

**§ 460.172 Documentation of disenrollment.**

A PACE organization must meet the following requirements:

- (a) Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.
- (b) Make documentation available for review by HCFA and the State administering agency.
- (c) Use the information on voluntary disenrollments in the PACE organization's internal quality assessment and performance improvement program.

**Subpart J—Payment**

**§ 460.180 Medicare payment to PACE organizations.**

(a) *Principle of payment.* Under a PACE program agreement, HCFA makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicare participant in a payment area based on the rate it pays to a Medicare+Choice organization.

(b) *Determination of rate.* (1) The PACE program agreement specifies the monthly capitation amount for each year applicable to a PACE organization.

(2) Except as specified in paragraph (b)(4) of this section, the monthly capitation amount is based on the aged Part A and Part B payment rates established for purposes of payment to Medicare+Choice organizations. As used in this section, "Medicare+Choice rates" means the Part A and Part B rates calculated by HCFA for making payment to Medicare+Choice organizations under section 1853 of the Act.

(3) The rates specified in paragraph (b)(2) of this section are adjusted by a frailty factor necessary to ensure comparability between PACE participants and the reference population in the Medicare system. The factor is specified in the PACE program agreement.

(4) For Medicare participants who require ESRD services, the monthly capitation amount is based on the Medicare+Choice State ESRD rate. The monthly rate is adjusted by a factor to recognize the frailer and older ESRD population being served by the PACE organization. The PACE program agreement specifies this factor.

(5) HCFA may adjust the monthly capitation amount to take into account other factors HCFA determines to be appropriate.

(6) The monthly capitation payment is a fixed amount, regardless of changes in the participant's health status.

(7) The monthly capitation payment amount is an all-inclusive payment for Medicare benefits provided to participants. A PACE organization must not seek any additional payment from Medicare. The only additional payment that a PACE organization may collect from, or on behalf of, a Medicare participant for PACE services is the following:

(i) Any applicable premium amount specified in § 460.186.

(ii) Any charge permitted under paragraph (d) of this section when Medicare is not the primary payer.

(iii) Any payment from the State, as specified in § 460.182, for a participant who is eligible for both Medicare and Medicaid.

(iv) Payment with respect to any applicable spenddown liability under §§ 435.121 and 435.831 of this chapter and any amount due under the post-eligibility treatment of income process under § 460.184 for a participant who is eligible for both Medicare and Medicaid.

(8) HCFA computes the Medicare monthly capitation payment amount under a PACE program agreement so that the total payment level for all participants is less than the projected payment under Medicare for a comparable population not enrolled under a PACE program.

(c) *Adjustments to payments.* If the actual number of Medicare participants differs from the estimated number of participants on which the amount of the prospective monthly payment was based, HCFA adjusts subsequent monthly payments to account for the difference.

(d) *Application of Medicare secondary payer provisions.* (1) *Basic rule.* HCFA does not pay for services to the extent that Medicare is not the primary payer under part 411 of this chapter.

(2) *Responsibilities of the PACE organization.* The PACE organization must do the following: