(B). **N/A** The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C) **N/A** The following formula is used to determine the needs allowance:

_____
_____

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

_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be less than the cost to the agency of providing State plan approved services to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the amount the state would have otherwise paid for a comparable population.

1. **~~X~~** Rates are set at a percent of the amount that would have otherwise been paid for a comparable population.
2. ___ Experience-based (contractors/State's cost experience or encounter data) (please describe)
3. ___ Adjusted Community Rate (please describe)
4. **X** Other (please describe)
See Page~~s~~ 37A ~~and 37B~~ for description of the ~~reimbursement~~ rate setting methodology for Program of All-Inclusive Care for the Elderly (PACE).

(Move below to page 38)

~~B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner.~~

~~C. The State will submit all capitated rates to CMS for prior approval, and will include the name, organizational affiliate of any actuary used, and attestation/description of the capitation rates.~~

~~III. Enrollment and Disenrollment~~

~~The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Program of All-Inclusive Care for the Elderly (PACE) ~~Reimbursement Methodology~~

The Arkansas PACE amount that would otherwise have been paid (AWOP) for a PACE comparable population and capitation rate amounts are developed for Medicaid Only and Dual Eligible populations, and may be further stratified by additional factors as appropriate. The state uses the most recent available Medicaid claims and eligibility data for a comparable population. The data used in the AWOP and PACE rate calculations is limited to recipients 55 or older who are eligible for~~based on the Upper Payment Limit methodology. The historical fee-for-service population data is extracted for claims and eligibility for a PACE eligible populations for more than one fiscal period. Data for recipient aged, blind and disabled aid categories for those 55 or greater is used in the UPL and rate calculations. The level of care codes are limited to~~ nursing facility level of care ~~eligible~~ or **ARChoices** Waiver level of care, and who are eligible for PACE but not enrolled in the program.

The base year data used in the AWOP and rate development is no more than three years prior to the rate year and is trended forward using the historical claims and eligibility information extracted for the PACE-comparable population. The claims data includes all services included in the state plan. Only claims that were actually paid are included in the analysis to create a historical per-member-per-month rate.

Base data, including Medicaid claims and eligibility data, are summarized by rate cell and category of service. Adjustments are then applied to project the base period data to the rating period and to reflect expected future costs. These adjustments include, but are not limited to, completion factors for incurred but not reported claims, removal of pharmacy rebates, fee schedule changes, and trend assumptions to account for changes in utilization, service mix, and unit costs. An adjustment is also applied to reflect to reflect state administrative expenses.

The projected AWOP reflects the expected costs of the comparable population for the rating period and is developed on a per member per month basis for each rate cell.

Rates are developed for the appropriate rate categories. All appropriate adjustments are considered in the development of the rates.~~The data includes both those that are eligible only for Medicaid and those that are eligible for both Medicaid and Medicare. In addition, this data includes only QMB-Plus and SLMB-Plus populations. The claims data includes all categories of service. The UPL and base rate information is also inclusive of patient liability.~~

In setting the PACE capitation rates, a managed care adjustment is applied to reduce the AWOP amounts by a percentage established by the state which reflects anticipated reductions in health care service costs resulting from the reduction in nursing facility services and increase in non-institutional care for PACE enrollees relative to the population underlying the AWOP development.

The percentage is determined by evaluating per member per month (PMPM) cost using the base data adjusted for the actual mix of PACE participants residing in the community, and dampening based on expected acuity for PACE vs. non-PACE home and community-based services. Historical financial performance for the PACE organizations is reviewed to validate the reasonableness of the final capitation rates.

The AWOPs and capitation rates will be rebased/recalculated every two years and the rebasing calculations will be completed for two calendar years (Jan-Dec). Separate AWOPs will be submitted for each year of the proposed two-year rating period. The rebasing/recalculations will be completed in accordance with the methodology described above and consistent with CMS rate-setting guidance.

~~The base rates are calculated using calendar year base data. The base year data is trended forward using the historical claims and eligibility information extracted for the fee-for-service population. The recent trend rates are compared to linear regression model trend rates to determine comparability, and to determine if any adjustments are necessary. The trend rates for future periods are expected to be consistent with historical rate changes rather than the more recent experience.~~

~~The following rate category groupings were developed for Arkansas: Pre-65 Medicaid Only, Pre-65 Dual Eligible, Post-65, and QMB Only. The UPL for QMB Only is based on actual expenditures for co-payments and deductibles for the base year period trended forward for inflation, and adjusted for investment income and administration expense. Due to the limited size population in the post-65 age group that was not Medicare eligible, it was determined that a Medicare eligibility rate for those over 65 would not improve predictability. The data did not reflect a necessity for a rate grouping for either geographic region or gender.~~

