Identifying PACE Markets and Opportunities for Expansion
Final Report

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Table of Contents

Appendices

Section 1: Executive Summary

Programs of All-inclusive Care for the Elderly (PACE) provide a comprehensive range of services that enable seniors to continue living in the community, rather than being placed in a nursing facility. PACE enrollees must be at least age 55, live in designated geographic service areas, be nursing home certifiable, and able to live safely in a community setting at the time of enrollment. With passage of the Balanced Budget Act of 1997, PACE became a permanent Medicare program and a state option under Medicaid. Since then, the number of PACE programs has grown from 15 programs operating in 9 states to 33 programs operating in 19 states. PACE programs receive a capitated monthly payment from Medicare and Medicaid in exchange for all health and aging services required to meet the needs of the people they serve.

This project identifies opportunities for PACE expansion in 15 service areas in eight states, which do not currently have PACE programs. The states participating in this study were Iowa, Kentucky, Minnesota, New Jersey, Oklahoma, Utah, Virginia, and West Virginia. In the states and service areas selected, market and environmental assessments were performed by:

1. Projecting PACE enrollment demand in areas not currently served by PACE;
2. Determining the interest of provider organizations to operate a PACE program; and
3. Assessing the readiness of state agencies to support PACE development.

States and providers can use this information in deciding whether or not they wish to start PACE programs, and to understand what actions are required by states to facilitate new PACE programs. These assessments are summarized below:

Projecting Enrollment: With an adequate population base in a designated service area, a PACE program can attract a sufficient number of enrollees so that it can successfully operate. After a start-up phase, enrollments of 90 or more are considered the lowest levels at which a program can be financially viable. In order to determine if an area can support a PACE program, an enrollment projection is needed. Using publicly available data and the methodology developed in this study, enrollments can be projected for a PACE program in a defined service area (using zip codes or

counties to define a catchment area). To assess potential demand for PACE, the population having PACE-like characteristics is obtained from the Bureau of the Census 2000 data files (available at http://factfinder.census.gov). This population is comprised of people who are clinically eligible for PACE (proxied by age and functional deficits) and are eligible for Medicaid. The census figures are reduced by a market penetration rate (10% of the eligible population) so that the projected number of enrollees is consistent with the historical experience of people who actually enroll in PACE. Although mature PACE sites, i.e., those in operation for more than five years, have a median market penetration of 16%, a lower estimate is used to reflect the penetration rates expected during a program start-up. Of the 15 service areas, six were in urban areas, four were in rural areas, and five were in small urban to rural areas, as described by the state agencies selecting them. The enrollment projections for sites in all six urban areas were 90 or more, while one rural and one small urban site had projected enrollment of under 50.

Provider Interest: To determine provider interest, health, aging services and housing providers were given opportunities to learn the PACE model. Provider organizations received an outreach letter indicating their state's interest in understanding the opportunities for PACE and inviting them to participate in an educational call. For states where multiple service areas were being assessed, the educational call was supplemented by an in-person meeting and discussion of PACE. An organization's interest in PACE was evaluated based upon its response to the outreach letter and subsequent registration for the educational call and, if offered, the in-person meeting. Throughout the 15 service areas assessed in this project, significant provider interest in PACE was found. Often health and aging service providers were unsure of their ability to start a new PACE program and to manage its financial risk. In each market, however, one or more prospective PACE providers were present.

Housing entities serve populations similar to PACE and represent significant enrollment and operational efficiency opportunities for PACE programs. It is estimated that between 15% and 20% of residents in senior housing projects are eligible for PACE. PACE programs and public housing entities can benefit by co-locating sites within public housing facilities. Benefits include cost efficiencies related to home health services, personal care, and transportation. Additionally, public housing relationships can help PACE programs assure the availability of suitable and

affordable community housing for their enrollees. With these opportunities in mind, new and existing PACE programs may need to initially focus on outreach to housing residents for enrollment with a later potential for co-location of services or financial partnerships.

State Readiness: States play a critical role in the establishment of a new PACE program. Prior to the start-up of PACE, a state must elect PACE as an optional benefit under their Medicaid program, establish a Medicaid rate for PACE, review and approve a PACE provider application, and establish administrative procedures for the enrollment and disenrollment of PACE participants. Given the primary role of states in PACE development, this project assessed state readiness and capacity to support PACE through two training sessions during which staff from NPA met with state staff. The initial meeting reviewed training and model practice resources available to state staff and identified which of these could help the state move forward. A second meeting included representatives from additional agencies and provided an overview of the project, the PACE model, and the areas requiring state capacity to support and expedite PACE expansion.

Based on these interactions with state staff, the project developed draft descriptions of the state's readiness to implement PACE. The states reviewed these draft descriptions and provided additional information through a structured interview. States consistently pointed to the need to have a motivated and viable potential PACE provider in order for a state to invest in the development of PACE program. Likewise, new PACE providers also look for a clear sign of state commitment prior to investing in a start-up program. This can create a stand-off with both states and providers waiting for the other to proceed first. Another common theme was the need to integrate PACE with other state initiatives designed to capitate and coordinate Medicaid services, particularly initiatives focusing on the frail. States were interested in how PACE could contribute to statewide solutions for this population.

In summary, the methodology and data sources for estimating the potential PACE service population can be easily replicated, so that the demand for PACE services can be projected. Provider interest in PACE in the 15 services areas was sufficient to expect that with state support more PACE programs would be developed to fulfill this potential. Interviews with state agency

staff indicate that state support for PACE expansion is primarily in response to provider interest. This reflects state agency staff shortages that make it difficult, if not impossible, for states to expend resources developing PACE as a new Medicaid program without an assurance that a provider will be interested in participating in the program. State reliance on provider initiation of PACE also reflects the competing priorities facing states with regard to how they structure their Medicaid services for the nursing home certifiable population. States indicated that they must consider how to support PACE development in the context of Medicaid waiver programs that also seek to capitate and coordinate services for a similar population. PACE expansion would be expedited by continued communications between prospective new providers and states related to this question.

Section 2: State Selection and Methods

The goal of this study is to assess the enrollment potential and opportunities for PACE expansion in selected states by:

- Projecting PACE enrollment demand in areas not currently served by PACE;
- Determining the interest and capacity of provider organizations to operate a PACE program; and
- Assessing the readiness of state agencies to support PACE development.

It is with these market and environmental assessments that states and providers can make informed decisions about starting PACE programs. It was important to look at PACE expansion in the context of state issues because of the critical role states play in the development of PACE programs. Prior to the start-up of PACE, states must elect PACE as an optional benefit under their Medicaid program, establish a Medicaid rate for PACE, review and approve a PACE provider application, and establish administrative procedures for the enrollment and disenrollment of PACE participants

To provide the market and environmental assessments, staff at the National PACE Association (NPA) collaborated with states, the Centers for Medicare & Medicaid Services (CMS), Technical Assistance Centers (TACs)[1], and a housing consultant. NPA staff were responsible for selecting states, conducting provider education and outreach, assessing state capacity, assessing provider interest and reporting on the project's activities. States were responsible for selecting a TAC, identifying potential markets for assessment, identifying prospective providers for education and outreach activities, hosting state summits, and reviewing draft reports. TACs were responsible for analyzing and reporting market demographics, assessing state environments, and supporting state capacity building. A housing consultant assessed and reported housing resources in each market**. Appendix 1** provides a detailed listing of project roles and responsibilities.

[1] Technical Assistance Centers are consulting organizations providing services related to PACE policies and operations primarily to prospective PACE providers but also to state agencies. Technical Assistance Centers have identified themselves to the National PACE Association.

State and area selection

The project began with state selection. The twenty-nine states invited to participate in the study did not have a PACE program already operating and had not participated in an earlier technical assistance program offered to states by the National PACE Association. Of the invited states, the following eight wished to participate in this project: Iowa, Kentucky, Minnesota, New Jersey, Oklahoma, Utah, Virginia, and West Virginia. Each state was allotted between one and three areas for a market demand assessment based on the strength of state and provider interest described in the states' applications. Three market areas were assessed for Virginia and New Jersey; two for Iowa, Minnesota, and Oklahoma; and one for Kentucky, Utah, and West Virginia.

States were notified of their participation in the project and the number of service areas to be assessed. Project staff asked state agencies to identify one or more markets for demographic analysis and outreach activities. With the exception of New Jersey, all of the participating states selected at least one rural market for evaluation. States indicated that they were interested in testing the potential of PACE to serve both rural and urban markets and that in many cases the greatest provider interest in PACE was in rural service areas. For all of the service areas selected by states and included in the study, the states were asked to define their markets by county or by zip code.

Methods

Once the participating states and their markets were selected, state education and capacity building began. NPA provided resources to state staff about state agencies' roles in supporting PACE development and administering PACE as a Medicaid benefit. These materials included existing NPA resources such as the Accelerating State Access to PACE (ASAP) Guidebook, Model Practices for State Administrators of PACE, an informational video, and literature about PACE. Additional educational resources were developed and distributed to participants as a result of this project, including a state workbook, a list of relevant state resources available through CMS and NPA, and a PowerPoint presentation (see **Appendix 2: PACE Overview**).

NPA staff provided on-site education and capacity building to each state. Participation in the project's training encompassed a wide range of state Medicaid and Department of Aging staff, state officials, state legislators, and liaisons from governors' offices.

Outreach to potential PACE providers in each state and provider education were conducted during the same period as the project's work with state agencies. Outreach to potential providers was directed to aging, health care, social service, and housing providers identified by state agency staff. These providers were invited to participate in an educational video conference or teleconference. NPA staff utilized existing resources about PACE to educate prospective providers, including an overview of the PACE model, background on PACE and housing partnerships, and steps for developing a new PACE program. In addition, NPA staff developed a PowerPoint presentation to educate providers about PACE. **Appendix 3** presents a list of materials distributed to providers.

Participating states selected consultants from PACE TACs to assess their state environments and to conduct the demographic market analysis for their market assessment reports. NPA staff worked with participating TACs to develop a standardized methodology and market assessment protocol for the project in order to ensure a uniform and consistent approach across participating states. This methodology uses publicly available data from the United States Bureau of the Census (http://americanfactfinder.census.gov) and a consistent methodology that can be replicated to study additional service areas (see **Appendix 4: Demographic Methodology**). A housing consultant assessed housing resources in each market. NPA staff assessed state capacity, provider interest, potential for partnerships, and recommended next steps. A preliminary market assessment report was drafted and disseminated to state project managers. Feedback was solicited from state project managers on the preliminary report to ensure accuracy.

A "PACE and Housing Summit" was offered in each state where multiple markets were assessed (Iowa, Minnesota, New Jersey, Oklahoma, and Virginia). At the summits, NPA staff, housing and TAC consultants, and state project managers presented their findings in a preliminary market assessment report to the provider community and other interested parties. Subsequently, some states distributed these reports to the public by posting it to their state websites.

Following dissemination of the preliminary market assessment reports and state summits, NPA staff finalized the market assessment reports and debriefed with state project managers and consultants. NPA staff solicited feedback on the project from state project managers. State feedback on the project is described in Section 4.

Section 3: Findings

Three factors were assessed related to the potential for PACE expansion:

1. Potential service population;
2. Interest of providers in developing PACE programs
3. State actions needed to implement PACE

A summary of the assessments is provided below. Detailed assessments were provided to participating states.

1. Potential Service Population

The PACE enrollment projection in each market area was developed using a publicly available data resource, the Census 2000 data. Participating states defined the service areas and were not restricted in an area's size or location. As a result, the size and nature of the service areas studied varied significantly. Using the census data available at http://americanfactfinder.census.gov, the following criteria were specified to approximate the PACE population:

- The population is over the age of 65.
- The population has functional deficits in two or more activities of daily living, one of which is self-care, or the inability to go outside the home.[2] These assumptions proxy state requirements that PACE enrollees meet a nursing home level of care.
- Because over 90% of PACE enrollees are currently financially eligible for Medicaid, an additional income limit designed to reflect the state's criteria for Medicaid was also applied.

[2] Consistently we found that the limitation in ability to go outside the home criterion yielded a significantly higher estimate of the likelihood of qualifying for a nursing home level of care. In fact, it typically yielded an estimate that was approximately double the estimate developed when using the "two or more limitations, one of which is self-care" measure.

These assumptions yield a conservative estimate of the PACE population because:

- The population aged 55-64 is excluded, although these individuals are eligible to enroll in PACE. Currently 10% of those individuals enrolled in PACE fall within this age range.

- The functional limitation criteria used to approximate a state's nursing home level of care criteria are the most restrictive of the criteria considered.

- People with income above the Medicaid financial eligibility limit are excluded, although they are eligible to enroll in PACE and pay privately. Currently 10% of PACE enrollees are private pay, and not eligible for Medicaid.

After these assumptions are used to find the eligible population of the census tract data, a market penetration factor is applied to approximate the expected level of PACE enrollment. Current PACE experience indicates a median market penetration for mature programs of 16%. Mature PACE programs are those operational for five or more years. Because the markets in the study would all be served by programs in a start-up mode, a more conservative market penetration rate of 10% was used to estimate potential enrollment. As programs mature, the higher penetration rate experienced by the existing PACE programs would be expected. The detailed methodology is shown in **Appendix 4** and is replicable using the Internet and a spreadsheet program.

Table 1 summarizes the service population estimates for each market by state. The table indicates the number of people who are clinically eligible (and over the age of 65) and the number of those who are also financially eligible for Medicaid. Of the 15 service areas studied, six were in urban areas, four were in rural areas and five were in small urban to rural areas. All six urban areas indicated PACE enrollment of 90 or more at a 10% market penetration level. Of the four rural areas, three were estimated to support PACE enrollment of 90 or more. Of the five small urban to rural areas, the projected enrollment in four exceeded 90. **Table 2** shows the projections by geographic location (urban/rural).

Table 1: Service Population Estimates by State

State	Market(s)	Rural (R) Urban (U) Small Urban w/Rural (SU/R)	Size of Area (Sq. Mile)	Clinically Eligible Population (From Census)	Clinically and Medicaid Eligible Population (From Census)	Estimated PACE Enrollment at 10% Market Penetration	Clinically Eligible/ Sq. Mile	Clinically and Medicaid Eligible/ Sq. Mile
Utah	Bear River Services District/Logan	R	2,226	916	387	39	0.4	0.2
Kentucky	Clinton, McCreary and Wayne Counties	R	1,084	5,911	992	99	5.5	0.9
West Virginia	Ohio County/ Wheeling	SU/R	106	778	373	37	7.3	3.5
Iowa	Des Moines[3]	SU/R	2,288	4,165	1,441	144	1.8	0.6
	Cedar Rapids[4]	SU/R	4,942	4,142	1,306	1	0.8	0.3
Minnesota	Twin Cities[5]	U	2,813	17,092	4,110	411	6.1	1.5
	Rochester[6]	SU/R	6,769	3,717	1,149	115	0.5	0.2
New Jersey	Camden County	U	222	5,662	2,061	206	25.5	9.3
	Essex County	U	126	9,463	3,522	352	75.1	28.0
	Mercer County	U	226	4,269	1,359	136	18.9	6.0
Oklahoma	Oklahoma City Area	U	1,815	11,517	4,014	401	6.3	2.2
	Chickasaw Nation Market	R	8,461	7,794	3,840	384	0.9	0.5
Virginia	Central Virginia/ Charlottesville	SU/R	3,190	2,736	965	97	0.9	0.3
	Southwest Virginia	R	3,215	4,970	2,898	290	1.5	0.9
	Northern Virginia	U	444	7,688	1,349	135	17.3	3.0

[3] Dallas, Madison, Polk, and Warren Counties
[4] Johnson, Linn, Benton, Cedar, Iowa, Muscatine, Tama, and Washington Counties
[5] Anoka, Ramsey, Washington, Dakota, Scott, Hennepin and Carver Counties
[6] Olmsted, Winona, Fillmore, Houston, Mower, Freeborn, Dodge, Steele, Rice, Goodhue, and Wabasha Counties

Table 2: Service Areas by Geographical Status (Rural, Small Urban/Rural, and Urban)

Rural/ Urban	Market(s)	State	Size of Area (Sq. Mile)	Clinically Eligible Population (From Census)	Clinically and Medicaid Eligible Population	Estimated Enrollment at 10% Market Penetration	Clinically Eligible/ Sq. Mile	Clinically and Medicaid Eligible/ Sq. Mile
R	Bear River Services District/Logan	Utah	2,226	916	387	39	0.4	0.2
R	Clinton, McCreary and Wayne Counties	Kentucky	1,084	5,911	992	99	5.5	0.9
R	Chickasaw Nation Market	Oklahoma	8,461	7,794	3,840	384	0.9	0.5
R	Southwest Virginia	Virginia	3,215	4,970	2,898	290	1.5	0.9
SU/R	Ohio County/ Wheeling	West Virginia	106	778	373	37	7.3	3.5
SU/R	Des Moines[7]	Iowa	2,288	4,165	1,441	144	1.8	0.6
SU/R	Cedar Rapids[8]	Iowa	4,942	4,142	1,306	131	0.8	0.3
SU/R	Rochester[9]	Minnesota	6,769	3,717	1,149	115	0.5	0.2
SU/R	Central Virginia/ Charlottesville	Virginia	3,190	2,736	965	97	0.9	0.3
U	Twin Cities[10]	Minnesota	2,813	17,092	4,110	411	6.1	1.5
U	Camden County	New Jersey	222	5,662	2,061	206	25.5	9.3
U	Essex County	New Jersey	126	9,463	3,522	352	75.1	28.0
U	Mercer County	New Jersey	226	4,269	1,359	136	18.9	6.0
U	Oklahoma City Area	Oklahoma	1,815	11,517	4,014	401	6.3	2.2
U	Northern Virginia	Virginia	444	7,688	1,349	135	17.3	3.0

[7] Dallas, Madison, Polk, and Warren Counties
[8] Johnson, Linn, Benton, Cedar, Iowa, Muscatine, Tama, and Washington Counties
[9] Olmsted, Winona, Fillmore, Houston, Mower, Freeborn, Dodge, Steele, Rice, Goodhue, and Wabasha Counties
[10] Anoka, Ramsey, Washington, Dakota, Scott, Hennepin and Carver Counties

Even though rural and small urban areas were found to have financially viable enrollment levels, there are some concerns:

- Rural areas have a sparse, widely distributed population, which presents operational and enrollment challenges.

- To achieve enrollments beyond 90 participants, rural PACE programs will generally need to serve a higher proportion of their service area's population than urban providers.

The financial viability of serving large rural areas remains untested as there are currently no rural PACE providers. A number of rural health providers are in the process of considering starting PACE. The experience of the Rural Partnership program, the Community Health Partnership in Eau Claire, Wisconsin, suggests that the PACE model can be adapted to a rural setting. The Partnership program is a Medicaid waiver program modeled after PACE. This program incorporates an interdisciplinary team approach, comprehensive care requirements, and capitated payment features. It also demonstrates features that rural PACE programs would be likely to explore, such as use of community physicians and reduced use of a central adult day care facility. These features may be incorporated into a PACE program if they are approved under the PACE flexibility regulations. Rural areas will likely support a sole PACE provider while many urban areas have sufficiently large potential service populations to support multiple PACE providers. Several urban areas including New York, Philadelphia and Boston now have multiple provider organizations serving their populations.

Because the service areas studied represent a considerable range in their geographic size, the estimated number of people that could be served by a PACE program may vary because of service area size variations or because of the underlying population's demand for PACE services. To compare enrollment projections across service areas the projected PACE enrollments are converted to densities of enrollees per square mile. **Table 3** shows that the urban service areas studied, predictably, have the highest PACE population density. Surprisingly, rural service areas generally have a higher service population density than small urban service areas. This suggests that rural areas, though less densely populated in general, have a higher density of the frail, low-income elderly population than small urban areas.

Table 3: Comparison of Service Population Density for Urban, Small Urban, and Rural Markets

Service Area Type (# sites in each market)	Clinically Eligible Pop. Density (People/Sq. Mi.)		Clinically and Medicaid Eligible Pop. Density (People/Sq. Mi.)	
	Minimum	Maximum	Minimum	Maximum
Urban (5 sites)	6.1	25.5	1.5	9.3
Rural (4)	.4	5.5	.2	.9
Small Urban/Rural Areas (4)	.5	1.8	.2	.6

2. Interest of providers in developing PACE programs

Health care providers are interested in learning more about the PACE model of care. In each of the markets surveyed numerous health care and aging services providers took advantage of the teleconference, the in-person state summit opportunities, or both to learn more about PACE. **Table 4** highlights the provider education events that were conducted, the number of providers invited, and the number of attendees.

In order to identify providers who might assist in the development of PACE, as a sponsor, contractor or partner, NPA worked closely with staff in each state. It is difficult to predict which provider types will be most likely to make the decision and commit the resources to develop PACE. PACE organizations have been started by hospitals, health systems, physician practices, schools of nursing, community-based organizations, and long term care providers.

