expenses of health care services in a defined contract period. Typical components of trend include changes in population, technology, program design, service delivery, service costs, and utilization. The intent of a trend factor analysis is to account for any:

- variations between the base years and the contract period that would impact the rates to be paid in the contract period; and
- other non-programmatic changes in the PACE program that would have a material impact on the reimbursement.

As part of the UPL development for the PACE program, Mercer developed annual per member per month (PMPM) trend rates by category of service. The base data was trended forward from the midpoint of the base period, July 2012, to the midpoint of the contract period, July 2014, which constituted 24 months. Therefore, the primary source of these trend factors is an analysis of the historical utilization trend experience, using various regression analysis techniques including rolling 12-month averages. All of the data sources mentioned above were utilized in the final development of the annual PMPM trend factors. The following table displays the annual trends used to project the historical FFS base data.

	Community (HCBS)		Institutional (NH)	
Category of Service	Dual Eligibles	Medicaid Only	Dual Eligibles	Medicaid Only
Nursing Facility	3.5%	3.5%	3.5%	3.5%
Inpatient	-1.5%	-1.5%	-1.5%	-1.5%
Outpatient	-1.0%	-1.0%	-1.0%	-1.0%
Pharmacy	1.0%	1.0%	1.0%	1.0%
Physician	2.0%	1.0%	2.0%	1.0%
HCBS	1.0%	3.0%	1.0%	3.0%
Hospice	2.0%	2.5%	2.0%	2.5%
Home Health	-1.5%	2.0%	-1.5%	2.0%
Case Management	1.0%	1.0%	1.0%	1.0%

	Community (HCBS)		Institutional (NH)	
Category of Service	Dual Eligibles	Medicaid Only	Dual Eligibles	Medicaid Only
Other	2.0%	2.0%	2.0%	2.0%

Claim Costs and UPLs

As mentioned previously, the PACE program has two distinct rating groups for which the State will pay capitation: Dual Eligible and Medicaid Only. Within each of these categories, Mercer developed separate expected claims cost for institutionalized and community (HCBS) populations. The sub-populations are blended using the population's relative mix in the FFS population based on the most recent period CY12 experience to produce a UPL that represents the expected cost of providing services to these individuals if they remain in the FFS environment. The attached exhibits provide more detail about the development of these rates, including base data by category of service, trend and program change adjustments, and the resulting claim costs and blend percentages.

Claim Costs

Rating Groups	Community (HCBS)	Institutional (NH)	Blended
Dual Eligibles	$ 2,270.09	$ 3,916.52	$ 3,537.84
Medicaid Only	$ 3,620.88	$ 5,542.65	$ 4,773.94

State Administration

The UPLs for the Dual Eligible and Medicaid Only rating groups include provision for the State's administrative expenses. Based upon Mercer's recent discussion with the State, there are no material changes to the State administration of the PACE program. Therefore, the projected administration expense as a percent of total medical expense was calculated based on the State's CY10 through CY13 CMS 64 reports. Mercer increased the Dual and Non-Dual claim costs by 6.0%, to reflect the State's administrative costs.

UPLs

Rating Groups	Blended Claim Cost	Administration	UPL
Dual Eligibles	$ 3,537.84	$212.27	$3,750.11
Medicaid Only	$ 4,773.94	$286.44	$5,060.38

UPL Certification

Mercer developed PACE UPLs for the period commencing on January 1, 2014 and ending on December 31, 2014. In developing the UPLs, Mercer has used and relied upon eligibility, claim, reimbursement level, benefit design, financial data, and program change information supplied by the State. The State is responsible for the validity and completeness of this supplied data and

information. We have reviewed the data and information for internal consistency and reasonableness and believe it to be appropriate for the intended purposes, but we did not audit it. If the data and information is incomplete or inaccurate, the values shown in this letter may need to be revised accordingly.

Mercer certifies that the PACE UPLs were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the population and services covered under the PACE program.

The PACE UPLs developed by Mercer are actuarial projections of future contingent events. Actual PACE provider costs will differ from these projections. Mercer has developed these UPLs on behalf of the State to demonstrate compliance with the CMS requirements identified in the CMS PACE Checklist and in accordance with applicable law and regulations. Use of these UPLs for any purpose beyond that stated may not be appropriate.

PACE providers are advised that the use of these UPLs may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these UPLs by PACE providers for any other purpose. Mercer recommends that any PACE provider considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these UPLs before deciding whether to contract with the State.