~~Claims completion factors are developed from the fee-for-service paid claims experience with the most recently available paid dates. Claims completion factors were developed for fourteen (14) primary groupings with comparable categories of service grouped for improved predictability. The completion factors were adjusted to exclude low and high outliers for each specific lag month.~~

~~The following adjustments are necessary in the development of the rates:~~

- ~~Prescription Drug (PD) Rebate – Reduce PD expenditure data to reflect the rebate received by Arkansas.~~
- ~~Investment Income – Reduce expenditure data by 0.2% for all Categories of Services (COS) to reflect an average payment lag of 2.49 months.~~
- ~~Administration Expense – Increase expenditure data for all COS by 0.3% to reflect the cost of administration of the fee-for-service program.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Statefferritory: ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

- Co-payments for Medicaid services – Increase the expenditures to reflect co-payment amounts.
- PCCM Fees – Decrease the base expenditures to exclude the PCCM fees.
- Non-emergency Transportation – Currently under waiver, Arkansas contracts for non-emergency transportation services for all Medicaid recipients eligible for the benefit (nursing facility residents are not eligible). A composite rate is developed with adjustments to reflect the PACE population morbidity.

The UPL amounts are reduced by a percentage amount to establish the PACE capitation rate. The Percentage(%) amount will be based on the anticipated reductions in health care service costs due to the implementation of the managed care PACE program. Reductions in costs are anticipated to be realized through a reduction in nursing facility and in-patient hospital costs.

The Upper Payment Limits (UPLs) will be rebased/recalculated every two years and the rebasing calculations will be completed for two State Fiscal Years (SFYs). Since the first UPLs and rates were calculated for SFYs 2005 and 2006, the first rebasing process will be completed for SFYs 2007 and 2008, which begin July 1, 2006 and July 1, 2007, respectively. The rebasing/recalculations will be completed in accordance with the methodology described above.

SUPERSEDES NONE· NEW PAGE

STATE Arkansas
DATE REC'D 6 Jan 04
DATE APPV'D 26 Mar 04
DATE EFF 1 Jul 04
HCFA 179 04-01

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

II. Rates and Payments (continued)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner.

C. The State will submit all capitated rates to ~~the~~ CMS ~~Regional Office~~ for prior approval, and will include the name, organizational affiliate of any actuary used, and attestation/description of the capitation rates.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

(B). **N/A** The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C) **N/A** The following formula is used to determine the needs allowance:

_____
_____

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

_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be less than the cost to the agency of providing State plan approved services to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the amount the state would have otherwise paid for a comparable population.

1. ___ Rates are set at a percent of the amount that would have otherwise been paid for a comparable population.
2. ___ Experience-based (contractors/State's cost experience or encounter data) (please describe)
3. ___ Adjusted Community Rate (please describe)
4. **X** Other (please describe)
See Page 37A for description of the rate setting methodology for Program of All-Inclusive Care for the Elderly (PACE).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

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

The Arkansas PACE amount that would otherwise have been paid (AWOP) for a PACE-comparable population and capitation rate amounts are developed for Medicaid Only and Dual Eligible populations and may be further stratified by additional factors as appropriate. The state uses the most recent available Medicaid - claims and eligibility data for a comparable population. The data used in the AWOP and PACE rate calculations is limited to recipients 55 or older who are eligible for nursing facility level of care or ARChoices Waiver level of care, and who are eligible for PACE but not enrolled in the program.

The base year data used in the AWOP and rate development is no more than three years prior to the rate year and is trended forward using the historical claims and eligibility information extracted for the PACE-comparable population. The claims data includes all services included in the state plan. Only claims that were actually paid are included in the analysis to create a historical per-member-per-month rate.

Base data, including Medicaid claims and eligibility data, are summarized by rate cell and category of service. Adjustments are then applied to project the base period data to the rating period and to reflect expected future costs. These adjustments include, but are not limited to, completion factors for incurred but not reported claims, removal of pharmacy rebates, fee schedule changes, and trend assumptions to account for changes in utilization, service mix, and unit costs. An adjustment is also applied to reflect state administrative expenses.

The projected AWOP reflects the expected costs of the comparable population for the rating period and is developed on a per member per month basis for each rate cell.

Rates are developed for the appropriate rate categories. All appropriate adjustments are considered in the development of the rates.

In setting the PACE capitation rates, a managed care adjustment is applied to reduce the AWOP amounts by a percentage established by the state which reflects anticipated reductions in health care service costs resulting from the reduction in nursing facility services and increase in non-institutional care for PACE enrollees relative to the population underlying the AWOP development.

The percentage is determined by evaluating per member per month (PMPM) cost using the base data adjusted for the actual mix of PACE participants residing in the community, and dampening based on expected acuity for PACE vs. non-PACE home and community-based services. Historical financial performance for the PACE organizations is reviewed to validate the reasonableness of the final capitation rates.

The AWOPs and capitation rates will be rebased/recalculated every two years and the rebasing calculations will be completed for two calendar years (Jan-Dec). Separate AWOPs will be submitted for each year of the proposed two-year rating period. The rebasing/recalculations will be completed in accordance with the methodology described above and consistent with CMS rate-setting guidance.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

II. Rates and Payments (continued)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner.

C. The State will submit all capitated rates to CMS for prior approval, and will include the name, organizational affiliate of any actuary used, and attestation/description of the capitation rates.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

PACE Medicaid Capitation Rate Setting Guide
Effective January 1, 2025

The Centers for Medicare and Medicaid Services (CMS) is releasing an update to the December 2015 PACE Medicaid Capitation Rate Setting Guide. This updated guide (effective January 1, 2025) is intended to serve as a resource for states related to their activities in development of PACE Medicaid Capitation rates under the Programs of All-inclusive Care for the Elderly (PACE).

States should continue to submit their proposed rates and supporting documentation to the CMS PACE rates mailbox (PACERateActions@cms.hhs.gov) for review and approval. States should complete and include the PACE AWOP & Rate Package Submission Cover Sheet (provided in Appendix B of the guide) in their submissions. The CMS analyst reviewing the rates will continue to work with the state during the review process and request any additional information as needed. Once approved, CMS will notify the state in writing of approval of the rates. The state must then notify the PACE organization(s) in writing to confirm the rates and effective dates.

In order for CMS to determine if the proposed PACE rates are consistent with the PACE Medicaid rate requirements of 42 CFR 460.182, it is important that the information outlined in this guide be supported in the rate documentation that is submitted to CMS.

Please note that rates must be approved by CMS prior to approval of a PACE application for a new organization.

The guide includes critical elements of rate setting that incorporate both the state development of the amount that would have otherwise been paid if individuals were not enrolled in PACE, and development of the PACE rates. This document may continue to be updated in the future to provide more detailed clarification in certain areas when necessary.

PACE Medicaid Capitation Rate Setting Guide
Effective January 1, 2025

Background

The Program of All-inclusive Care for the Elderly (PACE) is a fully integrated Medicare program and Medicaid state plan option that provides community-based care and services to people aged 55 or older who meet a state's nursing home level of care criteria. Federal regulations at 42 CFR 460.182 require that states make a prospective monthly capitation payment to a PACE organization for a Medicaid participant enrolled in PACE which:

- Is less than the amount that would have otherwise been paid (AWOP) under the state plan if not enrolled in PACE;
- Takes into account comparative frailty of participants;
- Is a fixed amount regardless of changes in a participant's health status.

To assist states in preparing PACE rates, CMS has developed a set of critical elements that should be considered as part of the rate development process and an associated set of questions that should be addressed in writing and submitted by states as part of their PACE rate setting packages.

The PACE rate setting package must include:

- PACE AWOP & Rate Package Submission Cover Sheet (see Appendix B)
- AWOP and PACE rates by rate cell for the rating period
- Supporting documentation

States must submit PACE rate documentation to CMS for review that addresses these critical elements. Documentation is reviewed against regulatory requirements and this guidance. Additional information is requested as needed.

The critical elements of rate-setting include the following:

1. Development of the amount that would have otherwise been paid (AWOP) and the required documentation:
    a. Identify the AWOP separately by rate cell
        i. The AWOP is calculated on a per member per month basis and includes all Medicaid covered services for the eligible population
        ii. Demonstrate basis for rate cells applied
            1. Separate rate cells may be used to more accurately project amounts that would have otherwise been paid.
            2. Rate cells can vary by age, gender, geographic region, eligibility category, Medicare status
            3. Rate cells should not cross-subsidize payments in another cell.
    b. Identify the future effective date for the projected AWOP

i. The AWOP should be established prospectively

ii. The AWOP should be calculated for a period no longer than 12 months. Mid-year changes to the AWOP are not allowed without CMS's prior approval.

1. CMS recognizes there may be unanticipated changes in costs and conditions during the year, but it is the expectation that those changes would be addressed by the state during the next rate period. In limited circumstances, CMS may consider a mid-year update to the AWOP in circumstances such as mandated across the board state legislative rate changes to be effective on a specific date that is within the rate period already approved. States are required to submit documented justification for a mid-year change to the AWOP in writing to CMS for approval prior to submitting a revised rate package to CMS for review.

iii. For rates that are effective longer than 12 months, separate AWOPs must be calculated, so that each AWOP is no longer than 12 months.

1. States must submit separate AWOPs <u>for each year</u> of the proposed rating period at the time of the submission.

c. Describe how the state determined the AWOP under the state plan

i. Base period data used,

1. Demonstrate that cost and utilization data used is reflective of the population consistent with frailty and age of PACE participants

2. Acceptable data may include fee for service (FFS) experience, managed care plan encounter data, managed care plan financial data and reports

3. Document how the base data was reviewed and validated, along with any concerns related to the quality of the data and steps being taken to enhance data quality

4. Clearly identify the time period of the base data used - most recent available year of data should be used, but should not be more than 3 years older than the rating period.

ii. Provide a narrative description of the data, assumptions and methodologies used to develop every adjustment, factor and cost applied to the base data used for the AWOP. Explanations should be provided for all adjustments, factors and costs listed below, including those that are not applicable:

1. Completion factors applied (such as any adjustments to account for claims that have been incurred but have not yet been paid).

2. Adjustments applied, including:

a. Payments/Recoupments not processed through the MMIS

b. Retrospective eligibility costs

c. FQHC/RHC cost settlements

d. Disproportionate Share Hospital Payments

e. Graduate Medical Education

f. Pharmacy rebates

g. Third Party Liability Payments

h. Patient liability

i. Copayments

3. Adjustments for changes in benefits, fee schedules, or eligibility requirements.

4. Trend factors applied, the projection period, and the basis for any trend factors used.

5. Non-benefit costs included - should only represent state costs for administering the program. Should not include PACE administrative costs.

6. Risk/Acuity adjustment to properly reflect the expected costs and frailty of the comparable PACE population.

7. The proportion of the comparable population expected to reside in an institution or community if not enrolled in PACE.

d. Additional documentation for states using Medicaid managed care data, including Medicaid managed long term services and supports program (MLTSS) data in the development of the AWOP. Refer to Appendix A for additional guidance.

i. Percentage of the PACE eligible population enrolled in Medicaid managed care.

ii. Documentation of any differences between the Medicaid managed care program and PACE and how these differences were considered in the rate setting for PACE. Differences should include any differences in eligibility, such as age or acuity/level of care, and services included/excluded in the managed care program.

iii. Actuarial certification of Medicaid managed care rates for the same rating period. If applicable, describe any differences between the AWOP and Medicaid managed care program rate development assumptions and methodologies including base data, base data adjustments, trend, non-benefit costs (including taxes, fees and other assessments), incentive/withhold payments, and acuity/risk adjustment.

2. Development of the PACE rates and required documentation:

a. Confirm and demonstrate that the PACE rate methodology is consistent with the AWOP and not in conflict with the rate description in the state plan. Describe the method for setting rate, for example - a percentage discount off of AWOP, actuarial approach, other.

b. Identify proposed PACE rates by rate cell

i. Rate is for a prospective payment paid on a per member per month capitated basis

ii. Rate cells should be the same as those used for AWOP as identified in section 1. a. ii.

c. Identify proposed effective dates of PACE rates, including start and end dates

i. Rates should be established prospectively.

ii. Effective dates of rates should be no less than one year but no more than 2 years.

iii. Time period for the rates should be consistent with that for the AWOP.

iv. Rates should not be adjusted prospectively or retroactively during the year. Mid-year changes to the PACE rate are not allowed without CMS's prior approval.

1. CMS recognizes there may be unanticipated changes in costs and conditions during the year, but it is the expectation that those changes would be addressed by the state

during the next rate period. In limited circumstances, CMS will consider a mid-year update to the PACE rates in circumstances such as mandated across the board state legislative rate changes. States are required to submit documented justification for a mid-year change to the PACE rates in writing to CMS for approval prior to submitting a revised rate package to CMS for review.

d. PACE organizations must be at full financial risk. Risk sharing and other risk mitigation mechanisms are not permitted for PACE.

e. Include additional documentation needed for CMS to make a determination of compliance with requirements.

    i. Comparison of the PACE rates to the AWOP by rate cell

    ii. Documentation of any incentive arrangements

        1. Describe how the arrangement is implemented.

        2. Quantify the incentive payments' expected impact on PACE rates.

        3. Provide the expected amount of the incentive payment and demonstrate that the sum of the PACE rate and the incentive payment is below the AWOP for each rate cell.