Table 4: Provider Outreach Events

State	Date	Call/meeting	Provider Outreach Mailings	Number of attendees
Kentucky	26-May-04	Educational Conference Call	270	11
Utah	24-Jun-04	Outreach Meeting	44	19
West Virginia	28-Jul-04	Educational Conference Call	20	5
Oklahoma	3-Aug-04	Educational Conference Call	417	11
Oklahoma	8-Sep-04	State PACE Summit	Not available-Event promoted by the State	41
New Jersey	Jul-04	Educational Conference Call	822	76
New Jersey	22-Jul-04	State PACE Summit	Not available-Event promoted by the State	63
Iowa	16-Jul-04	Educational Conference Call	172	12
Iowa	22-Jul-04	State PACE Summit	Not available-Event promoted by the State	40
Virginia	1-Jul-04	Educational Conference Call	275	39
Virginia	13-Jul-04	State PACE Summit	Not available-Event promoted by the State	40
Minnesota	1-Jul-04	Educational Conference Call	Not available-Event promoted by the State	218
Minnesota	14-Jul-04	State PACE Summit	Not available-Event promoted by the State	23

To supplement the teleconferences which provided a general overview of the PACE model for interested providers, in-person meetings were also held with states that were assessing multiple service areas. These in-person meetings presented detailed information about preparing a PACE provider application and the competencies that providers would need in order to successfully operate a PACE program. The in-person meetings also presented information on what the state would need to accomplish in order to support a PACE provider. In addition to the health and social service providers most likely to sponsor a PACE program, the project also targeted housing providers which offer enrollment and operational efficiency opportunities. Some PACE programs have developed successful referral relationships with low income public housing

entities and a few have co-located PACE services within housing developments. There are many advantages to exploring a relationship with a public housing entity. Enrolling public housing residents in a co-located site can reduce costs to a PACE program for home health services, personal care, and transportation. Additionally, public housing relationships can help PACE programs assure the availability of suitable and affordable community housing for their enrollees. Another potential benefit is the opportunity to lease or own space for a PACE center or an alternative delivery site (a PACE site that offers a subset of PACE services). This can increase community visibility of the PACE program and facilitate marketing efforts.

From a housing perspective, collaboration with PACE can address the care and service needs of aging residents without the housing sponsor's direct involvement in service delivery. Housing providers are generally wary of the regulatory and operational requirements associated with providing health services to their residents. As a result, partnerships between PACE providers and housing providers initially are likely to focus on coordination, communications and outreach. Once a housing provider becomes familiar with PACE, some co-location of PACE services and housing developments may have appeal for a housing provider. Housing providers may also be interested in integrating their service coordination services with services provided by a PACE program. Shared ownership or financing of PACE by a housing and health care provider is a new concept that has shown promise in more mature PACE markets and states (i.e., Pennsylvania).

The characteristics of residents in senior housing facilities, particularly older facilities, are similar to PACE enrollees in terms of age, financial status and functional limitations. This reflects the similarities between PACE enrollment criteria and the eligibility criteria for publicly funded senior housing. PACE participants must be over the age of 55 and meet their state's nursing home level of care criteria. Also, though not a requirement for PACE, over 90% of PACE participants qualify for Medicaid coverage. These criteria are similar to some of the most common requirements of senior housing, as shown in **Table 5**:

Table 5: Characteristics of PACE Enrollees versus Senior Public Housing

Attribute	PACE	Most Senior Public Housing
Minimum Age	55	62
Functional deficits	Nursing home certifiable, but can reside in the community with support	The aged are associated with increased functional deficits.
Income	90% of PACE enrollees are Medicaid eligible	A typical income limit for senior housing is 50% of the Annual Median Income (AMI), which is comparable to the 300% of the social security income (SSI) limit of $20,000 for the Medicaid program.

Asset tests for low income housing are set by the Department of Housing and Urban Development (HUD) nationally, while these tests are set by each state for Medicaid eligibility. Both HUD and most states allow for the retention of some assets. In the case of HUD this allowance covers "necessary personal property" while for Medicaid the allowance is typically for the residence of a spouse or certain other dependents. While some HUD programs do not have an asset test, HUD calculates an imputed annual income based on two percent of assets valued over $5,000.

Since PACE participants must be certified by a state to be nursing home eligible, only a portion of the residents in a senior housing facility may be eligible for PACE based upon their level of functional impairment. Given public housing eligibility criteria, it is estimated that between 15% and 20% of older persons residing in federally assisted senior housing would also meet PACE eligibility criteria.[11] Using the rates of 15% to 20%, the number of public housing residents who may be eligible for PACE in the 15 service areas can be projected.[12]

[11] This range was developed for illustrative purposes by the project's housing consultant Larry McNickle. The range is based on public housing providers' assumptions of frailty levels in their residents (between 20% and 30% at risk of needing a nursing home level of care) and the rate at which those at risk would proceed to require that level of care (approximately two-thirds). Applying this rate to the range in frailty percentages yields a range of 13.4% to 20%. This was rounded to 15% - 20%.

[12] The penetration rate referenced earlier, 10%, includes PACE enrollees who reside in public housing. Therefore, some of the projected demand using the 15-20% eligibility rate is already considered in the census projection above. Untapped demand for PACE in public housing is represented by the extent that these estimates do not overlap, which is unknown.

Table 6 projects PACE demand in public housing by multiplying the number of housing residents in a service area by the conversion factors, 15% and 20%. For example, in Des Moines, 20% of the 2009 housing residents totals 402. This estimate is a subset of the total projected population that is eligible for PACE in Des Moines, 1,441 (see **Table 1**). The estimated conversion rates do not take into account the extent to which a PACE program would actually be able to enroll a public housing resident; rather, they attempt to estimate the potential number of public housing residents that could be a part of the program's potential service population. With this limitation in mind, the estimates are illustrative of the potential for PACE to serve a public housing population.

Table 6: Projected Public Housing Residents Eligible for PACE

State	Market(s)	Rural (R) Urban (U) Small Urban w/Rural (SU/R)	Types of Housing in Market (see note below)	Total Estimated Housing Population	Population Potentially Eligible for PACE	
					At 15%	At 20%
Iowa	Des Moines[13]	SU/R	202, 221(d)3/4), PHA, 515, LIHTC, Sec.8	2,009	301	402
	Cedar Rapids[14]	SU/R	202, 221(d)(3/4), 515, LIHTC, Sec.8	1,263	188	252
Kentucky	Clinton, McCreary and Wayne Counties	R	202, 221(d)(4), PHA, 515, Sec.8	499	75	100
Minnesota	Twin Cities[15]	U	202, 221(d)(3/4), 236, PHA, 515, LIHTC, Sec.8	7,378	1,107	1,477
	Rochester[16]	SU/R	202, 221(d)(3/4), 236, PHA, 515, LIHTC, Sec.8	3,482	522	695
New Jersey	Camden County	U	202, 221(d)(4), PHA, 515, LIHTC, Sec.8	3,774	566	755
	Essex County	U	202, 221(d)(3/4), 236, PHA, 515, LIHTC, Sec.8	12,054	1,808	2,410
	Mercer County	U	202, 221(d)(4), PHA, 515, LIHTC, Sec.8	2,738	410	548
Oklahoma	Oklahoma City Area	U	202, 231, PHA, LIHTC	3,004	451	601
	Chickasaw Nation Market	R	NAHASDA, 202, 221(d)(4), 515, LIHTC	920	138	184
Utah	Bear River Services District/Logan	R	202, 221, 515, LIHTC	271	41	54
Virginia	Central Virginia/Charlottesville	SU/R	202, PHA, 515, LIHTC	518	78	104
	Southwest Virginia	R	PHA, 515, LIHTC	617	93	123
	Northern Virginia	U	202, 221(d)(4), 236, PHA, LIHTC	4,598	690	920
West Virginia	Ohio County/Wheeling	SU/R	202, 221(d)(4), 236, PHA	1,081	162	216

Note: The numbers refer to the Housing and Urban Development (HUD) program (e.g. 202 is the HUD 202 housing program); LIHTC refers to Low Income Housing Tax Credits; PHA refers to Public Housing Authority housing; and NAHASDA refers to the Native American Housing Assistance and Self Determination Act housing program. HUD's website *www.hud.gov* provides detailed descriptions of these programs.

[13] Dallas, Madison, Polk, and Warren Counties
[14] Johnson, Linn, Benton, Cedar, Iowa, Muscatine, Tama, and Washington Counties
[15] Anoka, Ramsey, Washington, Dakota, Scott, Hennepin and Carver Counties
[16] Olmsted, Winona, Fillmore, Houston, Mower, Freeborn, Dodge, Steele, Rice, Goodhue, and Wabasha Counties

3. State actions needed to implement PACE

States play a critical role in the establishment of a new PACE program. Most important, a state must elect PACE as an optional benefit under its Medicaid program. After this task, a state must have the administrative capacity to establish a Medicaid rate for PACE, review and approve a PACE provider application, and establish administrative procedures for the enrollment and disenrollment of PACE participants. To assess state readiness for PACE development, the project 1) assisted states in understanding the tasks that needed to be accomplished to support PACE and 2) supported states with information and resources related to those tasks they chose to address during the course of the project.

States began this project in various degrees of readiness for PACE administration. Some states had worked with providers in the past to address some of the key steps. For other states, education on the basics of the PACE model was a necessary starting point. State readiness at the end of the project was not only driven by where states were when the project started, but also by the amount of staff time invested in the project and the amount of provider interest generated.

Table 7 lists selected steps states must complete as they build their capacity to support PACE development and administer on-going PACE operations in the state. The steps are described in the Accelerating State Access to PACE Guidebook developed by NPA through a grant project funded by the John A. Hartford Foundation and The Robert Wood Johnson Foundation (the guidebook is available at www.npaonline.org/website/article/asp?id=119). **Appendix 5** lists the actions that state agencies identified to implement PACE.

Table 7: Development of PACE within a State

Key Steps (From NPA State Guidebook)	KY	MN	WV	IA	UT	OK	VA	NJ
Initial Policy Development								
Step 1.1—Identify decision makers and key players in the state	■	■	■	■	■	■	■	■
Step 1.2—Research and describe how PACE would fit into the state's long term care system	■	■	■	■	■	■	■	■
Step 1.3— Evaluate the advantages and disadvantages of selecting the state Medicaid agency as the PACE state administering agency	■	■	■	■	■	■	■	■
State Statutory and Regulatory Requirements								
Step 2.2—Identify issues that may require legislative or regulatory changes	■	■	■	■	■	■	■	■
Step 2.4—Identify current licensure/certification categories that may be applicable to PACE			■	■		■	■	■
Step 2.5—Evaluate the development of specific PACE licensure/certification categories				■		■	■	
Step 2.8—Identify current HMO licensure requirements and the advantages and disadvantages of applying these requirements to PACE	■	■		■		■	■	■
Step 2.11—Identify the legislative changes that may need to occur in order to *exempt* PACE provider organizations from HMO licensure requirements				■			■	■
Solicitation and Selection of PACE Providers								
Step 3.1—Identify and evaluate various criteria against which provider interest may be evaluated			■	■			■	■
Step 3.2—Select the criteria that will be used to select PACE provider organizations				■			■	
Step 3.6—Identify and evaluate various processes for soliciting provider participation	■	■	■	■			■	■
Enrollment Eligibility Issues								
Step 4.1— Develop assessment process compatible with state regulations		■	■	■		■	■	■
Step 4.4—Develop an ongoing process to educate state and/or county eligibility workers about PACE and its strategic position within the state's long term care system				■			■	■

	KY	MN	WV	IA	UT	OK	VA	NJ
Step 4.5—Develop the process by which the state will determine whether or not PACE participants meet the deeming requirements set forth in Federal regulation								
Step 4.6—Develop the process by which the state will oversee the PACE provider organization's administration of the criteria for determining if a potential PACE participant is safe to live in the community								
Step 4.8—Develop the policies and procedures for assessing eligibility and post-eligibility								
. **Processing Enrollments and Disenrollments**								
Step 5.1—Identify current enrollment and disenrollment procedures and cut-off dates for Medicare and Medicaid long term care programs								
Step 5.4—Establish procedures to review the disenrollment and denials of enrollment documentation maintained by PACE provider organizations								
Medicaid Management Information System (MMIS)								
Step 6.1—Identify changes to the MMIS that need to be made to implement PACE appropriately								
Rate Setting								
Step 7.2—Calculate the UPL								
Step 7.3—Identify the rate setting option preferred by your state								
Step 7.4—Calculate the rate								
State Plan Amendment								
Step 8.1—Ensure that all of the necessary state legislative and regulatory requirements have been met with respect to amending the state plan and implementing the requirements								
Step 8.2—Include all necessary information covering eligibility, rate setting and enrollments/disenrollments								

	KY	MN	WV	IA	UT	OK	VA	NJ
Step 8.3—Identify the key staff responsible for responding to the Request for Additional Information (RAI) and establish the necessary processes to ensure the RAI is responded to within 90 days								
Data Reporting Requirements								
Step 9.1—Identify any state-specific data reporting requirements that will be imposed. Identify the state agency that will use the data and describe the purpose for which the data will be collected								
Step 9.2—In consultation with PACE provider organizations, establish data collection timeframes and reporting mechanisms								
Step 9.3—Establish state monitoring and review procedures, and develop sample reports								
Step 9.4—Identify any potential confidentiality issues								
Step 9.5—Develop a quality assurance process to monitor the effectiveness of PACE								
Step 9.6—Develop written guidance for data reporting requirements								
Federal Provider Application Approval Process								
Step 10.1—Establish Provider Application review processes								
Step 10.5—Develop State Readiness Review process								
Monitoring Activities								
Step 11.1— In cooperation with the CMS Regional Office, develop the policies and procedures that will be used in the onsite survey process								
Step 11.5—Identify members of the state survey and review teams								
Administration Plan: Human Resources and Budgeting								
Step 12.2—Develop the necessary policies and procedures, memorandums of understanding, etc. that will be needed to ensure timely and effective inter-agency cooperation and interactions								

Section 4: Discussion and Feedback

NPA staff asked participating states to evaluate their experiences and the resources they received throughout the project. State project managers generally agreed that education and capacity building offered throughout the project expanded awareness of PACE in their state among state staff and the provider community. At least one state indicated that funding for state staff to visit a PACE center would have improved their understanding of the PACE model of care.

Although NPA staff assigned each state project manager a mentor (a state administrator experienced with PACE in another state), the states did not utilize their mentors as a resource. The NPA staff believes that project managers did not utilize their state mentors for a number of reasons. Participating states were in the very early stages of learning about PACE. They had unlimited access to NPA staff and TAC consultants; and they had a great deal of educational resources and activities demanding their time and attention throughout the project. Some of the participating states indicated that access to NPA staff and TAC consultants and the unique nature of each state created less need to reach out to state mentors. In hindsight, the NPA staff believes that project managers would have been more likely to utilize their mentors had NPA staff introduced them personally and drawn the mentors into monthly conference calls and other meetings.

States agreed that their assessment reports accurately, comprehensively, and objectively identified opportunities and challenges for PACE, pertinent development issues, state capacity, and demographics. A number of the states commented that it would have been helpful to have more markets assessed than allowed for under this project.

One state commented that the census data (and consequently the methodology used for the reports) does not consider assets of the financially eligible population. Historically, a large number (90%) of PACE enrollees have been Medicaid eligible. In rural areas, individuals who would otherwise be eligible for Medicaid due to their limited income may be disqualified given their assets. Individuals who are land rich and cash poor are generally not qualified for

Medicaid. In frontier rural states, many of these individuals are farmers or individuals who have generational ties to their land. As a result, they are resistant to giving up their land to access medical care. This tendency makes it difficult to pinpoint the potential eligible population for PACE and may make it difficult for states and providers to build census for PACE in rural areas. In general, participants considered the methodology used for the demographic analysis useful given census data limitations. No specific modifications to the report protocol or methodology were recommended by the states.

Historically, TAC consultants have assessed the feasibility of PACE for a specific provider, taking into consideration an individual provider's characteristics and resources. The state market assessment reports were designed to assess provider interest broadly across a generalized service area. However, states were hesitant to move forward absent a more detailed and traditional provider feasibility study. States were generally inclined to distribute their market assessment reports. Most states are sharing the results of the assessment across multiple state agencies, with state legislators, liaisons to their governors' offices, and interested providers. In moving forward, states identified a continued need to access NPA staff and TAC consultants as they develop PACE.

Interesting challenges faced states participating in this project, due in part to the populations they were seeking to serve with PACE and their state geography. A number of the states participating in the project were interested in serving tribal populations. The State of Oklahoma is paving the way in developing PACE for the Cherokee Nation. While participating in this project, Oklahoma state staff faced a number of policy and funding challenges related to serving tribal populations with PACE. The state is working with the Cherokee Nation, CMS, and Indian Health Services (IHS) to determine how to factor the federal medical assistance percentage (F-MAP) into their PACE rate and the implications for Indian and non-Indian Health providers and the populations they serve. Many of the policy issues facing states seeking to develop a tribal PACE program have yet to be resolved by CMS and IHS.

While health care providers located near state borders in rural areas often serve clients from multiple states, PACE development would require multiple applications, multiple state Medicaid

rates, and a great deal of collaboration between bordering states. The State of Utah considered collaborating with Idaho and Nevada on a PACE program, but was quickly discouraged by the process that would entail. Given the rurality of their state, Utah state staff found themselves limited to considering PACE programs in areas of the state where their own population density could offer a sufficient census to support PACE, without relying on drawing participants from other states.

Given the length of time it takes to develop PACE, some of the states participating in this project reported that it was and will continue to be difficult for them to sustain momentum for developing a program like PACE. This is in part because of changes in state administrations and turnover in state staff. The State of Kentucky provides an example of this challenge. Over the course of the project, Kentucky acquired a new commissioner, a new director of long term care, a new assistant director of long term care, and a new lead for this project. The changes in state staff impaired their ability to participate and maintain support for this project.

In addition, some states participating in the project indicated that their ability to develop PACE may be affected by pressure to develop programs that can be administered statewide, such as "cash and counseling" and "medical management" programs. Some states are seeking a one-size-fits-all solution to long term care. They want programs that will serve their entire Medicaid population statewide, including their young disabled population. Broader long term care reforms are making it difficult for states to make PACE development a priority. Competing state policy and budget demands are also presenting obstacles for states interested in developing PACE. At least one state participating in the project expressed concerns that CMS is more supportive of states expanding their HCBS programs than developing PACE. Another state indicated that they find PACE regulations overbearing.

Effectiveness of the Process

The primary objective of the project was to assess the potential for new PACE markets and to identify opportunities for expansion in those markets. The project identified markets across eight states. The diversity of the states in the project contributed to the project's ability to identify a

range of state issues that will have an impact on PACE development. Project results for each state were summarized in market assessments that address potential service populations, provider interest, opportunities for housing partnerships, and state capacity.

The process developed for this project was effective in building awareness of PACE, improving communication, and initiating collaboration across state agencies and providers. The process was also effective at stimulating interest and motivating seven of the eight states to move forward with PACE development. Iowa, New Jersey, Oklahoma, Utah, Virginia, and West Virginia have plans to establish draft Medicaid rates and to explore funding opportunities with their state legislators. These states are receptive to feasibility studies from prospective providers. Legislation to promote PACE development has been introduced in Iowa and Minnesota. Kentucky is the only participating state that is not currently moving forward with PACE development, due in large part to changes to state staff and competing demands on their long term care budget. However, they have not completely ruled out PACE, should internal support provide an opportunity for PACE in the future. Most of the states indicated that this project increased their interest, motivation, and progress in PACE development.

Section 5: Implications for the Future

This project identified opportunities for PACE development and expansion. Based on the potential service population estimates and provider interest, the study results indicate that there are significant opportunities to expand PACE in the service areas assessed. If this experience is representative of the country as a whole, then there are undoubtedly great opportunities for expansion nationwide. In all but two of the 15 service areas assessed, there were an adequate number of eligible people projected to support PACE development. Similarly, there is significant provider interest in developing PACE programs in all service areas.

States play a critical role in the expansion and growth of PACE. States must first elect PACE as a state option in their Medicaid program, then review and approve new PACE provider applications, and establish administrative procedures for PACE. States approach PACE development at a time when their interest in comprehensive, coordinated and capitated Medicaid programs for the frail is high. This interest offers an opportunity as well as a challenge for PACE. While state interest in capitated programs for their Medicaid populations is high, human and financial resources are limited. As a result, state agencies are increasingly seeking Medicaid capitation programs with the broadest possible reach in order to maximize the efficiency of state resources. This challenges PACE to demonstrate its ability to serve a significant proportion of frail Medicaid eligible individuals.

Expediting state development of PACE will require clear and consistent provider interest as well as technical support. Provider interest offers the state an assurance that its efforts to develop PACE as a part of its Medicaid program will be rewarded with a new, viable and operational service. Technical support for states can speed their understanding of the state role, and of the financial and administrative issues states must address.

Providers interested in moving forward with PACE are most likely to come from the long term care and aging services organizations. While linking with public housing providers may help to establish a referral source for PACE enrollment, housing providers that are unfamiliar with health care in general and PACE in particular are not likely to invest in the start-up of a new

PACE organization. Nonetheless, with similar age and income requirements, senior housing programs offer PACE a significant enrollment opportunity. Partnerships between PACE and housing providers may develop after PACE is established in a new service area.

Appendix 1
Project Roles and Responsibilities

Centers for Medicare and Medicaid Services – State Barriers and Opportunities for PACE Expansion

Service Area Assessment – Tasks and Responsibilities

The chart below summarizes the tasks and responsibilities related to the study of service areas for states selected to participate in the CMS-funded study of barriers and opportunities.

Task	Technical Assistance Center Role	Housing Consultant Role	National PACE Association Role	State Role
State Selection			Review State Applications Select States Send Award Letter Schedule and conduct project overview calls	Submit application Participate in project overview calls
Service Area(s) Selection			Select Service Area(s) – with state	Identify potential service area(s) Select Service Area(s) – with NPA
Consultant Selection	Provide information about services and experience to NPA		Forward TAC information to States	Select a TAC
Service Area(s) Definition	Agree on definition of service area(s)/SMSA		Agree on definition of service areas/SMSA	Agree on definition of service area(s)/SMSA
Service Area(s) Analysis	Access and analyze bureau of census data to complete standardized methodology section related to potential population served	Analyze availability and provision of housing	Request state data related to service area, as described in the standardized methodology	Provide requested data to the extent it is available

Task	Technical Assistance Center Role	Housing Consultant Role	National PACE Association Role	State Role
Provider outreach	Send list of any known health or aging service providers in service area(s) to NPA	Send list of housing providers in service area(s) to NPA	Incorporating providers in NPA's existing database, compile list of health, aging service and housing providers in service area(s) Distribute information on PACE to outreach list with feedback form for providers to describe level of interest in PACE	Send list of health, aging services and housing providers in service area(s) to NPA Provide notice to public if necessary or appropriate
Assess Provider Interest	Refer providers to NPA	Refer providers to NPA	Record results of feedback form Provide statewide summit registration information to interested providers Track registration for statewide summits Track submittal of letters of interest	Refer providers to NPA
State Capacity Building and Assessment	Participate in capacity building if possible, given travel and budget restrictions Develop assessment of state capacity, strengths and challenges		Conduct state capacity building Describe state strengths and challenges related to PACE Provide input to TAC on state capacity assessment	Participate in state capacity building Identify state strengths and challenges relative to PACE

Task	Technical Assistance Center Role	Housing Consultant Role	National PACE Association Role	State Role
Draft Assessment Report – Service Areas, including State Capacity	Draft Assessment Report sections on potential service population and state strengths and challenges	Draft Assessment Report section on housing	Coordinate review of draft assessment reports	Review draft assessment report
Statewide Summits	Coordinate with NPA on scheduling and provider participation Present draft assessment results	Coordinate with NPA on scheduling and provider participation Present draft housing section of assessment	Plan and conduct statewide summits	Coordinate with NPA to schedule summits Coordinate with NPA on provider participation Identify and reserve meeting space Attend and participate in summit
Developing Partnerships	Work with health, aging service and housing providers to develop partnership models	Work with health, aging service and housing providers to develop partnership models	Present examples of partnership models at statewide summit Work with health, aging service and housing providers to develop partnership models	Work with health, aging service and housing providers to develop partnership models
Final Assessment Report	Revise and finalize Assessment Report sections on potential service population and state strengths and challenges	Revise and finalize Assessment Report section on housing	Coordinate review of revised and finalized assessment reports	Review revised and finalized assessment report Identify state's next steps based on final report

Appendix 2
PACE Overview

PACE – An Overview

www.NPAonline.org

What is PACE?

An integrated system of care for the frail elderly that is:

- **Community-based**
- **Comprehensive**
- **Capitated**
- **Coordinated**

The PACE Model History

First Center — *1973*

Demo. Project — *1978*

Waivers/ Full Risk — *1983*

Ongoing Waivers — *1985*

The PACE Model History

Legislation Authorizing PACE Demonstration — **1986**

First Demonstration Sites Operational — **1990**

Congress Authorizes Permanent Provider Status — **1997**

Publication of Interim Final PACE Regulation — (Nov) **1999**

First Program Achieves Permanent PACE Provider Status — (Nov) **2001**

The PACE Model History

Publication of 2nd Interim Final PACE Regulation enhancing opportunities for program flexibility — (Oct) **2002**

Final PACE Rule — **Expected Fall of 2006**

The PACE Model Philosophy

Honors what frail elderly want

- To stay in familiar surroundings
- To maintain autonomy
- To maintain a maximum level of physical, social, and cognitive function

The PACE Model
Who Does It Serve?

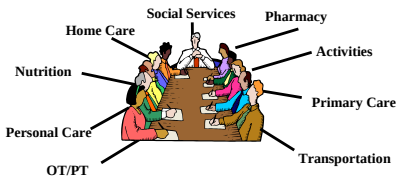
- 55 years of age or older
- Living in a PACE service area
- Certified as needing nursing home care
- Able to live safely in the community at the time of enrollment

Comprehensive Service Package

- Integrates preventive, acute, primary & long-term care services
- All Medicare & Medicaid services plus community long-term care service
- No benefit limitations, co-payments or deductibles

Integrated, Team Managed Care

Interdisciplinary Teams



Integrated, Team Managed Care

- An interdisciplinary team
- Team managed care vs. individual case manager
- Continuous process of assessment, treatment planning, service provision and monitoring
- Focus on primary, secondary, tertiary prevention

Capitated, Pooled Financing

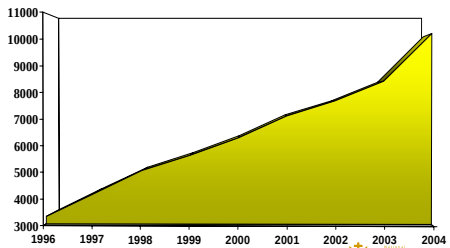
- Medicare capitation rate adjusted for the frailty of the PACE enrollees
- Integration of Medicare, Medicaid and private pay payments

Source of Service Revenue

- PACE Programs receive approximately:
  - 2/3 of their revenue from Medicaid
  - 1/3 from Medicare

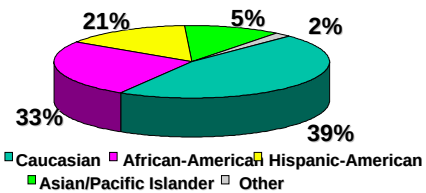
    (A small percentage of program revenue comes from private sources or enrollees paying privately)
    - 2004 Mean Medicare PMPM Rate: $1,787
    - 2004 Median Medicaid PMPM Rate: $2,984

Census Growth 1996 – 2004



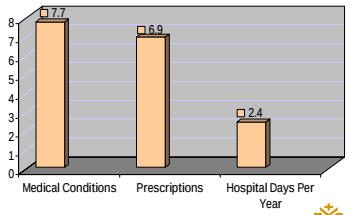
PACE Participants Racial/Ethnic Distribution

All PACE Participants as of 12/04



PACE Participants

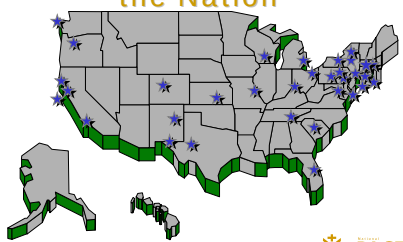
Average Number of…



Types of PACE Sponsors

- **LTC Providers**
- **Health Systems**
- **Community Organizations**
- **Hospitals**
- **States**

PACE Programs Around the Nation



Status of PACE Development

(as of 4/05)

- Thirty-two organizations are operating under dual capitation with eight additional provider applications in various stages of development.
- Eight sites are delivering services under Medicaid only capitation.
- Approximately twenty-five entities are actively moving forward with PACE planning and development.

PACE and Senior Housing

As PACE programs mature and their enrollees age, access to supportive housing environments becomes more important.

Most PACE organizations have some informal or formal link to senior housing.

PACE and Senior Housing Benefits

- **Residents** - **aging in place, quality care, future needs, cost**
- **Housing** - **role and responsibility with frail elderly, licensing, costs**
- **PACE** – **increased enrollment, community visibility, administrative simplicity**
- **HUD-HHS** - **collaboration opportunity**

PACE and Senior Housing Relationships

- Enrollment of frail residents in PACE
- Assist PACE enrollees access to suitable and affordable housing
- Lease/own community space and/or units
- Collaborate with development
  - ownership and/or management
  - joint funding (housing/common space)
- Co-location

Challenges for Providers

- Begin to think in terms of ***People*** vs. ***Sentinel Events***.
- Abandon the assumption that ***more*** is ***better***.
- Understand that ***not all*** aspects of care are clinically based, some require simple creativity.
- Embrace the importance of a consistent care delivery system over time.

What are PACE's Opportunities?

- Community rather than institutional focus.
- Only national fully integrated comprehensive model of care for the frail elderly.
- Applicability to other chronically-ill populations.
- Ability to link with other managed and long-term care initiatives.

What are PACE's Opportunities?

- Ability to provide the full range of needed services regardless of reimbursement.
- Ability to provide services consistent with emerging consumer demands.
- Maximum flexibility in service provision tailored to meet the specific needs of individuals served.

What are PACE's Challenges?

- Marketing and enrollment
- Lack of long-term care financing for middle-income population
- Building partnerships at the federal, state, regional and provider levels

Why PACE ?

FOR CONSUMERS:
- Comprehensive, preferred method of care
- Stay in the community as long as possible
- One-stop shopping

FOR PROVIDERS:
- Freedom from traditional FFS restrictions
- Focus on the entire range of needs of individual

FOR PAYERS:
- Cost savings & predictable expenditures
- Comprehensive service package

Appendix 3
List of Materials Provided to States

PACE Materials Distributed to Providers For the "Identifying PACE Markets and Impediments to Expansion Project"

1. Introductory Letter
2. List of Markets for the CMS PACE Project
3. NPA Fact Sheet – Program of All-inclusive Care for the Elderly
4. NPA Fact Sheet - PACE FAQs
5. NPA Fact Sheet - An Overview of Self-Assessment Considerations
6. "Setting the PACE for Rural Elder Care: A Framework for Action"
7. "Keeping PACE" article extract from *Advance*, March/April 2002
8. "PACE Providers Add Housing to the PACE Model Menu" an article extract from *Best Practices*, Summer, 2002.

Appendix 4
Demographic Methodology

CMS State PACE Market Assessment Project
Demographic Methodology

In preparing for the market assessments to be done as part of the CMS State Market Assessment Project, NPA brought together staff from member Technical Assistance Centers to develop a common methodology for reporting demographic data. Through the process, a methodology was developed derived from publicly available data collected by the U.S. Census Bureau during the 2000 Census.

The Census data is available through a web site called, American Fact Finder. It is at http://factfinder.census.gov/ .

On the site, select Data Sets from the button bar on the right. (If the site has been redesigned, there should be some type of link to the Data Sets that may be near something that says "For Expert Users" or "Go directly to Data Sets")

Once you are on the page that lists all the data sets, select Census 2000 Summary File 3 (SF3) – Sample Data by clicking the open circle next to it. (The current link to this page is http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=DEC&_lang=en)

A list of options will appear at the right, select Detailed Tables.
(The current link to this page is http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=DEC_2000_SF4_U&_lang=en&_ts=131445974671)

From this page you will be able to request several tables that contain the data that is needed for the market assessment. First you must identify the geographic area for which you want to pull data. Choices include: an urban area, a county, a sub section of a county, a three digit zip code or a 5 digit zip code. For the project, tables and maps were constructed pulling data for each zip code. This was done primarily so that areas of high concentrations of potential enrollees could be identified.

If you choose to select a 5-digit zip code, you first have to select the first 3-digits from the pull-down menu. That will lead you to another menu below where you can select the 5-digit zip code. You can add as many zip codes that begin with those first three digits as you wish.

Beside the box that you load the zip codes into, or other geographic describers, click on the Next button.

A box will appear with the identification numbers and names of several Census tables. Scrolling through the list, you need to add five tables to the box below.

The five tables are:

- P8. Sex by Age
- P55. Age of Householder by Household in 1999
- PCT26. Sex by Age by Types of Disability for the Civilian Noninstitutionalized Population 5+ Years
- PCT30. Sex by Age by Self-are Disability by Employment Status for the Civilian Noninstitutional Population 5+ Years
- PCT31. Sex by Age by Go-Outside-Home Disability by Employment Status for the Civilian Noninstitutional Population 16+ Years

Select the Show Results button beside the box.

Each of the requested tables will appear in the next web page. Each table reports many different data fields. Here are the fields you will need from each table.

