DEPARTMENT OF HUMAN SERVICES

Legislative Report

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

Managed Care Contracting and Rates/Aging Divisions

Aging and Adult Services

November 2024

For more information contact:

Minnesota Department of Human Services
Aging and Adult Services
P.O. Box 64976
St. Paul, MN 55164-0976

651-431-2600

For accessible formats of this information or assistance with additional equal access to human services, email us at DHS.info@state.mn.us, call 651-431-2000, or use your preferred relay service. ADA1 (3-24)

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $173,000.

Printed with a minimum of 10 percent post-consumer material. Please recycle.

Contents

Program of All-Inclusive Care for the Elderly (PACE) Implementation Analysis....1
Managed Care Contracting and Rates/Aging Divisions....1
Aging and Adult Services....1
Contents....3
Revision History....5
Document Purpose....5
I. Executive Summary....6
II. Legislation....10
III. Introduction....11
III.i Project Background....11
III.ii Methodology....14
III.iii Deliverable Assumptions....15
IV. PACE Administrative Framework....16
IV.i PACE Overview....16
IV.ii Findings from the Literature Review....19
IV.iii PACE Operational Overview for States....25
IV.iv Financing and Payment Model....26
IV.v Requirements of the PACE Model for PACE Organizations....28
V. PACE Actuarial Analysis....37
VI.i Insights from Other States....38
VI.ii Participant Outreach and Enrollment....46
VI.iii MSHO, MSC+, and Special Needs Basic Care (SNBC) Landscape....47
VI.iv Program Design and Implementation....49
VI.v State-Specific Criteria and Licensing....55

VI.vi PACE Approval Process 58
VI.vii SAA Ongoing Administration and Oversight 60
VI.viii PACE Implementation Checklist 61
VII. Results of Community Engagement 64
VII.i Background 64
VII.ii Minnesota Agency Engagement Session 66
VII.iii Community Member Engagement Session 1: Fall 2023 67
VI.iv Community Member Engagement Session 2: April 2024 70
VII.v Community Member Engagement Session 3: Spring 2024 72
VIII. Conclusions and Considerations 74
VIII.i Additional Considerations 76
IV. Appendices 79
Appendix A: List of Acronyms 79
Appendix B: List of Community Member Engagement Session Attendees 82
Appendix C: PACE Member Rights 84
Appendix D: Adult Day Compliance Checklist 87
Appendix E: NOIA 90
Appendix F: Clarification of Fiscal Soundness Memos 91
Appendix G: Community Member Feedback Letters 94
Actuarial and Financial Considerations 94
Implementation & Operational Considerations 95
Stakeholder Outreach Considerations 96
Appendix H: PACE Membership Rates 113
Appendix I: Actuarial Analysis 115

Revision History

The Revision History identifies the document version number, date, and a brief description of revisions applied.

Table i: Version History

Document Iteration	Date	Revisions Applied
1.0	11/13/2023	Initial Deliverable Expectations Document (DED) Draft
2.0	12/15/2023	DED Draft v2.0
3.0	1/31/2024	DED Draft v3.0
4.0	4/26/2024	Initial Report
4.1	5/16/2024	Initial Report updated based on discussion with DHS
5.0	6/18/2024	Final Report

Document Purpose

The purpose of this Final Report is to build on the initial background information on administrative frameworks for a potential PACE in Minnesota. This Final Report includes information gathered as part of December 2023, April 2024, and May 2024 Community Member sessions as well as peer state research. The Final Report also details the PACE administrative framework, implementation components, and overview of actuarial analysis. The outputs of the project and the information provided in this Final Report will help inform discussions at the legislature about whether to implement PACE in Minnesota.

I. Executive Summary

The Executive Summary of the PACE Implementation Analysis Final Report provides a high-level overview of the project. It lays out primary findings from the analysis of administrative framework and incorporates program considerations that impact PACE implementation.

The Program of All-Inclusive Care for the Elderly (PACE) is a unique, comprehensive medical and social services benefit design that is available to certain frail, community-dwelling, older individuals, most of whom are dually eligible for Medicare and Medicaid. The primary objective of PACE is to deliver comprehensive healthcare and support services to eligible older adults wanting to maintain their independence in the community, rather than residing in nursing homes or other institutional settings. PACE operates under a collaborative three-way relationship involving the Centers for Medicare & Medicaid Services (CMS), individual states, and PACE organizations. States can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit through a State Plan Amendment (SPA).

