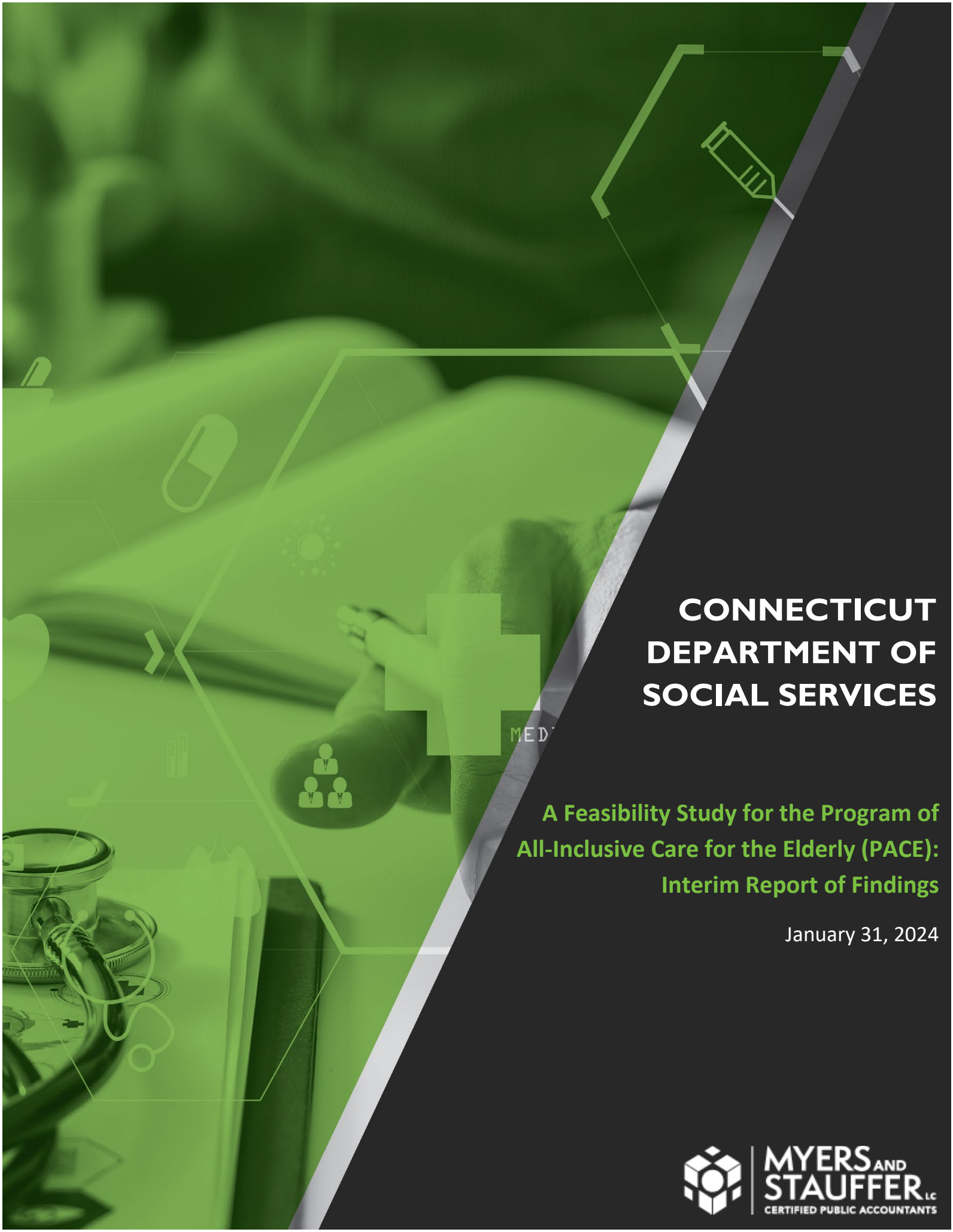

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

A Feasibility Study for the Program of All-Inclusive Care for the Elderly (PACE): Interim Report of Findings

January 31, 2024

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CERTIFIED PUBLIC ACCOUNTANTS

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Overview of PACE

The Program of All-Inclusive Care for the Elderly (PACE) is an optional benefit for states under their Medicaid State Plan. The purpose of PACE is to provide patient-focused comprehensive medical services for eligible individuals while attempting to address certain social needs, as well as ensuring they maintain their place in the home and community for as long as possible.

Eligibility

PACE is widely regarded as an innovative model of care for the elderly — eligible individuals must be at least 55 years of age, meet state-defined nursing facility level of care, reside in a PACE organization service area, and be able to live safely in the community.

What is a PACE Organization?

A PACE organization is an entity that has in effect a PACE program agreement, approved by both the Centers for Medicare & Medicaid Services (CMS) and the State (known as a three-way agreement) to operate a PACE program. The three-way agreement is structured to contain the terms that describe how the PACE organization will provide comprehensive, coordinated, community-based, and capitated health care services to PACE enrollees. The program is comprehensive and coordinated, in that a PACE organization is responsible to provide care that meets the needs of each participant across all care settings, 24 hours a day, every day of the year. PACE participants receive services covered under Medicaid and Medicare, as well as any other medically-necessary service as long as it is authorized by the interdisciplinary team (IDT). The IDT is a team of 11 professionals within the organization, including physicians, social workers, and other disciplines that meet daily to manage, monitor, discuss, and document the care needs of participants. Benefit limitations or conditions relating to amount, scope, or duration of services, deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid do not apply in PACE. The PACE organization is financially responsible for all services required for participants.

The PACE Objective

PACE is designed to enhance the quality of life and autonomy for frail, older adults, while maximizing dignity and respect that enables participants to live in the community as long as medically and socially feasible.

Service Determinations

Participants, their designated representatives, and caregivers may request the PACE organization to initiate a service, modify (increase, reduce, eliminate, or otherwise change) an existing service, and/or

request to continue coverage of a service the PACE organization is recommending be discontinued or reduced. Participants may submit requests, either orally or in writing, to any employee or contractor of the PACE organization that provides direct care to a participant in the participant's residence, the PACE center, or during transport. With certain exceptions, the IDT must process these service determination requests as expeditiously as the participant's condition requires, but within three calendar days of the date the request was received by the IDT.

PACE Services

PACE services include, but are not limited to:

- *Primary care*
- *Nursing services*
- *Social services*
- *Physical therapy*
- *Occupational therapy*
- *Personal care and supportive services*
- *Nutritional counseling*
- *Recreational therapy*
- *Meals*
- *Transportation*
- *Nursing home*
- *Inpatient*
- *Home health care*
- *Prescription drugs*
- *Specialty care*
- *Dental services*

PACE services also include any other service necessary to meet the needs of a participant, when approved by the IDT.

The IDT

Participant care is designed and implemented by an 11-member team that is responsible to assess participants and establish, coordinate, implement, and monitor participant-specific care plans to ensure that identified care needs are met, either by PACE center staff or contracted providers. The IDT completes an assessment of the participant needs within 30 days of enrollment and at least semi-annually and develops comprehensive care plans designed to meet participant needs across all care settings on a 24-hour basis, each day of the year. The IDT is composed of at least the following members:

- *Primary care physician*
- *Registered nurse*
- *Social worker*
- *Physical therapist*
- *Occupational therapist*
- *Recreational therapist*
- *Dietician*
- *PACE center manager*
- *Home-care coordinator*
- *Personal care attendant*
- *Driver*

Brief History of PACE

PACE has a 50-year history. The first PACE program was launched by On Lok Senior Health Services, a not-for-profit community-based organization in San Francisco, in the early 1970s to address the long-term care needs of elderly immigrants. In 1974, Medicaid began reimbursing On Lok for adult day health services and later broadened reimbursable services to include comprehensive medical care for older adults certified to be nursing home-eligible. In 1979, the United States Department of Health and Human Services provided a four-year grant to On Lok to develop a model of care delivery for individuals with long-term care needs. With a one-year grant from The Robert Wood Johnson Foundation (RWJF), On Lok initiated a project to determine the feasibility of replicating the model in other parts of the country. Following the 1986 authorization of 10 replication site waivers by Congress, RWJF provided grant funding for replication sites. By 1994, there were ten operational replication sites. The demonstration continued until PACE was established as a permanent Medicare program by the Balanced Budget Act of 1997 (BBA). Not only did the BBA establish PACE permanently within the Medicare program, but it also enabled states to provide services to Medicaid participants as a State Plan option. California was the first state to offer PACE. There are 18 states not currently offering PACE services, with two of those in various stages of the implementation process. We are aware of at least two states, including Connecticut, that are actively assessing the feasibility of PACE.

PACE Rate Setting and Service Funding

PACE organizations are paid with capitation payments on a per-member, per-month basis. PACE organizations receive two capitation payments per month for dually-eligible participants (i.e., those eligible for both Medicaid and Medicare), which comprise approximately 75 to 80 percent of participants. For these participants, a capitation payment is paid for their Medicaid eligibility portion as well as their Medicare eligibility portion. Approximately 10 to 15 percent of participants are Medicaid only. For these participants, a capitation payment is paid for their Medicaid eligibility portion. For the remaining smaller percentage of participants that are either Medicare only or private pay, a single capitation payment is made to the PACE organization from the Medicare Administrative Contractor or through a private insurance premium, as applicable. PACE organizations combine capitation revenue into a common pool from which health care expenses are paid. This capitated financing allows PACE organizations to deliver all services participants need rather than be limited to those strictly reimbursable under the Medicare and Medicaid fee-for-service systems. The PACE organization assumes full financial risk for the health care services participants need, so long as they are approved by the IDT.