P8. Sex by Age

Often the tables do not report the value we are looking for in one field, so we have to add the values in several fields together. The data is also separated by gender, so we need values for the following highlighted fields:

For information on confidentiality protection, sampling error, nonsampling error, and definitions see http://factfinder.census.gov/home/en/datanotes/expsf3.htm.

	66701 5-Digit ZCTA, 667 3-Digit ZCTA
Total:	12,474
Male:	5,993
Under 1 year	77
1 year	86
2 years	66
3 years	81
4 years	96
5 years	55
6 years	75
7 years	109
8 years	116
9 years	90
10 years	73
11 years	91
12 years	72
13 years	121
14 years	138
15 years	104
16 years	74
17 years	138
18 years	122
19 years	118

20 years	138
21 years	87
22 to 24 years	184
25 to 29 years	369
30 to 34 years	226
35 to 39 years	495
40 to 44 years	445
45 to 49 years	399
50 to 54 years	308
55 to 59 years	302
60 and 61 years	164
62 to 64 years	78
65 and 66 years	78
67 to 69 years	90
70 to 74 years	258
75 to 79 years	154
80 to 84 years	190
85 years and over	126
Female:	6,481
Under 1 year	46
1 year	102
2 years	29
3 years	90
4 years	109
5 years	77
6 years	75
7 years	107
8 years	90
9 years	115
10 years	61
11 years	120
12 years	70
13 years	81
14 years	110
15 years	101
16 years	106
17 years	65
18 years	84
19 years	110
20 years	63
21 years	106
22 to 24 years	246
25 to 29 years	315
30 to 34 years	316
35 to 39 years	435
40 to 44 years	422
45 to 49 years	449
50 to 54 years	375
55 to 59 years	358

60 and 61 years	91
62 to 64 years	150
65 and 66 years	145
67 to 69 years	183
70 to 74 years	280
75 to 79 years	294
80 to 84 years	224
85 years and over	281

U.S. Census Bureau
Census 2000

P55. Age of Householder by Household in 1999

For information on confidentiality protection, sampling error, nonsampling error, and definitions see http://factfinder.census.gov/home/en/datanotes/expsf3.htm.

	66701 5-Digit ZCTA, 667 3-Digit ZCTA
Total:	4,997
Householder under 25 years:	359
Less than $10,000	124
$10,000 to $14,999	40
$15,000 to $19,999	32
$20,000 to $24,999	57
$25,000 to $29,999	30
$30,000 to $34,999	17
$35,000 to $39,999	5
$40,000 to $44,999	0
$45,000 to $49,999	9
$50,000 to $59,999	34
$60,000 to $74,999	5
$75,000 to $99,999	0
$100,000 to $124,999	0
$125,000 to $149,999	0
$150,000 to $199,999	0
$200,000 or more	6
Householder 25 to 34 years:	683
Less than $10,000	40
$10,000 to $14,999	38
$15,000 to $19,999	31
$20,000 to $24,999	109
$25,000 to $29,999	63
$30,000 to $34,999	121
$35,000 to $39,999	63
$40,000 to $44,999	54
$45,000 to $49,999	36
$50,000 to $59,999	67
$60,000 to $74,999	41
$75,000 to $99,999	20
$100,000 to $124,999	0
$125,000 to $149,999	0

$150,000 to $199,999	0
$200,000 or more	0
Householder 35 to 44 years:	950
Less than $10,000	71
$10,000 to $14,999	34
$15,000 to $19,999	38
$20,000 to $24,999	63
$25,000 to $29,999	69
$30,000 to $34,999	71
$35,000 to $39,999	55
$40,000 to $44,999	55
$45,000 to $49,999	81
$50,000 to $59,999	124
$60,000 to $74,999	153
$75,000 to $99,999	78
$100,000 to $124,999	33
$125,000 to $149,999	12
$150,000 to $199,999	0
$200,000 or more	13
Householder 45 to 54 years:	819
Less than $10,000	25
$10,000 to $14,999	73
$15,000 to $19,999	36
$20,000 to $24,999	53
$25,000 to $29,999	51
$30,000 to $34,999	56
$35,000 to $39,999	50
$40,000 to $44,999	43
$45,000 to $49,999	72
$50,000 to $59,999	132
$60,000 to $74,999	97
$75,000 to $99,999	77
$100,000 to $124,999	12
$125,000 to $149,999	17
$150,000 to $199,999	25
$200,000 or more	0
Householder 55 to 64 years:	675
Less than $10,000	64
$10,000 to $14,999	34
$15,000 to $19,999	45
$20,000 to $24,999	70
$25,000 to $29,999	58
$30,000 to $34,999	64
$35,000 to $39,999	43
$40,000 to $44,999	68
$45,000 to $49,999	35
$50,000 to $59,999	55
$60,000 to $74,999	90
$75,000 to $99,999	38
$100,000 to $124,999	0
$125,000 to $149,999	5
$150,000 to $199,999	0
$200,000 or more	6

Householder 65 to 74 years:	718
Less than $10,000	109
$10,000 to $14,999	137
$15,000 to $19,999	56
$20,000 to $24,999	73
$25,000 to $29,999	96
$30,000 to $34,999	69
$35,000 to $39,999	22
$40,000 to $44,999	43
$45,000 to $49,999	41
$50,000 to $59,999	18
$60,000 to $74,999	16
$75,000 to $99,999	14
$100,000 to $124,999	5
$125,000 to $149,999	10
$150,000 to $199,999	0
$200,000 or more	9
Householder 75 years and over:	793
Less than $10,000	222
$10,000 to $14,999	126
$15,000 to $19,999	113
$20,000 to $24,999	71
$25,000 to $29,999	55
$30,000 to $34,999	33
$35,000 to $39,999	62
$40,000 to $44,999	14
$45,000 to $49,999	28
$50,000 to $59,999	12
$60,000 to $74,999	12
$75,000 to $99,999	16
$100,000 to $124,999	7
$125,000 to $149,999	5
$150,000 to $199,999	0
$200,000 or more	17

U.S. Census Bureau
Census 2000

PCT26. Sex by Age by Types of Disability for the Civilian Noninstitutionalized Population 5+ Years

For information on confidentiality protection, sampling error, nonsampling error, and definitions see http://factfinder.census.gov/home/en/datanotes/expsf3.htm.

	66701 5-Digit ZCTA, 667 3-Digit ZCTA
Total:	11,469
Male:	5,469
5 to 15 years:	1,044
With one type of disability:	64
Sensory disability	13
Physical disability	5
Mental disability	41
Self-care disability	5
With two or more types of	9

disability:	
Includes self-care disability	4
Does not include self-care disability	5
No disability	971
16 to 20 years:	590
With one type of disability:	59
Sensory disability	0
Physical disability	9
Mental disability	0
Self-care disability	0
Go-outside-home disability	16
Employment disability	34
With two or more types of disability:	9
Includes self-care disability	0
Does not include self-care disability:	9
Go-outside home and employment only	6
Other combination	3
No disability	522
21 to 64 years:	3,018
With one type of disability:	489
Sensory disability	97
Physical disability	122
Mental disability	26
Self-care disability	0
Go-outside-home disability	4
Employment disability	240
With two or more types of disability:	346
Includes self-care disability	72
Does not include self-care disability:	274
Go-outside home and employment only	127
Other combination	147
No disability	2,183
65 years and over:	817
With one type of disability:	163
Sensory disability	42
Physical disability	79
Mental disability	11
Self-care disability	0
Go-outside-home disability	31
With two or more types of disability:	176
Includes self-care disability	76
Does not include self-care disability:	100
No disability	478
Female:	6,000
5 to 15 years:	1,007

With one type of disability:	28
Sensory disability	14
Physical disability	4
Mental disability	10
Self-care disability	0
With two or more types of disability:	7
Includes self-care disability	7
Does not include self-care disability	0
No disability	972
16 to 20 years:	428
With one type of disability:	25
Sensory disability	5
Physical disability	0
Mental disability	0
Self-care disability	0
Go-outside-home disability	4
Employment disability	16
With two or more types of disability:	20
Includes self-care disability	7
Does not include self-care disability:	13
Go-outside home and employment only	7
Other combination	6
No disability	383
21 to 64 years:	3,263
With one type of disability:	389
Sensory disability	23
Physical disability	74
Mental disability	14
Self-care disability	0
Go-outside-home disability	32
Employment disability	246
With two or more types of disability:	362
Includes self-care disability	113
Does not include self-care disability:	249
Go-outside home and employment only	71
Other combination	178
No disability	2,512
65 years and over:	1,302
With one type of disability:	311
Sensory disability	48
Physical disability	163
Mental disability	32
Self-care disability	4
Go-outside-home disability	64
With two or more types of	326

disability:	
Includes self-care disability	126
Does not include self-care disability:	200
No disability	665

U.S. Census Bureau
Census 2000

PCT30. Sex by Age by Self-are Disability by Employment Status for the Civilian Noninstitutional Population 5+ Years

For information on confidentiality protection, sampling error, nonsampling error, and definitions see http://factfinder.census.gov/home/en/datanotes/expsf3.htm.

	66701 5-Digit ZCTA, 667 3-Digit ZCTA
Total:	11,469
Male:	5,469
5 to 15 years:	1,044
With a self-care disability	9
No self-care disability	1,035
16 to 20 years:	590
With a self-care disability:	0
Employed	0
Not employed	0
No self-care disability:	590
Employed	374
Not employed	216
21 to 64 years:	3,018
With a self-care disability:	72
Employed	8
Not employed	64
No self-care disability:	2,946
Employed	2,537
Not employed	409
65 to 74 years:	426
With a self-care disability	19
No self-care disability	407
75 years and over:	391
With a self-care disability	57
No self-care disability	334
Female:	6,000
5 to 15 years:	1,007
With a self-care disability	7
No self-care disability	1,000
16 to 20 years:	428
With a self-care disability:	7
Employed	0
Not employed	7
No self-care disability:	421
Employed	254
Not employed	167
21 to 64 years:	3,263

With a self-care disability:	113
Employed	12
Not employed	101
No self-care disability:	3,150
Employed	2,473
Not employed	677
65 to 74 years:	608
With a self-care disability	46
No self-care disability	562
75 years and over:	694
With a self-care disability	84
No self-care disability	610

U.S. Census Bureau
Census 2000

PCT31. Sex by Age by Go-Outside-Home Disability by Employment Status for the Civilian Noninstitutional Population 16+ Years

For information on confidentiality protection, sampling error, nonsampling error, and definitions see http://factfinder.census.gov/home/en/datanotes/expsf3.htm.