This certification letter assumes the reader is familiar with the North Carolina PACE program, PACE eligibility rules, and actuarial rating techniques. It is intended for the State and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

If you have any questions related to the PACE UPL development, please feel free to call me at +1 404 442 3249.

Sincerely,

Sudha Shenoy

Sudha Shenoy, FSA, MAAA, CERA
Principal

Attachments

Copy: Brian K. Passineau (North Carolina Division of Medical Assistance)
Gail S. Stone (North Carolina Division of Medical Assistance)
William T. Funk (North Carolina Division of Medical Assistance)
Ed Fischer (Mercer)
Gustav Hattingh (Mercer)

MERCER

Category of Aid:	Nursing Home		
Eligibility:	Dual		
Contract Period:	January 1, 2014 through December 31, 2014	**Trend Months:**	24

	Starting Midpoint	Contract Midpoint
	July 2, 2012	July 3, 2014

	Year 12
Member Months	253,872

	Blended Data			Adjustments		Projected FFSE CY 14		
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Category of Service	Util/1000	Unit Cost	PMPM	Annual Trend	Program Changes	Util/1000	Unit Cost	PMPM
Nursing Facility	343,392	$ 126.78	$ 3,627.91	3.5%	-3.0%	367,850	$ 122.98	$ 3,769.72
Inpatient	61	$ 76.94	$ 0.39	-1.5%	0.0%	59	$ 76.84	$ 0.38
Outpatient	1,109	$ 72.76	$ 6.73	-1.0%	-6.4%	1,087	$ 68.13	$ 6.17
Pharmacy	3,897	$ 11.21	$ 3.64	1.0%	0.0%	3,976	$ 11.21	$ 3.71
Physician	21,866	$ 18.83	$ 34.31	2.0%	-2.3%	22,750	$ 18.39	$ 34.86
HCBS	1	$ 435.06	$ 0.04	1.0%	0.0%	1	$ 435.06	$ 0.04
Hospice	6,369	$ 121.57	$ 64.52	2.0%	1.7%	6,626	$ 123.64	$ 68.27
Home Health	60	$ 92.56	$ 0.46	-1.5%	0.0%	58	$ 92.56	$ 0.45
Case Management	12	$ 8.14	$ 0.01	1.0%	0.0%	12	$ 8.14	$ 0.01
Other	7,160	$ 56.48	$ 33.70	2.0%	-6.1%	7,449	$ 53.02	$ 32.62
	383,927	$ 117.69	$ 3,771.70			409,868	$ 114.67	$ 3,916.52

Category of Aid:	Home and Community Based Services (HCBS) Waiver		
Eligibility:	Dual		
Contract Period:	January 1, 2014 through December 31, 2014	**Trend Months:**	24

	Starting Midpoint	Contract Midpoint
	July 2, 2012	July 3, 2014

	Year 12
Member Months	77,635

	Blended Data			Adjustments		Projected FFSE CY 14		
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Category of Service	Util/1000	Unit Cost	PMPM	Annual Trend	Program Changes	Util/1000	Unit Cost	PMPM
Nursing Facility	8,200	$ 90.03	$ 61.52	3.5%	-3.0%	8,784	$ 87.33	$ 63.93
Inpatient	127	$ -	$ -	-1.5%	0.0%	123	$ -	$ -
Outpatient	3,015	$ 58.18	$ 14.62	-1.0%	-6.4%	2,955	$ 54.48	$ 13.42
Pharmacy	3,825	$ 7.43	$ 2.37	1.0%	0.0%	3,902	$ 7.43	$ 2.41
Physician	44,433	$ 17.61	$ 65.21	2.0%	-2.3%	46,228	$ 17.20	$ 66.26
HCBS	74,856	$ 314.38	$ 1,995.84	1.0%	0.0%	76,157	$ 314.38	$ 1,995.15
Hospice	66	$ 139.28	$ 0.77	2.0%	1.7%	69	$ 141.55	$ 0.81
Home Health	8,933	$ 94.42	$ 70.28	-1.5%	0.0%	8,667	$ 94.42	$ 68.19
Case Management	30	$ 8.40	$ 0.02	1.0%	0.0%	31	$ 8.40	$ 0.02
Other	12,819	$ 57.40	$ 61.32	2.0%	-6.1%	13,337	$ 53.69	$ 59.69
	156,104	$ 171.57	$ 2,231.95			160,252	$ 169.99	$ 2,270.09