State Medicaid Funding

Under a PACE program agreement, the state administering agency makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid participant. The monthly capitation amount is less than the amount that would otherwise have been paid (AWOP) under the State Plan if the participants were not enrolled under the PACE program. Capitation rates are set

annually and take into account the comparative frailty of PACE participants and remain fixed regardless of changes in the participant's health status.

The PACE organization must accept the capitation payment amount as payment in full and may not bill, charge, collect, or receive any other form of payment from the State administering agency or from, or on behalf of, the participant, except payment with respect to any applicable spenddown liability, any amounts due under the post-eligibility treatment of income (PETI) process, or Medicare payment received from CMS or from other payers.

The PACE Landscape

PACE Adoption by States

Although the origins of PACE date back to the early 1970s, the program continues to expand and evolve, with more states across the country implementing the program for the first time or expanding an existing PACE program.

According to the National PACE Association (NPA),[1] there are 155 PACE organizations across the United States operating in 32 states and the District of Columbia, accounting for more than 300 PACE centers. The 32 states' programs are at varying stages of implementation and maturity; therefore, as programs grow with increased enrollment and the addition of new PACE organizations, the census data below will continue to increase.

PACE Enrollment by State

States and District of Columbia	Census as of December 2023 Report by NPA
Alabama	183
Arkansas	532
California	19,876
Colorado	4,450
District of Columbia	36
Delaware	346
Florida	2,825
Iowa	659
Indiana	548
Kansas	974
Kentucky	104
Louisiana	405
Massachusetts	5,480
Maryland	147
Michigan	4,963
Missouri	49
North Carolina	2,027

States and District of Columbia	Census as of December 2023 Report by NPA
North Dakota	190
Nebraska	217
New Jersey	1,305
New Mexico	481
New York	8,627
Ohio	646
Oklahoma	813
Oregon	1,916
Pennsylvania	8,198
Rhode Island	399
South Carolina	521
Tennessee	281
Texas	1,150
Virginia	1,900
Washington	1,423
Wisconsin	534
Total	**72,205**

[1] https://www.npaonline.org/docs/default-source/public-files/pace-in-the-states.pdf?sfvrsn=d82e6997_1

The state of Illinois is in the implementation phase. States currently without a PACE program include: Alaska, Arizona, Connecticut, Georgia, Hawaii, Idaho, Maine, Minnesota, Mississippi, Montana, Nevada, New Hampshire, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

Growth of PACE

The top 10 states by enrollment make up approximately 83 percent of the total PACE census, according to NPA data reporting in December 2023. Many states are continuing to expand current PACE markets and consider expansion applications, leading to growth across the country. One contributing factor to the growth of PACE involves the availability of American Rescue Plan Act funding. Some states elected to use this funding to explore implementing or studying the potential to implement a PACE program. As states contemplate the aging baby boomer generation, they are considering various options to offer long-term services and supports to this population. As a result, providing services within the community through a PACE program, while allowing aging adults to remain in their home, may be an attractive option.

Top PACE State Programs by Census

Top 10 State PACE Programs by Census	Census[2]	Percent
California	19,876	33.0%
New York	8,627	14.3%
Pennsylvania	8,198	13.6%
Massachusetts	5,480	9.1%
Michigan	4,963	8.2%
Colorado	4,450	7.4%
Florida	2,825	4.7%
North Carolina	2,027	3.4%
Oregon	1,916	3.2%
Virginia	1,900	3.2%
All Others (n= 23)[3]	11,943	16.54%
Total	**72,205**	**100%**

[2] https://www.npaonline.org/docs/default-source/public-files/pace-in-the-states.pdf?sfvrsn=d82e6997_1

[3] Census for each of the remaining 23 programs ranges from 36 participants (District of Columbia) to 1,423 participants (state of Washington), with an average of 519 and a median of 481.

The Impacts of PACE

Research

PACE programs have existed in other states for decades. Over that time, the program has been studied extensively to gain insights into whether the program has the potential to: (1) offer better health outcomes relative to other programs; (2) create a high level of satisfaction for participants; (3) promote quality care and services; and (4) be cost effective.

At the core of PACE are several key success factors that need to be addressed. For purposes of this Interim Report, these questions are tabled; however, they will be researched and documented in the final study report. More research is necessary to address the primary objective of the study, which is to determine if a PACE program is right for the State of Connecticut. Functional areas that will be explored further include the following:

- ***Participation and Enrollment Levels***
  - *Is there a large enough pool of potential PACE participants?*
  - *What other programs may compete with PACE for enrollment / participants?*
- ***Health Outcomes***
  - *Are there opportunities for improvement in outcomes, and does PACE offer the potential for hospitalizations and other costly services to be mitigated by reductions in utilization?*
- ***Potential PACE Organization History and Viability***
  - *Can the PACE model be financially sustainable in Connecticut?*
  - *What are the histories of those organizations interested in providing PACE services in the state?*
  - *How will each organization leverage existing community partnerships and develop other relationships needed to provide comprehensive participant care?*
- ***Community Awareness and Integration***
  - *How does PACE fit within the local health care ecosystem and market conditions?*
  - *What is the level of community acceptance and understanding of PACE?*
  - *What is the demand for PACE services?*
- ***What state resources are required to support PACE?***
  - *What is the opportunity cost of implementing a PACE program in Connecticut?*

- *What staffing resources are required?*
- *What information systems are required?*
- *How will quality and service delivery be monitored?*

Overall, studies have come to the following conclusions:

- *PACE provides quality and cost-effective community-based care to older adults who could otherwise require a nursing home or other model of care.*[4]
- *There has been steady census growth, good consumer satisfaction, reduction in use of institutional care, and controlled utilization of medical services.*[5]
- *PACE has been associated with the following statistically significant impacts:*
  - ***Formal support services*** *— a higher probability of attending a day health center and more day health center days; a lower probability of receiving any nurse visits to home.*
  - ***Utilization of medical services*** *— a lower probability of having a hospital admission and fewer inpatient hospital nights; a lower probability of having a nursing home admission and fewer nursing home nights; a higher probability of receiving ambulatory care and more ambulatory visits.*
  - ***Health status, quality of life, and satisfaction*** *— a higher probability of being in good or excellent health, finding life to be satisfying, attending social programs at least once per week.*
  - ***Functional status*** *— a lower probability of having a visual or hearing disability or weekly bowel/bladder incontinence; a lower level of activities of daily living (ADL) limitations.*[6]
- *Data from NPA found that PACE reduced family caregiver burden and provided support to improve family caregiving:*
  - *More than 96 percent of family members report being satisfied with the support they receive through PACE and 97.5 percent of family caregivers would recommend PACE to someone in a similar situation.*

[4] Arku, D.; Felix, M.; Warholak, T.; Axon, D.R. Program of All-Inclusive Care for the Elderly (PACE) versus Other Programs: A Scoping Review of Health Outcomes. Geriatrics 2022, 7, 31. https://doi.org/10.3390/geriatrics 7020031
[5] C Eng, J Pedulla, G P Eleazer, R McCann, N Fox. Program of All-inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing. J Am Ger Soc, 1997 Feb; 45(2):223-32
[6] The Impact of PACE on Participant Outcomes, Pinka Chatterji, PhD Nancy R. Burstein, PhD David Kidder, PhD Alan White, PhD, July 1998.

- *While nearly half of family members reported a high caregiver burden at the time their loved one enrolled in PACE, more than 58 percent experienced less burden after enrollment.*[7]

- *27 percent of new PACE enrollees scored as depressed on an assessment administered before enrollment. Nine months later, 80 percent of those individuals no longer scored as depressed.*[8]

What Other States Say

New York

According to the New York Department of Health, PACE has led to reduced hospital admissions, better preventive care, high rates of community residence, and high caregiver satisfaction.[9] In summary, results in New York indicate the following:

- *PACE members have a 24 percent lower hospitalization rate than other dually-eligible participants who receive Medicaid nursing home services.*
- *PACE participants receive better preventive care, specifically with respect to hearing and vision screenings, flu shots, and pneumococcal vaccines.*
- *95 percent of participants live in the community instead of nursing homes.*
- *96 percent of family members are satisfied with PACE support.*
- *97.5 percent of caregivers would recommend PACE.*

Rhode Island

Rhode Island reports[10] the following results:

- *93 percent of participants rate their care very favorably (good, very good, and excellent).*
- *72 percent of participants enrolled for at least a year have not had an inpatient stay in twelve months.*
- *PACE participants enter a nursing facility four years later, on average, than a similar population not enrolled in PACE.*
- *PACE participants make 11 percent fewer visits to the emergency department than other participants with similar health conditions.*

[7] National PACE Association. (2018). PACE Reduces Burden of Family Caregivers, Aug. 30.
[8] Vouri, S.M., Crist, S.M., Sutcliffe, S., Austin, S. (2015). Changes in Mood in New Enrollees at a Program of All-Inclusive Care for the Elderly. The Consultant Pharmacist®, 30 (8): 463-71.
[9] New York State Department of Health. Discussion of Structural Alternatives for PACE Expansion in New York. June 2022. https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2022-06-02/docs/pace.pdf
[10] https://pace-ri.org/

California

California reports the following results:

- *The PACE program has a very low rate of voluntary disenrollment.*
- *The rate of satisfaction with care for PACE participants is greater than 90 percent.*
- *PACE participants would refer PACE to a close friend 94 percent of the time.*[11] [12]

The Challenges of Enrollment, Participant Barriers, and Costs

Like any other program, PACE is not without its challenges. PACE is complex, requires time to implement, and the cost-effectiveness of PACE for states and PACE organizations is highly contingent on many factors. The success of PACE organizations usually depends on competition for enrollment, competition for human resources, community collaboration, and start-up costs. Implementation of a PACE program is not insurmountable, but does require careful planning, communication, and coordination.