	66701 5-Digit ZCTA, 667 3-Digit ZCTA
Total:	9,418
Male:	4,425
16 to 20 years:	590
With a go-outside-home disability:	25
Employed	9
Not employed	16
No go-outside-home disability:	565
Employed	365
Not employed	200
21 to 64 years:	3,018
With a go-outside-home disability:	218
Employed	114
Not employed	104
No go-outside-home disability:	2,800
Employed	2,431
Not employed	369
65 to 74 years:	426
With a go-outside-home disability	44
No go-outside-home disability	382
75 years and over:	391
With a go-outside-home disability	100
No go-outside-home disability	291
Female:	4,993
16 to 20 years:	428

With a go-outside-home disability:	24
Employed	7
Not employed	17
No go-outside-home disability:	404
Employed	247
Not employed	157
21 to 64 years:	3,263
With a go-outside-home disability:	269
Employed	82
Not employed	187
No go-outside-home disability:	2,994
Employed	2,403
Not employed	591
65 to 74 years:	608
With a go-outside-home disability	105
No go-outside-home disability	503
75 years and over:	694
With a go-outside-home disability	169
No go-outside-home disability	525

U.S. Census Bureau
Census 2000

Using the data to generate market demographic estimates

By pulling the appropriate information from the tables above, a demographic market assessment can be done. The process can be broken into five steps:

- general estimate of the 65+ population
- estimates of proportion of 65+ population estimated to be clinically eligibility,
- estimates of proportion of 65+ population estimated to be financially eligible,
- number of 65+ estimated by clinically eligible, and
- number of 65+ estimated to be clinically and financially eligible.

General Estimate of the 65+ Population

To develop a count of the total 65+ population, the male and female population over the age of 65 is summed based on data presented in Table P8.

Variable Name	**Zip Code/County/other descriptor**
Variable Value	

Variable Name	**Age 65+, All**
Source Table	P8

Table Field(s)	Value(s)
Male	
65 and 66 years	
67 to 69 years	
70 to 74 years	
75 to 79 years	
80 to 84 years	
85 years and over	
Female	
65 and 66 years	
67 to 69 years	
70 to 74 years	
75 to 79 years	
80 to 84 years	
85 years and over	
Variable Value*	

***** Add above values together

To describe the total population age 65+ that is noninstitutional, the male and female populations are summed using Table PCT 30. This population is used as the denominator in calculating the percentage of the population that is 65+ with a range of disabilities. The noninstitutional 65+ population is used as the denominator because disability data is only provided for the noninstitutional population in the Census data.

Variable Name	**Age 65+, Noninstitutional**
Source Table	PCT. 30
Table Field(s)	Value(s)
Male	
65 to 74 years:	
75 years and over:	
Female	
65 to 74 years:	
75 years and over:	
Variable Value*	

*Add above values together

Proportion of 65+ Population Estimated to be Clinically Eligible

To develop an estimate of the number of people aged 65+ with a self-care disability, data by gender from Table PCT 30 is summed.

Variable Name	**Self-Care**
Source Table	PCT. 30
Table Field(s)	Value(s)
Male	
65 to 74 years: With a self-care disability	
75 years and over: With a self-care disability	
Female	
65 to 74 years:	

With a self-care disability	
75 years and over: With a self-care disability	
Variable Value*	

*Add above values together

To calculate the percent of those 65+ with a self-care disability, the summed number above is divided by the total number of those 65+ who are noninstitutional (see above).

Variable Name	**Self-Care Percentage**
Self-Care Percentage = Self-Care / Age 65+ Noninstitutionalized	

To develop an estimate of the number of people aged 65+ with a go-outside-home disability, data by gender from Table PCT 31 is summed.

Variable Name	**Go-Outside Home**
Source Table	PCT. 31
Table Field(s)	Value(s)
Male	
65 to 74 years: With a go-outside-home disability	
75 years and over: With a go-outside-home disability	
Female	
65 to 74 years: With a go-outside-home disability	
75 years and over: With a go-outside-home disability	
Variable Value*	

*Add above values together

To calculate the percent of those 65+ with a go-outside-home disability, the summed number above is divided by the total number of those 65+ who are noninstitutional (see above).

Variable Name	**Go-Outside Home Percentage**
Go-Outside Home Percentage = Go-Outside Home / Age 65+ Noninstitutionalized	
Variable Value	

To develop an estimate of the number of people aged 65+ with two of more disabilities, including self-care, data by gender from Table PCT 30 is summed.

Variable Name	**2 ADLs (incl. Self-Care)**
Source Table	PCT. 26
Table Field(s)	Value(s)
Male	
65 years and over: With two or more types of	

disability: Includes self-care disability	
Female	
65 years and over: With two or more types of disability: Includes self-care disability	
Variable Value*	

* Add the above values together

To calculate the percent of those 65+ with two or more disabilities, including self-care, the summed number above is divided by the total number of those 65+ who are noninstitutional (see above).

Variable Name	**2 ADLs (incl. Self-Care) Percentage**
2 ADLs (incl. Self-Care) Percentage = 2 ADLs (incl. Self-Care) / Age 65+ Noninstitutionalized	
Variable Value	

Proportion of 65+ Households Estimated to be Financially Eligible

To calculated the number of households with a householder age 65+, the number of households across a series of householder income ranges are summed for those age 65-74 and those 75+.

Variable Name	**Age 65+ Households**
Source Table	P55
Table Field(s)	Value(s)
Householder 65 to 74 years:	
Less than $10,000	
$10,000 to $14,999	
$15,000 to $19,999	
$20,000 to $24,999	
$25,000 to $29,999	
$30,000 to $34,999	
$35,000 to $39,999	
$40,000 to $44,999	
$45,000 to $49,999	
$50,000 to $59,999	
$60,000 to $74,999	
$75,000 to $99,999	
$100,000 to $124,999	
$125,000 to $149,999	
$150,000 to $199,999	
$200,000 or more	
Householder 75 years and over:	
Less than $10,000	
$10,000 to $14,999	
$15,000 to $19,999	
$20,000 to $24,999	
$25,000 to $29,999	

$30,000 to $34,999	
$35,000 to $39,999	
$40,000 to $44,999	
$45,000 to $49,999	
$50,000 to $59,999	
$60,000 to $74,999	
$75,000 to $99,999	
$100,000 to $124,999	
$125,000 to $149,999	
$150,000 to $199,999	
$200,000 or more	
Variable Value*	

*Add above values together

To calculate the number of 65+ households with an income below the Medicaid financial eligibility limit, the number of households below the specified limit (usually $20,000) are summed across the range of limits for households age 65-74 and 75+.

Variable Name	**65+ Households below income level ($20,000)***
Source Table	P55
Table Field(s)	Value(s)
Householder 65 to 74 years:	
Less than $10,000	
$10,000 to $14,999	
$15,000 to $19,999	
Householder 75 years and over:	
Less than $10,000	
$10,000 to $14,999	
$15,000 to $19,999	
Variable Value**	

*Select income category that best fits state's Medicaid financial eligibility criteria
**Add above values together

To calculate the percent of 65+ households with an income at or below the Medicaid financially eligible limit, the summed number above is divided by the total number of households age 65+ (see above).

Variable Name	**Percentage of 65+ Households Estimated to be Financially Eligible**
Percentage = 65+ Households below income level / 65+ Households	
Variable Value	

Number or 65+ Estimated to be Clinically Eligible

Since there is no perfect fit between state Medicaid eligibility requirements and data collected and reported by the Census, it is recommended that three different fields that report disability be calculated. It is generally believed that the "2 ADLs including Self-Care" most closely approximates the clinical eligibility requires of the greatest number of states.

To estimate the number of people age 65+ with a specified disability (go outside home, self care, or two or more disabilities including self care), the percentaged calculated above for each disability are multiplied by the total number of people age 65+ (see above).

Self Care:

Variable Name	**Number of 65+ Estimated to be Clinically Eligible using the Self-Care Variable**
Multiply (Age 65+, Noninstitutional) * (Self-Care Percentage)	
Variable Value	

Go Outside Home:

Variable Name	**Number of 65+ Estimated to be Clinically Eligible using the Go-Outside Home Variable**
Multiply (Age 65+, Noninstitutional) * (Go-Outside Home Percentage)	
Variable Value	

Two of more disabilities, including self-care:

Variable Name	**Number of 65+ Estimated to be Clinically Eligible using the 2 ADLs including Self-Care Variable**
Multiply (Age 65+, Noninstitutional) * (2 ADLs including Self-Care Percentage)	
Variable Value	

Number of 65+ Estimated to be Clinically and Financially Eligible

This final category will also derive three different estimate numbers because it combines the measure of financial eligibility with the three different measures of clinical eligibility. Each of the estimates of the clinically eligible population (developed using the three different disability measures) is multiplied by the percentage of households 65+ that are below the Medicaid financial eligibility limit.

Clinically and Financially Eligible - Self-care measure:

Variable Name	**Number of 65+ Estimated to be Clinically and Financially Eligible using the Self-Care Variable**
Multiply (Number of 65+ Estimated to be Clinically Eligible using the Self-Care Variable) * (Percentage of 65+ Households Estimated to be Financially Eligible)	
Variable Value	

Clinically and Financially Eligible - Go outside home measure:

Variable Name	**Number of 65+ Estimated to be Clinically and Financially Eligible**

	using the Go-Outside Home Variable
Multiply (Number of 65+ Estimated to be Clinically Eligible using the Go-Outside Home Variable) * (Percentage of 65+ Households Estimated to be Financially Eligible)	
Variable Value	

Clinically and Financially Eligible – Two or more ADLs, Including Self Care Measure:

Variable Name	**Number of 65+ Estimated to be Clinically and Financially Eligible using the 2 ADLs including Self-Care Variable**
Multiply (Number of 65+ Estimated to be Clinically Eligible using the 2 ADLs including Self-Care Variable) * (Percentage of 65+ Households Estimated to be Financially Eligible)	
Variable Value	

Appendix 5
State Next Steps to Implement PACE

Appendix 6: Next Steps to Develop PACE

Through discussions with the participating states, the NPA identified steps needed to elect a PACE option under their Medicaid program. A summary of these actions is shown below.

Kentucky

Kentucky has a long history of supporting PACE development. Kentucky has two very strong and committed providers that have, even prior to the beginning of this project, pursued PACE development through working with the state and others to generate a state PACE rate, discuss licensure and find creative solutions to concerns regarding budget neutrality.

In order to implement PACE, Kentucky would focus on the following:

- Establish a target date for and develop a draft PACE Medicaid capitation rate in order to enable interested providers to develop financial forecasts of the economic viability of PACE development in their selected service areas;
- Maintain inter-agency coordination for their PACE Team and provide education and build awareness of PACE across additional state agencies as needed;
- Determine what state licensing or certification criteria (if any) will be applied to PACE;
- Determine data reporting requirements and monitoring activities for PACE;
- Establish a referral process for PACE;
- Establish clinical and financial eligibility criteria and enrollment and disenrollment processes for PACE, assessing whether the criteria and processes already established for their other long term care programs will work for PACE;
- Determine whether the grievance and appeals processes they have already established for their Passport program will be applicable to PACE;
- Communicate their goals and objectives relative to PACE to their state legislature and request the state Medicaid Director secure from the state legislature a separate line item to fund PACE;

- DMS staff should reach out to CMS regional and central office staff as they move forward with PACE development;
- Establish a Request for Proposal (RFP) or similar process for selecting a provider(s), secure commitment to develop PACE from prospective provider(s) and collaborate with provider(s) as they develop and submit PACE provider applications; and
- State agencies in health and housing services should collaborate to facilitate partnerships between prospective PACE organizations and housing providers.