Upper Payment Limit	Projected FFSE	Blending Percentage	Blended Rate
Nursing Home	$ 3,916.52	77.0%	$ 3,015.72
Home and Community Based Services	$ 2,270.09	23.0%	$ 522.12
Blended PMPM			$ 3,537.84
State Administration			$ 212.27
Upper Payment Limit			$ 3,750.11

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		Starting Midpoint	Contract Midpoint
Category of Aid:	Nursing Home		
Eligibility:	Non-Dual	July 2, 2012	July 3, 2014
Contract Period:	January 1, 2014 through December 31, 2014	**Trend Months:**	24

	Year 12
Member Months	10,473

	Blended Data			Adjustments		Projected FFSE CY 14		
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Category of Service	Util/1000	Unit Cost	PMPM	Annual Trend	Program Changes	Util/1000	Unit Cost	PMPM
Nursing Facility	301,200	$ 161.63	$ 4,056.97	3.5%	-3.0%	322,653	$ 156.78	$ 4,215.55
Inpatient	5,148	$ 928.85	$ 397.49	-1.5%	-3.0%	4,993	$ 899.04	$ 374.09
Outpatient	6,249	$ 238.35	$ 124.12	-1.0%	-7.5%	6,125	$ 220.50	$ 112.54
Pharmacy	114,148	$ 35.96	$ 342.05	1.0%	0.0%	116,443	$ 35.96	$ 348.92
Physician	36,760	$ 100.51	$ 307.88	1.0%	-2.5%	37,499	$ 97.96	$ 306.13
HCBS	11	$ 863.63	$ 0.83	3.0%	0.0%	12	$ 863.63	$ 0.89
Hospice	5,356	$ 151.66	$ 67.69	2.5%	1.7%	5,627	$ 154.24	$ 72.32
Home Health	1,078	$ 89.78	$ 8.06	2.0%	0.0%	1,121	$ 89.78	$ 8.39
Case Management	7	$ 7.53	$ 0.00	1.0%	0.0%	7	$ 7.53	$ 0.00
Other	17,674	$ 70.37	$ 103.65	2.0%	-3.7%	18,388	$ 67.76	$ 103.82
	487,630	$ 133.10	$ 5,408.75			512,868	$ 129.69	$ 5,542.65

		Starting Midpoint	Contract Midpoint
Category of Aid:	Home and Community Based Services (HCBS) Waiver		
Eligibility:	Non-Dual	July 2, 2012	July 3, 2014
Contract Period:	January 1, 2014 through December 31, 2014	**Trend Months:**	24

	Year 12
Member Months	6,946

	Blended Data			Adjustments		Projected FFSE CY 14		
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Category of Service	Util/1000	Unit Cost	PMPM	Annual Trend	Program Changes	Util/1000	Unit Cost	PMPM
Nursing Facility	4,747	$ 156.29	$ 61.83	3.5%	-3.0%	5,085	$ 151.60	$ 64.24
Inpatient	5,425	$ 928.06	$ 419.55	-1.5%	-3.0%	5,263	$ 900.21	$ 394.85
Outpatient	6,708	$ 408.56	$ 228.38	-1.0%	-7.5%	6,574	$ 377.96	$ 207.07
Pharmacy	116,707	$ 47.83	$ 465.19	1.0%	0.0%	119,053	$ 47.83	$ 474.64
Physician	54,905	$ 73.90	$ 338.14	1.0%	-2.5%	56,009	$ 72.03	$ 336.21
HCBS	69,374	$ 290.18	$ 1,677.59	3.0%	0.0%	73,599	$ 290.18	$ 1,779.75
Hospice	1,641	$ 207.35	$ 28.35	2.5%	1.7%	1,724	$ 210.87	$ 30.29
Home Health	15,103	$ 87.36	$ 109.96	2.0%	0.0%	15,713	$ 87.36	$ 114.40
Case Management	390	$ 8.34	$ 0.27	1.0%	0.0%	398	$ 8.34	$ 0.28
Other	18,749	$ 140.08	$ 216.87	2.0%	-3.7%	19,507	$ 134.87	$ 219.24
	293,750	$ 144.94	$ 3,548.13			302,926	$ 143.44	$ 3,620.88

Upper Payment Limit	Projected FFSE	Blending Percentage	Blended Rate
Nursing Home	$ 5,542.65	60.0%	$ 3,325.59
Home and Community Based Services	$ 3,620.88	40.0%	$ 1,448.35
Blended PMPM			$ 4,773.94
State Administration			$ 286.44
Upper Payment Limit			$ 5,060.38