PACE is almost always implemented in a health care arena that already has other established waivers for the elderly and other community resources and organizations that advocate for and serve the elderly. PACE may be viewed by some in the provider community as a "competitor" for customers. Physicians could be concerned about losing patients to PACE organizations. Other community resources that serve seniors may fear decreases in the number of clients served. We believe a success factor is community buy-in, acceptance, and support. It is important for the community to understand the PACE model and how it can be interwoven into the existing health care environment.

A primary goal of PACE is to help participants continue to live safely in the community. Nursing homes and other institutional providers must understand the role of PACE in relation to their own interests. We have witnessed situations where the introduction of PACE programs have opened new opportunities for collaboration and innovative thinking, especially when it comes to community partnerships and multi-specialty owned provider organizations.

Before patients can be enrolled, PACE organizations must establish facilities, purchase or lease property, acquire appropriate staff, market, and address other needs. Often, there can be significant start-up investments for organizations without existing, established operations within the state. Locations of PACE centers in proximity to potential participants is essential and requires significant analysis prior to PACE program implementation. In terms of staffing, PACE organizations must have IDTs that can plan, implement, coordinate, and evaluate services needed by PACE participants. It is common for PACE

[11] https://www.altamed.org/PACE
https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2019/12/Presentation-2-PACE-Expansion-Key-Measurement-and-Data.pdf
[12] https://calpace.org/wp-content/uploads/2017/12/PACE-Cost-Effective-Fact-Sheet-updated-2-21-20.pdf

organizations to face competition for health care and operational staff resources in the communities they serve.

Key PACE organization staff must include, at a minimum, the following:

- *Primary care physician*
- *Registered nurse*
- *Master's level social worker*
- *Physical therapist*
- *Occupational therapist*
- *Recreational therapist or activity coordinator*
- *Dietitian*
- *Center manager*
- *Home care coordinator*
- *Personal care attendant representative*
- *Driver/representative*

PACE offers a robust service catalog with little to no cost for participants who are Medicaid eligible. In fact, PACE could easily be considered too good to be true by potential participants. The PACE benefits package can, in and of itself, be a potential problem for participant enrollment. Potential participants often think it sounds like a scam when they initially learn of PACE.

Another barrier to participant enrollment or consideration of PACE is misperception about the effect on participant assets. There is anecdotal discussion in the long-term-care world that participants lose all, or most of, their assets when they agree to enroll in programs. PACE is no different. PACE organizations receive capitated payments from both Medicaid and Medicare to cover the cost of providing comprehensive services for dual-eligible participants. The PACE organization must accept the capitation payment amount as payment in full and may not bill, charge, collect, or receive any other form of payment from the State administrative agency or from, or on behalf of, the participant. Participants may still be liable for any applicable spenddown or amounts due under the PETI process.

PACE has the potential to alter existing relationships between participants and their medical team. For many participants, it can be undesirable to change a trusted physician relationship and instead delegate care to an unknown doctor at an unknown PACE organization. Myers and Stauffer has spoken with CMS about this requirement on behalf of another state, and we do not anticipate the requirement changing. Therefore, we see it as an opportunity area for most PACE organizations to educate and relieve anxieties of potential enrollees. The PACE organization may need to demonstrate that the PACE primary care provider is at least as technically competent as the potential participant's community-based provider.

Finally, PACE enrollment and participation requires a PACE organization to communicate effectively with potential and enrolled participants. A growing percentage of the elderly are minorities and those whose first language is one other than English. PACE organizations must be able to recruit and retain staff who speak other languages, based on the demographics of the population around the PACE center(s). In addition, they must be able to develop instructional and promotional materials in multiple languages contingent on the makeup of the population within their service area.

Connecticut Long-Term Care and Waiver Landscape

Structural Overview

Connecticut seniors are served by a mix of programs and organizations for long-term care. Traditional facilities and community programs cater to Connecticut seniors for various needs they may face in their lives. Long-term care facilities include nursing homes, intermediate care facilities (ICFs), and assisted living facilities. These entities are licensed by the state and certified to participate in the Medicaid and/or Medicare programs. Medicaid coverage of services provided in assisted living facilities is limited to individuals participating in the assisted living demonstration project. There are approximately 200 nursing facilities in Connecticut. While institutional care has been a traditional pillar of elder care, the state has moved aggressively toward community-based options and other options that allow seniors to maintain their independence in their own homes and communities. The state Medicaid program, known as HUSKY Health, uses State Plan options to finance home and community-based services (HCBS) and a number of Medicaid waiver programs.

Home and Community Based Services (HCBS)

CMS grants “waivers” of program requirements, with an appropriate state request. HCBS waivers in Connecticut are structured to help seniors remain in their homes and avert placement in long-term-care settings, such as nursing homes. The federal share of reimbursement to the state is about 50 percent. Assistance is managed through HUSKY, and seniors who receive services must be enrolled in a HUSKY program to participate. While there may be variants, typically waiver programs require one of three types of criteria for eligible seniors:

- ***Nursing Facility Level of Care***

  Some waiver programs require that eligible seniors meet a nursing facility level of health care; this means that the senior requires assistance with critical needs such as bathing, dressing, eating, toileting, or taking medications.

- ***Intermediate Care Facility (ICF) Level of Care***

  Other programs require that eligible seniors meet an ICF level of care. An ICF is a long-term care facility that provides nursing and supportive care to residents on a non-continuous skilled nursing care basis, under a physician's direction.

- ***Condition-Specific***

  Waiver programs exist that require that seniors have specific conditions and diagnoses. It is important to consider HCBS waiver services, their structure, the populations they serve, and their level of saturation in relation to PACE.

Below, we have highlighted the major HCBS programs in Connecticut.

- ***Personal Care Assistance Waiver***

  The Personal Care Assistance (PCA) Waiver program serves adults who have permanent, severe, and chronic physical disabilities and meet a nursing facility level of care. The program provides adult day health, agency-based personal care assistant, care management, meals on wheels, adult family living, mental health counseling, and personal emergency response system. This waiver operates with a concurrent 1915(b)(4) authority.

- ***Connecticut Home Care Program for Elders (CHCPE)***

  The CHCPE serves seniors age 65 and older who may require long-term facility services or have health conditions that meet nursing home level of care criteria. The program provides adult day health, homemaker, companion, emergency response system, home delivered meals, chore services, mental health counseling, personal care attendant, assistive technology, adult family living, care management, environmental accessibility adaptations, transportation, chronic disease self-management, and respite. This program helps low income, elderly residents afford the high cost of assisted living (non-skilled nursing, residential care). Presently, all of Connecticut's Medicaid funding for assisted living, a demonstration program, is administered through the CHCPE. This program operates with a concurrent 1915(b)(4) authority.

- ***Connecticut Housing Engagement and Support Services (CHESS)***

  The CHESS Program is for Medicaid members who are experiencing homelessness and higher rates of hospitalizations than would otherwise be expected based on diagnoses and other risk factors. The program provides key services to assist these individuals and operates with a blended State Plan option with a Medicaid waiver (through section 1915[i] and the 1915[b] options).

- ***Mental Health Waiver***

  Provides adult day health, community support program, supported employment, assisted living, assistive technology, brief episode stabilization, chore services, home accessibility adaptations, home delivered meals, interpreter, mental health counseling, non-medical transportation, overnight recovery assistant, peer supports, personal emergency response systems, recovery assistant, specialized medical equipment, and transitional case management services to individuals with mental illness ages 22 or older who meet a nursing facility level of care.

Connecticut Home Care Program for the Disabled

The Connecticut Home Care Program for the Disabled serves those who have been diagnosed with such neurological conditions as Multiple Sclerosis, Alzheimer's Disease, Parkinson's, and Huntington's. Services include: homemaker, visiting nurse, home health, occupational and physical therapy, chore services, meals on wheels, care management, companion, adult day care, emergency response system, mental health counseling, adult family living, minor home modifications, assisted living services in approved managed residential communities, PCA services, highly skilled chore services, and transportation.

Acquired Brain Injury (ABI) Waivers

The ABI waivers are available to those with brain injury who meet a hospital, nursing facility, or intermediate care facilities for individuals with intellectual disabilities (ICF/IID) level of care. The program provides group day, adult day health, homemaker, personal care, prevocational services, respite, supported employment, ABI recovery assistant II, ABI recovery assistant, assistive technology, chore services, cognitive behavioral programs, community living support services, companion, consultation services, environmental accessibility modifications, home delivered meals, independent living skills training, personal emergency response systems, substance abuse programs, transportation, and vehicle modification services.

Comprehensive Supports Waiver

The Comprehensive Supports waiver is available to those with developmental disabilities who meet an ICF/IID level of care. Services available include adult day health, blended supports, group day supports, group supported employment, live-in caregiver, prevocational services, respite, independent support broker, assisted living, assistive technology, behavioral support services, community companion homes, community living arrangements, companion supports (i.e., adult companion), continuous residential supports, customized employment supports, employment transitional services, environmental modifications, health care coordination, home delivered meals, individual directed goods and services, individual supported employment, individualized day supports, individualized home supports, interpreter, nutrition, parenting support, peer support, personal emergency response system, personal support, remote supports service, senior supports, shared living, specialized medical equipment and supplies, training/counseling/support services for unpaid caregivers, transportation, and vehicle modification services.

Individual and Family Support Waiver

The Individual and Family Support Waiver program serves those with developmental or intellectual disabilities who meet an ICF/IID level of care. Services offered by the program include adult day health, blended supports, community companion homes, group day supports,

individual supported employment, live-in companion, prevocational services, respite, independent support broker, assistive technology, behavioral support services, adult companion, continuous residential supports, customized employment supports, employment transitional services, environmental modifications, group supported employment, health care coordination, home delivered meals, individualized day supports, individualized home supports, individually directed goods and services, interpreter, nutrition, parenting support, peer support, personal emergency response system, personal support, remote supports services, senior supports, shared living, specialized medical equipment and supplies, training/counseling/support services for unpaid caregivers, transportation, and vehicle modification services.

- ***Employment and Day Supports Waiver***

The Employment and Day Supports waiver is available to those with developmental or intellectual disabilities who meet an ICF/IID level of care. The program provides adult day health, blended supports, group day supports, individual supported employment, prevocational services, respite, independent support broker, peer support, assistive technology, behavioral support services, customized employment supports, employment transitional services, environmental modifications, group supported employment, home delivered meals, individual direct goods and services, individualized day support, interpreter, personal emergency response system, remote supports, specialized medical equipment and supplies, training/counseling/support services for unpaid caregivers, transportation, and vehicle modification services.

- ***Home and Community Supports Waiver for Persons with Autism***

The Autism waiver is available to those with autism who meet ICF/IID level of care. This program provides live-in companion, respite, assistive technology, clinical behavioral support services, community mentor, individual goods and services, interpreter, job coaching, life skills coach, non-medical transportation, personal emergency response system, social skills group, and specialized driving assessment services.

- ***Community First Choice***

The Community First Choice program offers personal care attendant and other services through self-direction that help eligible persons remain in their communities and not become institutionalized. Eligible persons must meet functional or medical criteria that reflects a nursing home level of care.

- ***Money Follows the Person***

  Money Follows the Person (MFP) is a federal demonstration program for Medicaid eligible individuals who have lived in a long-term-care or hospital setting for at least two months and want to live in their own homes and communities. To participate in the program, you must be eligible for Medicaid and be eligible for one of the community service packages. Housing available includes apartments and group homes. Available services include housing and care such as modifications, rent, and care in the community, moving expenses, security deposits, and other costs to setup the apartment.

How PACE Aligns With the Existing Long-Term Care and HCBS Environment

HCBS waiver programs in Connecticut are robust, and many are available. Multiple agencies manage programs that serve seniors, and there are also options in the community that are not administered by the State. PACE may fit within the existing long-term care and long-term services and supports environment in Connecticut, offering enhanced complementary options to existing services while underscoring the primary wish of most seniors—to remain healthy, in their homes, and with little to no health care-related cost. PACE can also help alleviate burdens on highly-utilized programs that have waitlists and are not able to provide services to all seniors who need them because of these constraints.

A PACE program in Connecticut may be able to offer additional options in solving a chief health barrier seniors face—gaps in care coverage and periods without care. When seniors become ineligible for existing programs, a PACE program may offer a solution. Seniors may be eligible for PACE enrollment and receive comprehensive health care coverage.

Existing programs and service providers in Connecticut could have the option of ensuring that no senior goes without care at any time or that such periods are mitigated to the extent possible. PACE has the flexibility and primary mission of catering to the individual needs of seniors, including specializations in geriatric care, their culture, their language needs, and their social and cognitive needs. PACE stakeholders tend to be very fond of the program, and other organizations tend to promote PACE. It is not uncommon for competing programs to refer seniors to the PACE program and PACE organizations in their area.

Potential PACE Eligibility in Connecticut

Overall

Myers and Stauffer prepared a preliminary analysis of the Connecticut PACE market to identify the potential number of eligible participants. As used herein, an "eligible" is an individual that meets criteria but who has not actually enrolled in a PACE organization. An "enrollee" is an individual that meets criteria and is assumed to have enrolled in a PACE organization. The number of enrollees will always be less than the number of eligibles. An enrollee must be an eligible, but an eligible does not need to be an enrollee.

We created a market inventory by estimating the number of PACE-eligible residents in each Connecticut zip code. We utilized census data to generate the estimates, organized the data into tables listing each zip code in the state, and then created heat maps to illustrate how the concentration of PACE-eligible individuals varies across the state. This approach allowed us to clearly identify areas of the state that appear to be viable PACE markets.

Methodology

Overall, the eligibility requirements can be summarized as: age, frailty, ability to live in the community, and geographic location. PACE participation is not restricted by a participant's Medicare or Medicaid eligibility. However, PACE premiums are often prohibitive for those who are not entitled to Medicare Part A, enrolled under Medicare Part B, or eligible for Medicaid. As such, we consider an economic factor in estimating eligible participants.

To estimate the number of participants that would likely be eligible for the PACE program, Myers and Stauffer relied on three qualifying factors: individuals must be age 55 or over, they must meet a clinical eligibility threshold, and they must meet a financial eligibility threshold. This report used data from the American Community Survey (ACS) completed in 2022 to determine estimates for each of these factors.

Myers and Stauffer utilized several different tables from the ACS to perform this study. The tables used provided data in these key areas:

1) Population by zip code.
2) Population that report difficulty with self-care and were age 65 and over.
3) Population that report difficulty with activities of daily living (ADLs).
4) Population that would be deemed financially eligible utilizing the federal poverty data available.

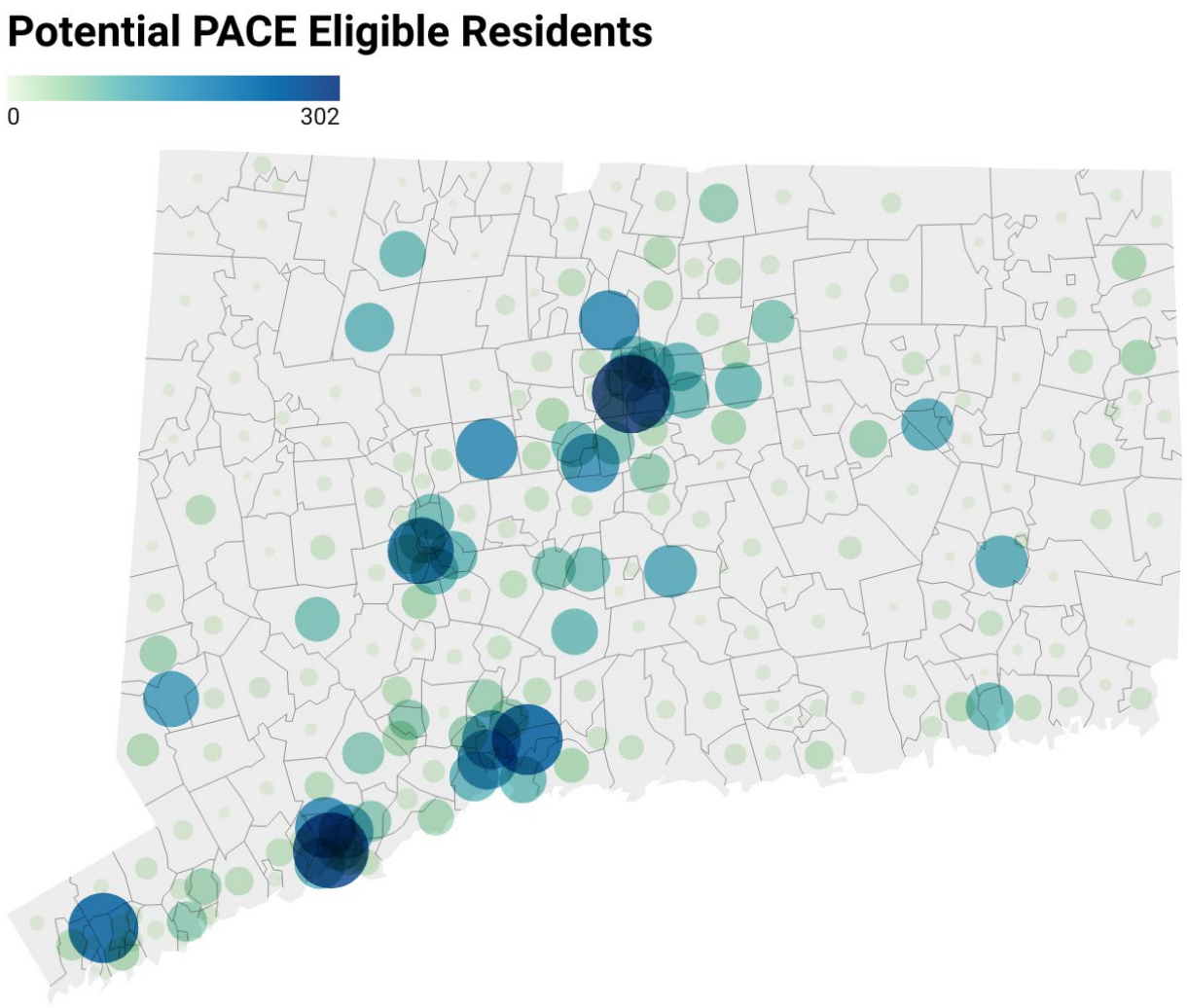
Results

According to U.S. Census Bureau data, Connecticut has a total population of 3,611,317. Of those, 32 percent, or 1,151,163 people, are over the age of 55. Within that subset, 95,742 have difficulty living independently and 49,224 have difficulty with self-care. When combined with economic data and Medicaid eligibility data, we estimate that 9,255 people state-wide may be eligible for PACE services. These Connecticut residents are spread across the state, but are most heavily concentrated in urban areas. From a visual perspective, we noted they are more concentrated centrally in the state and south and west primarily.

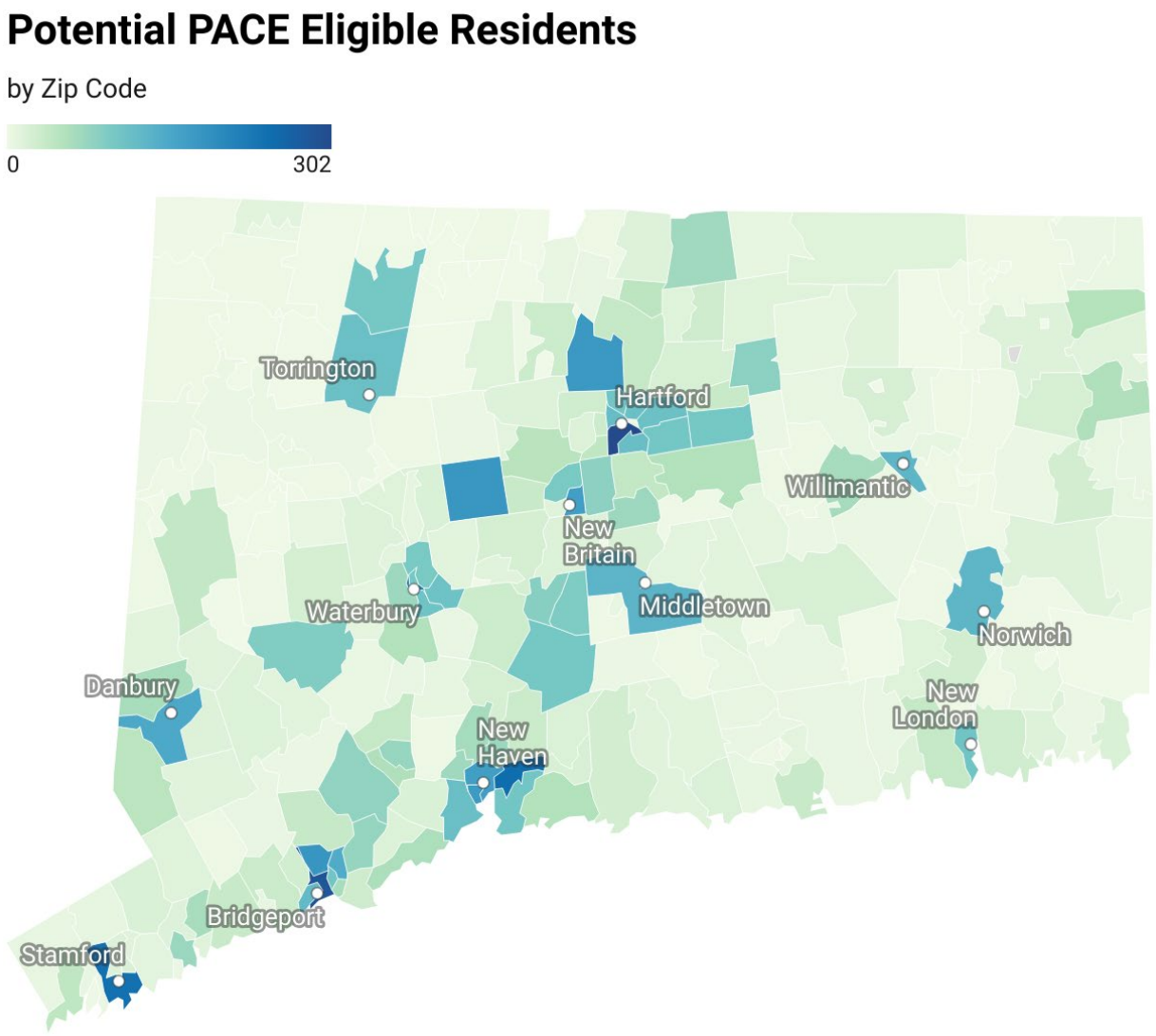
Using U.S. Postal Service official post office names, we estimate the following cities and towns (cities) to contain the ten highest numbers of potential PACE eligible persons:

Top Ten Cities by Population	Estimated PACE Eligible
1. Bridgeport	895
2. Hartford	755
3. Waterbury	696
4. New Haven	660
5. Stamford	346
6. Danbury	210
7. Norwalk	168
8. New Britain	275
9. West Hartford	118
10. Greenwich	49
Total	**4,172**

The heat map below shows the concentration of PACE-eligible residents. Warmer colors (dark blue, blue, green) indicate areas with a higher number of estimated PACE-eligible residents. Cooler colors (light green) indicate areas with a lower number.

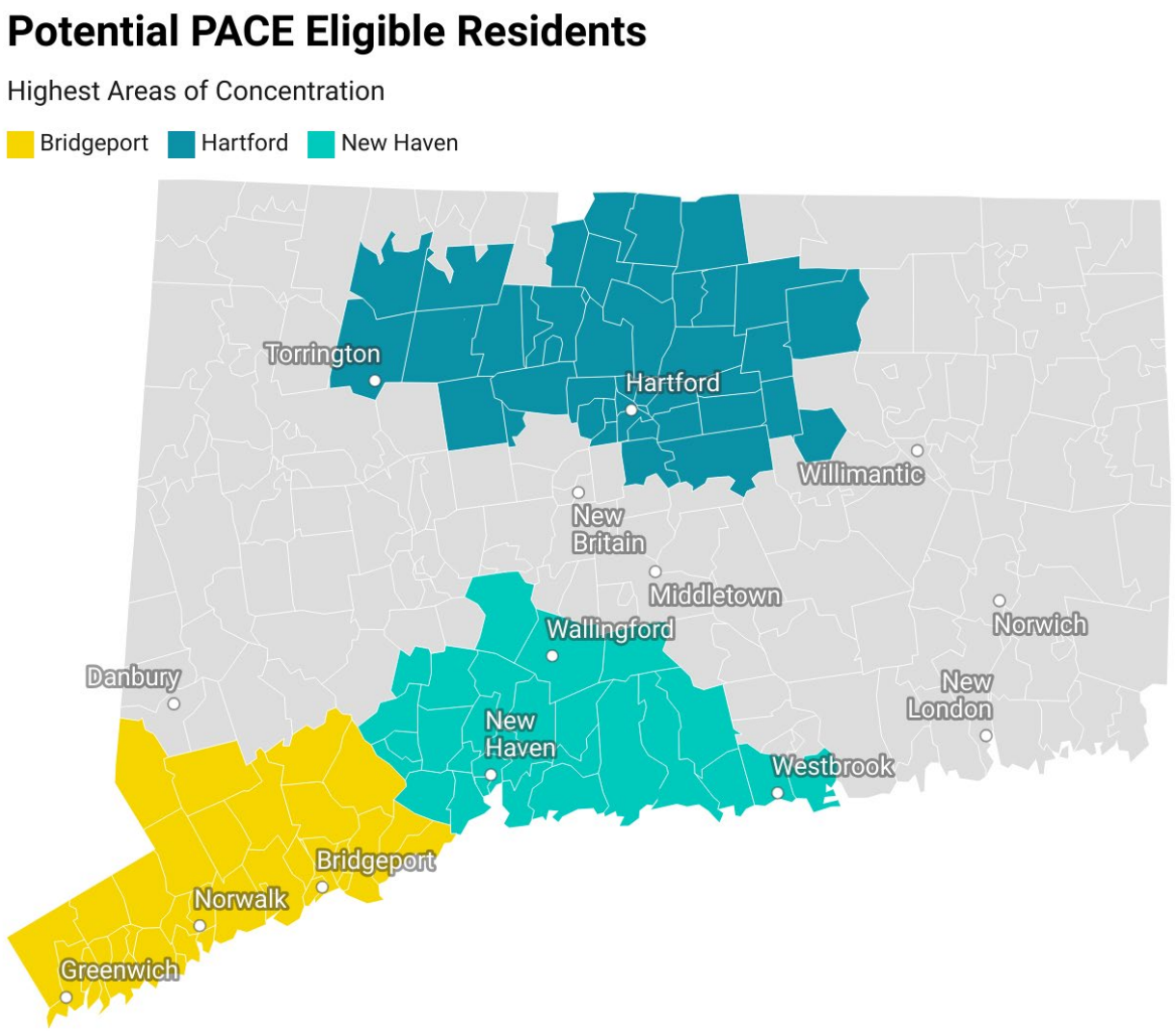


We have also included a heat map below which outlines each of the state's 278 5-digit zip codes. Each zip code on the map is shaded based on the number of estimated PACE-eligible residents. Darker shading is used to identify the zip codes with the highest number of PACE-eligible residents. Lighter shading is used to indicate the areas of the state with the lowest concentration of PACE-eligible residents.



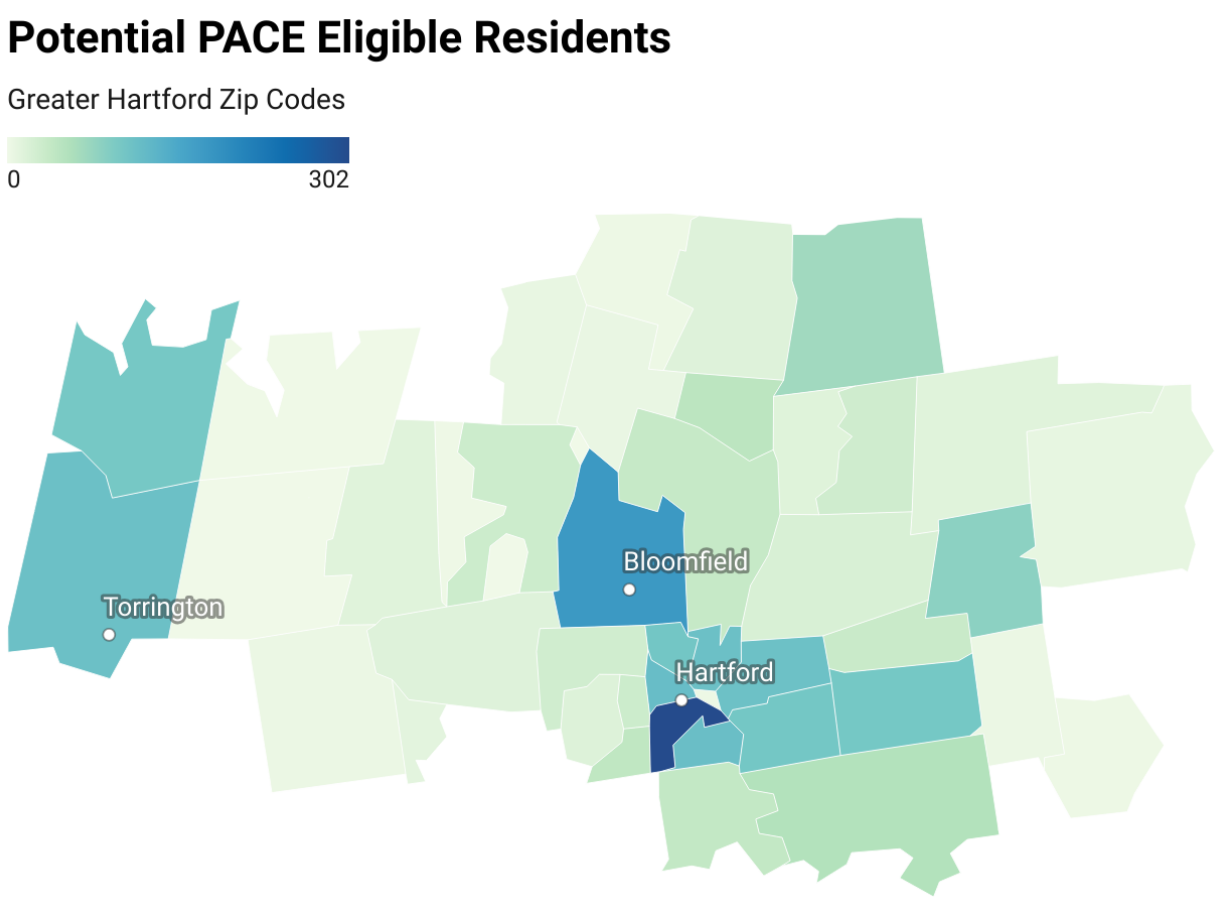
By Major Town

The southwest corner of the state and the greater Hartford area see the highest concentration of potential PACE-eligible residents. We explore these areas in more detail in the following maps.



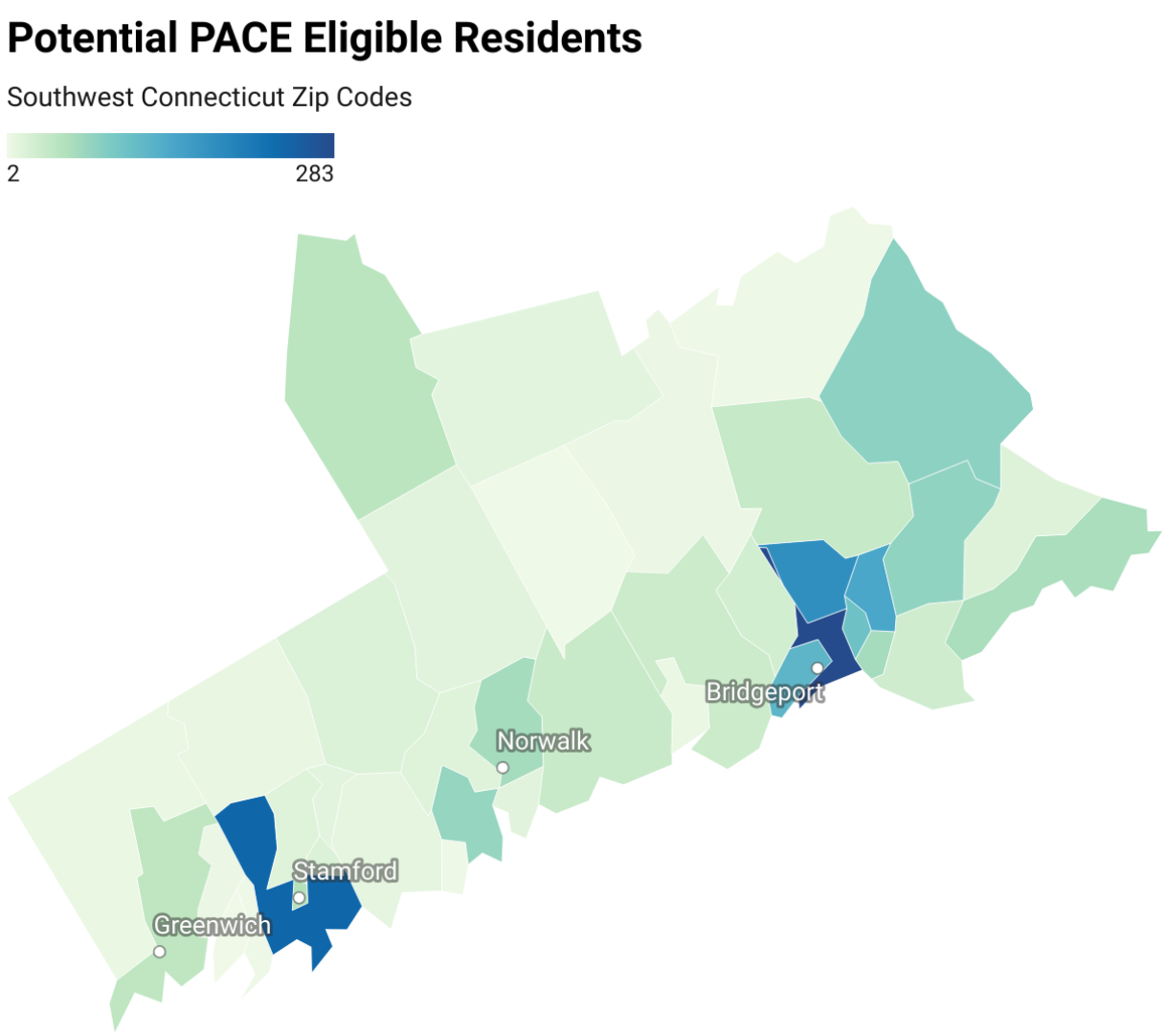
Greater Hartford

The largest concentration of potential PACE-eligible residents is centered on the greater metropolitan area of Hartford. The area below shows locations within a 45-60 minute drive of downtown Hartford and contains an estimated 2,140 potential PACE-eligible residents. This is nearly a quarter of the estimated PACE-eligible residents in the state. Zip code 06106, in the southwest corner of Hartford, contains the highest number of estimated PACE-eligible residents in the state with 302.