        4. States are not required to submit additional documentation of the final incentive payments made to PACE plans, but the state must make sure:

            a. The actual payments made are equal to or below the expected amount of the incentive payment included in the approved rate package.

            b. The total PACE capitation rate plus actual incentive payments made are below the AWOP for each rate cell in the approved rate package.

    iii. Projected member months for each rate cell

3. While federal regulations at 42 CFR 460.182 do not require an actuary to certify the amounts that would have otherwise been paid or the payment rates paid to PACE organizations, CMS encourages states to submit an actuarial certification with their rate package. If an actuary provides a certification, the rate review package should contain adequate actuarial documentation to support the data, assumptions and methodologies used. The actuary should provide sufficient documentation as described by the Actuarial Standards of Practice.

Appendix A: Additional considerations for using Medicaid managed care data in the development of the AWOP

Background

As states create and expand Medicaid managed care programs, including Managed Long-Term Services and Supports (MLTSS), the options for participants also eligible for PACE has changed. Fee for service (FFS) is often no longer the only alternative to PACE for eligible participants. To determine the amount that would have otherwise been paid (AWOP), the use of Medicaid managed care data may be more appropriate in states where Medicaid managed care programs cover all or a portion of the benefits for the population also eligible to enroll in PACE. If a state with significant Medicaid managed care presence decides not to use available Medicaid managed care data to develop the AWOP, the state should provide adequate justification within the PACE documentation.

Options for incorporating Medicaid managed care data

This Appendix lays out three options on how to incorporate Medicaid managed care data into the development of the AWOP:

- Base AWOP on Medicaid managed care rates (Option 1)
- Base AWOP on Medicaid managed care encounter and/or financial data (Option 2)
- Base AWOP on a blend of FFS data and Medicaid managed care rates/data (Option 3)

CMS does not prescribe any one option for states considering using Medicaid managed care data in the development of the AWOP. Justification for the option selected and how the Medicaid managed care data is incorporated in the development of the AWOP should be documented. To the extent the AWOP documentation relies on the certified Medicaid managed care rates or Medicaid managed care data/adjustments, the state should include the referenced actuarial rate certifications and exhibits with the PACE rate setting package.

General considerations for states to evaluate and select the most appropriate option include:

- How prevalent Medicaid managed care is in the state, including whether the Medicaid managed care program is mandatory or voluntary; and
- How closely the specific Medicaid managed care program design and state eligibility requirements align with the PACE program.

Making appropriate adjustments

When the Medicaid managed care program and the PACE program do not fully align in terms of the population composition, eligibility requirements and/or required services, states should consider the differences in eligibility and benefits between the Medicaid managed care program and PACE and make appropriate adjustments.

Appropriate adjustments to the Medicaid managed care data/rates in developing the AWOP include, but are not limited to:

- Adjust Medicaid managed care data/rates if the Medicaid managed care rate cell includes participants under age 55
- Adjust Medicaid managed care data/rates based on PACE geographic regions
- Include additional state plan services or populations not included in the Medicaid managed care contract but required in PACE
- Adjust or combine Medicaid managed care rates in a different rating period to align with the PACE rating period
- Exclude Medicaid managed care participants who do not meet the state's PACE eligibility criteria for nursing home level of care
- Adjust Medicaid managed care rate setting assumptions (between PACE and Medicaid managed care) to account for differences appropriate for the PACE eligible population including:
    a. Trend
    b. Program change adjustments
    c. Administrative costs
    d. Managed care efficiencies/savings
    e. Risk/acuity of a comparably frail population
    f. Case mix for Nursing Facility/HCBS
- Explanations should be provided for all adjustments listed above, including those that are not applicable.

Other Medicaid managed care considerations

When there are mid-year rate changes in the Medicaid managed care program that is used to develop the AWOP, states should discuss the need for an alternative rating period length of less than one year, such as for interim rate adjustments, with the CMS Analyst in advance of developing the PACE rates or modifying the AWOP. PACE rates should not be adjusted during the year without advanced approval from CMS. However, PACE rates are required to be less than the AWOP for the same time period. If the interim rate adjustments impact the data, assumptions and methodologies used in determining the AWOP, CMS may require the AWOP and PACE rates to be recalculated.

When the AWOP is based on Medicaid managed care rate ranges, the assumptions certified in the final Medicaid managed care rate should be selected. States should provide sufficient justification in the documentation when the rate assumption used to determine the AWOP deviates from the certified assumptions used to determine the Medicaid managed care rate. For

example, if a state chooses the upper bound (instead of the certified best estimate) of the Medicaid managed care rate range to be the base for AWOP, states should sufficiently document why the upper bound selection is more appropriate.