These steps will do much to advance the work already done by the state and providers in making PACE a reality for the frail elderly of Kentucky.

Minnesota

Minnesota already has valuable experience in developing managed care programs and innovative approaches to meeting the needs of frail elders requiring long term care with community based options. This experience well equips the state for developing PACE. To develop PACE, a number of steps would need to be taken:

- Determine how the state will position PACE within its long term care system;
- Determine whether there are a sufficient numbers of eligible beneficiaries to support three managed care options: PACE; MSHO; and PMAP (and ultimately Minnesota Senior Care);
- Identify potential opportunities for collaboration among PACE and the state's other managed care programs;
- Identify the processes the state will need to establish in order to educate eligible beneficiaries of competing long term care options;
- Determine whether existing referral sources and processes for establishing Medicaid functional and financial eligibility are supportive of PACE development and identify any modifications that may need consideration;
- Evaluate the efficiency of existing financial and clinical eligibility determination processes;

- Introduce legislation to authorize PACE, obtain appropriations for state staff and actuarial work, and acquire HMO exemption;
- Elect PACE in Minnesota's State Plan Amendment;
- Develop a plan for funding PACE services;
- Develop draft and final capitated Medicaid rate; and
- Identify prospective providers (develop Request for Proposals (RFP) if necessary).

These steps will do much to make PACE a reality, thereby furthering the state's commitment to expand community based long term care options for frail elders in Minnesota. At this juncture, the most important step is for the state and DHS to commit to incorporating PACE into their long term care system and to make PACE development a priority.

West Virginia

State staff in West Virginia have clearly thought through many of the development issues relevant to PACE and have begun collaborating with interested providers. The state remains interested and committed to incorporating PACE into their long term care system. Given this commitment, the state environment, provider interest, and state demographics, there is clearly a need and an opportunity to incorporate PACE into West Virginia's long term care system. Thus far, minimal challenges or barriers to PACE development have been identified. The steps listed below will help the state make PACE a reality for frail elders in West Virginia:

- Elect PACE in their state Medicaid Plan;
- Identify available funds, establish an RFP, and hire an actuary to develop a PACE rate;
- Pull the necessary Medicaid data for the actuary;
- Educate the new administration about PACE;
- Determine whether and/or how PACE will be licensed;
- Work with the state insurance commission to resolve whether HMO licensing will be required;

- Assess the potential and develop strategies for preventing conflict of interest among gatekeepers who are direct providers of health care and who may view PACE as competition, thereby affecting a PACE program's ability to build census;
- Work with advocacy and consumer groups to educate them about PACE and address their concerns that PACE may be a "medical model" as well as their concerns that PACE does not provide "participant directed care;"
- Review and approve a PACE provider application and submit to CMS;
- Prepare for an on-site review; and
- Execute a provider contract/program agreement.

During the state capacity building meeting in West Virginia, three potential challenges were identified. First, the group had concerns that there could be a potential conflict of interest for gatekeepers, who are also direct providers of care, that could affect a PACE program's ability to build census. A strategy for overcoming this challenge was not explored during the state capacity building meeting, but should be explored further by the state. The second concern was that some very strong consumer and advocacy groups in the state would view PACE as a medical model of care. The third concern was that these same groups would not support PACE if they did not perceive it as offering participant directed care. Education about the PACE model was discussed among state staff as one strategy for overcoming these last two challenges.

Iowa

Iowa has already built a strong foundation for PACE. Given this foundation, the state environment, state readiness, provider interest, and state demographics, there is clearly an opportunity to incorporate PACE into Iowa's long term care system. In addition, the State of Iowa has already begun implementing state-specific strategies for overcoming these challenges. However, there are a number of "next steps" which the state will need to consider in order to incorporate PACE into their long term care system. These steps include:

- Determine which state agency will serve as the administering agency for PACE;

- Identify all issues requiring legislative action and develop strategies and a timeline for obtaining the necessary legislative support for PACE;
- Secure funding, authorization, and support from state legislature to move forward with PACE;
- Update the Upper Payment Limit and rate setting methodology by defining comparable population in the fee-for-service population, pulling data, and establishing a draft (or estimated) rate to share with prospective providers;
- Determine availability of grant funds for PACE development;
- Finalize licensing and/or certification requirements for PACE; and
- Secure commitment from prospective providers to complete a provider application.

During the Iowa PACE Summit, participants explored opportunities and challenges, potential development strategies, and next steps for PACE in Iowa. Most of the identified challenges related to financing concerns and the need to obtain legislative action. The strategies identified for overcoming these challenges involved a broad range of education and outreach activities geared toward state officials, legislators, providers, consumer, and advocacy organizations. Participants at the summit also identified a number of reasons why they believe PACE will work well in Iowa. These reasons included: an improved quality and preferred option for receiving care for consumers; a better way of delivering care and improving collaboration among providers; and greater predictability in expenditures, cost containment, and reduced risk for the state.

Utah

The State of Utah is quite capable of incorporating PACE into their long term care system; however, they have yet to make the commitment to do so. There are a number of issues that state staffs need to work through internally before making this commitment. First, state staff intend to calculate a Medicaid payment rate for PACE. With the necessary commitment, the state will be well positioned to incorporate PACE into its long term care system. As the State of Utah assesses the value that PACE can add to their long term care system, the following steps will be important for the state to consider:

- Determine how PACE will fit in the state's long term care system, particularly with respect to its existing Medicaid managed care program;
- Secure internal commitment to incorporate PACE into Utah's long term care system;
- Develop strategies for obtaining legislative support (to obtain required approval on new Medicaid program) and funding to expand the state Medicaid budget to support PACE;
- Collaborate with providers to develop strategies for overcoming risk aversion;
- Work with prospective providers to complete feasibility studies;
- Collaborate with prospective providers on the completion of the PACE provider application;
- Submit State Plan Amendment to CMS;
- Develop a work group from various divisions to discuss comparable population, rate setting and determine eligibility and level of care criteria for PACE;
- Identify comparable population in fee-for-service system, pull and analyze data, and develop draft rate for PACE; and
- Meet with Region VIII staff to prepare for CMS application.

Until the state demonstrates an internal commitment to incorporate PACE into its long term care system, it will be difficult for interested providers to move forward with PACE development. There is a considerable amount of work that needs to be done by the state and providers in order for PACE to become a reality for frail elders in Utah.

Oklahoma

The State of Oklahoma is well positioned to incorporate PACE into their long term care system. Provider interest appears strong. There are multiple markets that have the demographics and the provider interest to support a PACE program. The state is clearly committed and energized toward making this happen. The state has thought through and developed many of the strategies needed to develop PACE. Given provider interest, the market demographics, state environment and state readiness, the following steps will be important for the state to consider as they implement PACE:

- Develop a draft (and final) Medicaid rate;
- Determine the final Medicaid rate;
- Determine whether (and if so, how) PACE will be licensed;
- Secure legislative support for dedicated state staff and funding for PACE;
- Review and approve a PACE provider application and submit to CMS;
- Prepare for an on-site review; and
- Complete a provider contract/program agreement.

As the state continues to develop PACE, it will be important for the state to collaborate with prospective providers to develop strategies for overcoming the challenges identified at the summit and to build on the opportunities that PACE will bring to their state.

Virginia

At the beginning of this project, Virginia had already established its legislative and regulatory provisions for PACE development. The state also has developed a PACE payment rate. There is a history of working across multiple state agencies to develop PACE, and DMAS benefits from staff that understand PACE and the state's role in supporting PACE providers. Steps the State can take to move forward include:

- Complete, submit and respond to any requests for additional information needed to secure approval of a state plan amendment that specifies how PACE will be administered in Virginia.
- With planned modifications to the state's Medicaid funded assisted living benefit, the state will need to address how PACE and this benefit will fit together. Regulatory and payment issues will need to be defined and resolved.
- Currently, Medicaid beneficiaries living in an Assisted Living Facility receive an auxiliary payment to support the housing cost component of the assisted living facility. This payment is used in addition to the Medicaid payment to the assisted living provider for medical services to cover all of the costs of assisted living. If an individual enrolled in PACE required placement in an Assisted Living Facility PACE would become the sole

payer for all services. The auxiliary payment for the housing component would be discontinued.

- State regulations limit the collocation of an adult day care center and an assisted living facility. The PACE center includes an adult day care component. Regulations will need to clarify the appropriateness of collocating a PACE center and an assisted living facility.
- Bring housing providers together with PACE providers to create effective partnerships.
- Establish a staffing and transition plan for PACE to become an operating program within the Department of Medical Assistance and Services.
- Review licensing standards to determine their applicability to PACE service components such as adult day care, home care, and outpatient services.
- Determine the financial eligibility criteria for Medicaid recipients seeking to access PACE services. Specify the criteria and assessing their comparability to home and community based waiver services will be important in supporting PACE enrollment.
- Consider establishing a request for proposal process for selecting prospective PACE providers or, as an alternative, articulate the state's approach to dealing with PACE provider applications submitted by prospective PACE organizations.
- Establish a review and authorization process for approval of PACE provider applications and coordination with the federal Center for Medicare and Medicaid Services to complete the review and approval of a PACE program agreement.
- Expand HMO exemption beyond individuals receiving Medicare or Medicaid to include those receiving support from other public sources, such as the Veteran's Administration and counties, to meet their health needs.
- Specify grant opportunities provided by the state to support PACE development. Are there grant opportunities specifically for rural development?

<u>New Jersey</u>

While the State of New Jersey is well on its way to being able to support PACE programs, many questions and tasks still remain to be accomplished. Many of the final steps that states undertake to support PACE are among the most difficult since they often force state agencies to work together and with federal agencies and providers in new ways. However, the New Jersey state

staff has developed a process to address each of the outstanding issues and an estimated timeframe for accomplishing each task:

- Complete the rate setting process.
- Develop a process for provider selection.
- Determine health care licensing regulation to be applied to PACE.
- Determine how PACE provider applications will be reviewed.
- Review State Plan Amendment for accuracy.
- Finalize eligibility and enrollment/disenrollment processes.
- Determine Grievance procedures and Appeal procedures.
- Clarify the State Administrating Agency roles in oversight of PACE.
- Clarify exact enrollment and disenrollment process for PACE including determination of process for review of all denials of enrollment and involuntary disenrollment.
- Determine the need for any additional state contract or agreement other than the 3-way agreement between PACE provider, CMS, and state.
- Determine data collection requirements, if any, above and beyond CMS requirements, including interface with the MMIS system.
- Determine what, if any, rules apply to the development of marketing materials.
- Develop administrative polices or rule making procedures, as applicable, to the administrative oversight and operation of PACE by DHSS in New Jersey.
- Develop training plan for NJ EASE staff on the PACE program and how it fits with other long term care services provided by the state.

The state has been enthusiastic about working with and encouraging potential providers, which should also help in achieving its target of being able to support a PACE program by October 1, 2005.