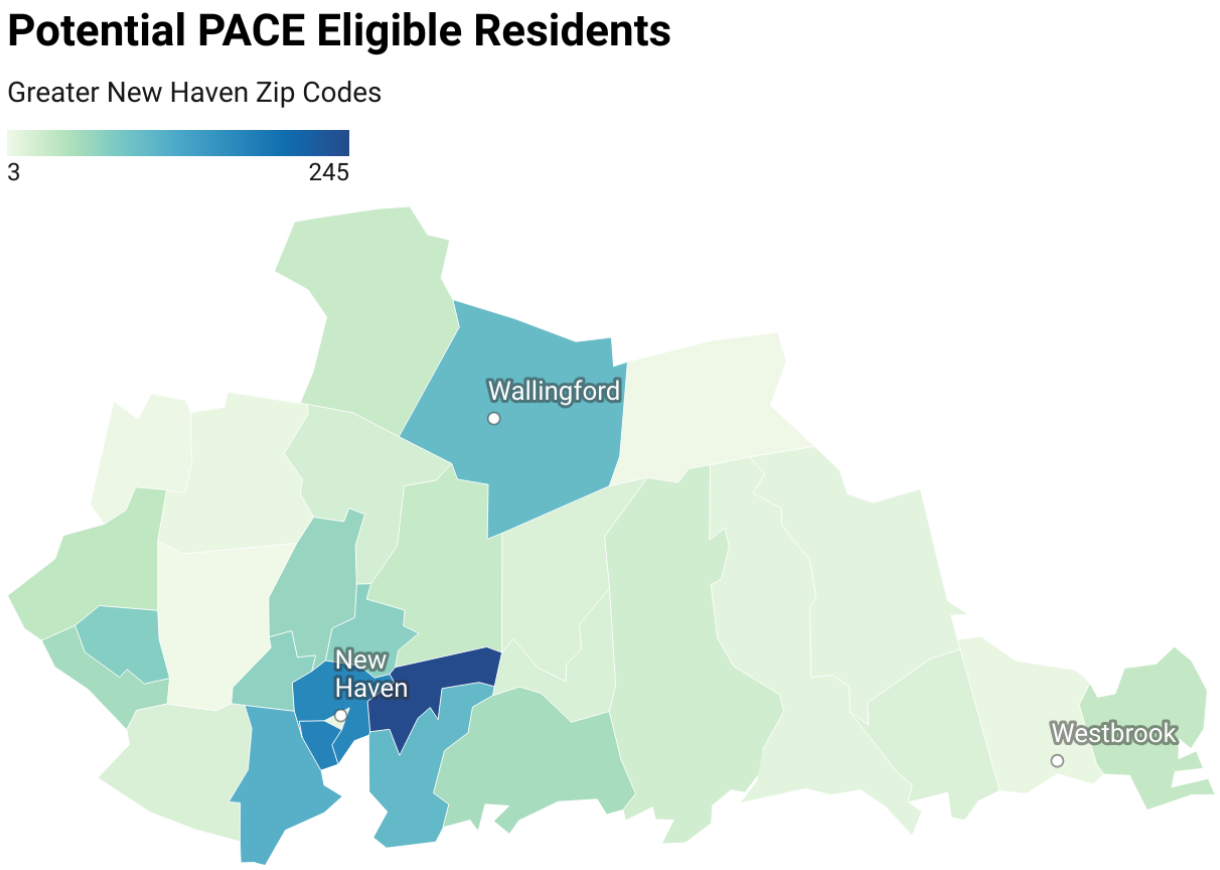
Bridgeport / Stamford / Norwalk / Greenwich

Along the I-95 corridor lie the towns of Greenwich, Stamford, Norwalk, and Bridgeport. The areas shaded in blues, below, represent a total of 1,981 potential PACE eligible residents. The highest concentration of these residents are in zip codes 06902 (Stamford) and 06604 (Bridgeport).



New Haven / Wallingford

Continuing eastward along the I-95 corridor and northward toward Hartford are the towns of New Haven, Westbrook, and Wallingford. This south central region, green-shaded in the map below, contains 1,605 residents we estimate to be PACE-eligible. Zip codes 06513 (New Haven) and 06492 (Wallingford), contain the highest number of potential eligible residents.



PACE Organization Benchmarking

For many years, PACE advocates have asserted that a PACE organization must have approximately 100 to 150 members in order to be viable. These same advocates have often stated that a 10 to 15 percent market penetration is a reasonable expectation for a PACE organization; that is, the PACE organization can expect to enroll approximately 10 to 15 percent of the eligible individuals in its service area. Thus, in order to achieve a minimum enrollment of 100, a prospective PACE organization service area would need to have at least 1,000 potentially eligible individuals.

PACE service areas must be fairly densely populated with potentially eligible PACE participants in order to make PACE a viable program. This is due to the heavy transportation and community services requirements placed on PACE organizations. We will further explore time and distance, as well as other health and economic factors within potential service areas, later in our study.

Other Connecticut Considerations

There are many factors that may influence the design, implementation, operation, and maintenance of a PACE program. Every state is encouraged to build programs to their uniqueness. Connecticut has no shortage of unique features and presents the opportunity to craft a PACE program to cater to those factors. As Connecticut explores the potential of a PACE program, there are many other factors to potentially consider. Several are offered below for initial consideration.

A. Advocates and Resources for Seniors

Seniors in Connecticut have no shortage of organizations, advocates, interest groups, and resources that seek to aid them. PACE would be another layer in this mix. The addition of PACE to Connecticut's programs will likely be of interest to many other entities that serve seniors in the state. Coordination, awareness, and sensitivity to and by these groups toward PACE would be highly valuable to the overall welfare of seniors in Connecticut. Below, we have highlighted some of the primary entities and stakeholders relevant to seniors and PACE.

- ***Department of Aging and Disability Services***

  With a mission to promote the self-sufficiency, independence, and overall health of seniors and those with disabilities, the Department of Aging and Disability Services is a major stakeholder in the welfare of the populations that would be served by PACE.

- ***Area Agencies on Aging (AAAs)***

  AAAs are private advocate organizations for seniors. They are involved in counseling, training, case management, education, and promotion of senior care in Connecticut. They typically help seniors obtain social services, nutritional services, disease prevention and health promotion services, caregiver services, and certain adult day care. AAAs are contracted with the Department of Aging and Disability Services.

- ***Long-Term Care Ombudsman Program***

  Connecticut's Long-Term Care Ombudsman advocates for the rights and safety of seniors in facilities, including nursing homes, residential care homes, assisted living facilities, and others. The Ombudsman also assists with information regarding long-term care facilities in the state.

- ***Aging and Disability Resources Center***

  Via its Community Choices Program, the Aging and Disability Resources Center offers seniors help planning for long-term care, facilitating transitional care, obtaining information regarding facilities and other options, assisting with applications, and other services. The program intends to be a complete resource to the community regarding all aspects of long-term care.

- ***Congregate Housing Services Program***

  With a mission to help seniors stay independent, the Congregate Housing Services Program helps eligible people to obtain housing assistance and other services, including housekeeping, companion, personal emergency response, transportation, and medication management. The program advocates for seniors to be healthy in their homes and communities and avoid institutionalization. The Department of Aging and Disability Services administers and funds the program in tandem with the federal Department of Housing and Urban Development.

- ***MyPlaceCT***

  MyPlaceCT serves as a resource center for caregivers and seniors seeking services. Online, telephonic, and in-person support is available to help people explore long-term care options, apply for services, examine facility quality, and find other needed information.

- ***Connecticut Partnership for Long-Term Care***

  Via a collaboration between the Connecticut Office of Policy and Management and private insurance companies, the Connecticut Partnership for Long-Term Care seeks to be a resource for those looking for long-term care, offering assistance finding affordable long-term care insurance and needed care with the least impact on personal assets.

B. Regional Considerations

Connecticut is a state steeped in history, with colonial roots. It is bordered by the states of New York, Rhode Island, and Massachusetts. The Atlantic Ocean is immediately south of the state. Connecticut's colonial birth and traditions, neighboring states, and proximity to the ocean all impact it. Regions in the state can be identified by traditions, income, history, industries, educational institutions, and other factors. We believe that PACE must be integrated with respect to the regional values and uniqueness of Connecticut, in addition to where potential participants are saturated and clustered in the various communities.

A vital component of PACE would be the selection of service areas covered by PACE organizations. States may elect to implement PACE state-wide, in certain urban centers, or with respect to geographical, infrastructural, economic, or other aspects. The full market analysis will take into consideration these geographical regions in greater detail. Below, we have highlighted the major regions in the state that are commonly recognized and could be studied further for PACE feasibility.

- ***Fairfield Region***

  Located in the southwestern area of Connecticut, on the shore, sits the Fairfield region. This region is in close proximity to New York and has many of the same economic, industrial, cultural, financial, and technological values of the neighboring state.

Hartford Region

Hartford is not only the capital of Connecticut; it has historically been known as the insurance capital of the world. The Hartford region also boasts historic New England-style homes, culture, and traditions. The University of Connecticut, Trinity College, University of Hartford, and the University of St. Joseph's are also located in the region.

Litchfield Region

The Litchfield Region is a confederation of 21 towns in northwest Connecticut. With its scenic areas and rich New England roots, the area has industries related to manufacturing and alternative energies.

New Haven Region

Yale University, Quinnipiac University, Albertus Magnus College, the University of New Haven, Southern Connecticut State University, and Gateway Community College are located in the New Haven Region of Connecticut.

New London Region

Along the Atlantic shore lies the New London Region of Connecticut. Steeped in colonial history and military importance, the region has a vitally valuable port and is home to the Coast Guard Academy. This area was the first port in Connecticut. Though now dominated by other maritime activities, such as submarine manufacturing, the area had a significant history in whaling.

Middlesex Region

Along the Connecticut River, with a significant American-Sicilian culture, the Middlesex Region was a hub of ship manufacturing during early colonial and American history. Middlesex has one of the highest median household incomes in the United States.

Tolland Region

Mostly rural in appearance, the Tolland Region is situated in North-Central Connecticut. Comprised of 13 towns, the area crosses into the Hartford Region and is home to the University of Connecticut's main campus.

Windham Region

When one pictures the traditional New England towns and homes painted into American culture, one is probably imagining the Windham Region. This area is mostly small communities. It also has key naval, manufacturing, and other military interests.

C. Community Beliefs, Heritage, Culture, and Values

PACE emphasizes community, and with regard to community, PACE seeks to cater to the makeup, values, beliefs, and other community customs and standards that may influence health care. PACE organizations may develop their structures, service mechanisms, staff, and other aspects based on the community they serve. Such things as language barriers, cultural perceptions, stereotypes, family models, religions, and traditions play a part of every person's decisions on when, how, where, and if to access health care services. PACE organizations and PACE program administrators should have a firm understanding of the populations served and try, to the most reasonable extent possible, to understand and accommodate cultural, religious, language, and other such factors that influence enrollees' care.

Although the state has one of the largest Italian-American populations in the United States, Connecticut also is home to many other cultures and communities, including French, Spanish, Japanese, British, South Korean, Swiss, Puerto Rican, Portuguese, Jamaican, Polish, Chinese, and many more. Studies have found that health care access and decisions by seniors can be influenced by their religious beliefs. The majority of Connecticut is Christian, with the largest group being Protestants. There are also large groups of Roman Catholics and non-religious residents. A small number of Jewish, Mormon, and Muslim people reside in Connecticut as well, along with other religious groups.

PACE organizations may fare better when they tailor their centers and services to fit the culture, beliefs, and values of potential and enrolled participants in the surrounding community. Health equity is a major theme, and the beliefs of enrollees may influence how they access services, participate in center activities, express their happiness with services, communicate with their health team, and comply with medical plans. Muslim participants may have particular requirements for service hours during daily prayer times and Ramadan. Muslim and other women may have particular beliefs about men other than their spouses coming in contact with them, affecting primary care physician selection and other services. Other religions may have aversions to transfusions, palliative care, medication content, or seemingly thwarting the will of a spiritual entity. In some faiths and cultures it is viewed as rude to disagree with service providers, and participants may not actively express themselves in making decisions about their care. Fasting, aversions to modern medicine, preferences for herbal medicines, and faith-healing can all influence health care as well. While it may seem a minor factor in the often small numbers of minority PACE participants, CMS, the National Committee on Quality Insurance, and the Joint Commission on Accreditation of Healthcare Organizations all emphasize cultural competency for organizations.

D. Adult Day Care – A Key Factor in Participant Well-Being

At the heart of PACE organization services lies adult day care services. These services typically become the hub of social, cognitive, nutritional, and health promotion activities for participants. It is probably the most important service that assists seniors in realizing their greatest personal satisfaction and promotes good health outcomes from PACE by keeping participants mentally and physically active. Physical and mental activity are important to all people's health care and critically important to seniors'

health. Adult day care is where participants interact, discuss various topics, and otherwise engage with each other and the organization's staff in mental and physical activities. It is critically important to PACE organizations and the success of PACE, from the participant perspective, that adult day care shine. Adult day care centers may offer services such as medication management, recreation therapy, trips, outside activities, meals, nutritional counseling, transportation, social workers, aides, spiritual services, showers and baths, participant need-based-bathrooms, rehabilitation, and more. Participants may engage in group and individual activities such as dancing, music, exercise class, cooking, games, sewing, knitting, computer classes, bingo, cards, and sporting event outings. For dual-eligible participants, the low cost of participating in the PACE program is a very attractive option for seniors and their caregivers who want better socialization, less isolation and loneliness, and more cognitive and physical activities, as well as better health outcomes.

Overview of the PACE Feasibility Study

Myers and Stauffer has been engaged by the Connecticut Department of Social Services (DSS) to conduct a feasibility study to offer recommendations on whether to adopt and implement the Medicaid optional State Plan service for PACE. The goal of the study is to prepare information that assists the Department with a recommendation on whether a PACE program is right for the State of Connecticut and how to move forward, if appropriate.

The feasibility study consists of two primary components – an in-depth market analysis and a readiness assessment.

In-Depth Market Analysis

Myers and Stauffer will build upon the preliminary market study performed to inform this Interim Report. In addition to the market inventory and estimation of the number of PACE-eligible participants, the following associated activities will be conducted:

- *Convene focus groups to gain input from stakeholders in areas of the state where individuals may be a good fit for the program and gather any other input that may inform the feasibility study, including an assessment of support for the program.*
- *Identify underserved and/or health shortage areas or target areas suggested by DSS.*
- *Identify areas of the state that appear to be viable PACE markets based on estimated eligible residents.*
- *Assess criteria for consideration when constructing potential PACE service areas in Connecticut, such as areas where provider networks may be insufficient.*
- *Design potential PACE service areas throughout Connecticut in consideration of potential cultural and geographic boundaries.*
- *Analyze current waiver enrollment to identify areas where there is adequate coverage of services and, therefore, PACE viability may be challenging.*
- *Evaluate potential workforce availability to support markets identified within the state.*
- *Create heat map overlays to illustrate potential PACE eligibility, proposed service areas, underserved areas, waiver lists, and labor shortages, where appropriate.*

State Readiness Assessment

The second component of the PACE feasibility study will involve assessing the existing infrastructure in the state to determine its ability to support a PACE program. We shall:

- *Perform compressed scope assessment of existing Medicaid Management Information System, eligibility determination process, level-of-care determination process, capitation screens, encounter process, policies and procedures to determine readiness, and feasibility to implement PACE.*
- *Perform compressed scope assessment of licensing, regulations, State Plan, waivers, policies, and procedures.*
- *Evaluate DSS internal resources and systems that would be necessary for implementation and support of PACE.*
- *Perform preliminary assessment of potential rate setting issues involving the computation of the AWOP for rate bands in service regions under consideration, given the administrative services organization model used in Connecticut.*
- *Discuss potential quality monitoring goals and assist DSS with establishing a vision for quality oversight.*
- *Evaluate provider interest through a town hall-style stakeholder meeting, which could be conducted virtually or in-person and will allow potentially interested providers to identify themselves, ask preliminary questions, and have dialogue with DSS.*
- *Determine, based on the stakeholder meeting, which providers are interested, whether they have the resources for the necessary investment, and whether they have financial resources and experience necessary to start a PACE organization. These data points could be gathered through a carefully crafted limited scope survey or in a request for information that is part of another initiative.*

Following these activities, Myers and Stauffer will synthesize information from the feasibility study and draft a report of findings. The draft will include findings and recommendations, as applicable, for the Department's consideration.

Conclusions

PACE has the potential for both advantages and disadvantages; however, experiences reflect that the benefits of PACE to participants, states, and other stakeholders typically outweigh the negative aspects in most states. Most negatively viewed aspects of PACE can be overcome with careful design and coordination as well as cultural competency, community integration and collaboration within the health care infrastructure, and appropriate financial awareness.

PACE is a program that, when implemented with effective communication and transparency, many participants find they greatly enjoy. The next phase of the assessment will have the opportunity to engage stakeholders to inform the study and to learn more about the Connecticut health care ecosystem. Time constraints limited some of these activities in this initial phase. Based on past research, PACE generally has good efficacy and high consumer satisfaction. However, each state is unique with respect to resource needs and opportunity cost.

Connecticut has many clearly-defined population centers and regions where those who are eligible to participate in PACE reside. With an analysis of the existing health care infrastructure of service providers who specialize in care needed by seniors, PACE service areas could be developed in several areas of the state. It will be important to assess other health care and economic conditions in potential service areas and overlay the information to get a better picture of true PACE potential for both eligibility and possible PACE providers who may be interested in operating in Connecticut.

The existing long-term care and long-term services and supports environment in Connecticut is characterized by many programs that could potentially complement PACE. Preliminary research suggests that most existing programs in Connecticut are highly saturated with participants and have some cost considerations. PACE can complement the current situation and offer more options for seniors to receive needed care and remain independent.

Based on our experience, there are multiple options available that state agencies can use to procure and establish relationships with PACE organizations. These include a letter of intent selection process, request for application, request for information procurement, or request for proposal. Detailed information for each of these options will be included in the final report once specific Connecticut procurement processes are thoroughly analyzed.

Our preliminary estimates of Connecticut seniors eligible for PACE participation reflects a strong pool of potential PACE participants. The potential participant pool requires additional study to best assess the services currently being received, better confirm eligibility, better understand the cultural and social needs of the population, and assess other factors that can be used to forecast potential PACE eligible

residents and assist development of service areas. It is important to reiterate that we did not have the opportunity to evaluate PACE in relation to other programs, which is an important aspect of the study.

We look forward to working with DSS to complete the PACE Feasibility Study. Questions regarding the study should be directed to Angelique Pearson, Department of Social Services at angelique.pearson@ct.gov. Questions regarding Myers and Stauffer or general PACE questions should be directed to Jared Duzan, principal, at jduzan@mslc.com.