In 2023, legislation called for Minnesota DHS to conduct an actuarial and program analysis of implementing PACE. The actuarial and feasibility analysis of PACE aims to inform legislative discussions about whether to implement PACE. Minnesota DHS engaged BerryDunn to perform the administrative and implementation analysis, which included the following tasks:

- Analyzing the administrative framework and those items that impact the cost of PACE implementation and administration
- Facilitating community member engagement to elicit input on PACE framework options as well as on the PACE actuarial report
- Developing an Initial Report regarding administrative frameworks, as well as this Final Report regarding PACE implementation

Administrative Framework

The administrative framework for PACE is centered around three key organizations: CMS, the State Administrating Agency (SAA), and the PACE organization. Each of the three organizations is responsible for distinct aspects of PACE governance, oversight, and program execution. As of 2022, national PACE enrollment statistics show 90% of PACE members were dually eligible for Medicaid and Medicare with 9% solely eligible for Medicaid and being comprised of a relatively younger population. Finally, the remaining 1% were only eligible

for Medicare or alternatively used private pay to access PACE services.[1] Studies have demonstrated specific health benefits of PACE access and enrollment.

PACE organizations follow a capitated payment model. Capitation refers to a set rate paid monthly to PACE organizations in advance for services rendered to enrolled PACE members. A capitated payment model differs from a fee-for-service (FFS) model in that there is a single rate paid to the PACE organization based on the number of participants and their corresponding cohorts (e.g., age, gender, rural/urban) as opposed to the FFS model where payments are made to providers based on the services provided.

Actuarial Analysis

In February 2024, Milliman, Minnesota's contracted actuary, released their actuarial analysis for PACE in Minnesota. The report detailed illustrative capitated rates for calendar year (CY) 2024. While the rates do not represent actual payment for services, the rates indicate a potential Medicaid cost per member per month of PACE, not including the administrative costs of running the program for DHS. Milliman's Illustrative CY 2024 Capitation Rates for a Potential PACE is found in Appendix I.

Other State Experiences

As part of this report, BerryDunn performed a national scan to examine diverse state experiences with implementing PACE. PACE continues to grow nationally, with 155 currently operating PACE organizations in the U.S. In addition, BerryDunn collected in-depth research on three identified peer states' PACE models: Indiana, Michigan, and North Dakota.

BerryDunn found that the size of the programs varied among the three peer states, with North Dakota featuring one PACE organization enrolling just under 200 members in four locations, Indiana overseeing six PACE organizations with 543 members, and Michigan enrolling 4,589 members across 14 organizations. Similarly, the administration and oversight by the state varied as well. North Dakota and Indiana had one dedicated staff person managing the program, however they drew on additional internal expertise such as contracting staff, fiscal staff, quality staff, Home and Community Based Services (HCBS) staff, legal, and federal relations staff. Michigan followed a similar model with four dedicated staff that drew on additional internal expertise.

Staffing needs varied throughout the lifecycle of the program with more staff time needed for the start of the program. Overall, we estimate that the total need for Indiana and North Dakota was approximately 2-3 full time equivalents (FTEs) across all needs, while Michigan we estimate as many as 7 FTEs across all needs. FTEs are defined as full-time hours worked by all employees for a given program, like PACE. DHS will need to determine current staff capacity to manage the program and may need to anticipate a blend of hiring additional dedicated

[1] Harootunian, Laura et al. October 4, 2022. *Improving PACE: Improving Access to and Enrollment in Programs of All-Inclusive Care for the Elderly*. Bipartisan Policy Center. Accessed January 22, 2024. https://tinyurl.com/3c8y2tkc

staff along with internal experts in supporting departments. For implementation of PACE, additional support may be needed in the short term to design, develop, and implement PACE in Minnesota.

Long Term Care Landscape in Minnesota

Minnesota's long-term services and support (LTSS) environment includes a range of programs such as the Minnesota Senior Health Options (MSHO) program, which focuses on keeping aging adults in the community. MSHO and PACE differ and can remain separate and complementary programs in Minnesota. In a future state with both programs, enrollees who qualify for either could select the program that best fits their needs, geographic location, and future care goals.

As Minnesota considers PACE, it may also consider the feasibility of providing alternative HCBS to Medicaid-eligible individuals 55 through 64 years of age, essentially lowering the initial age limit for individuals who may benefit from Minnesota Senior Care Plus (MSC+), MSHO, or Elderly Waiver (EW). Currently, this age group may receive HCBS through the Minnesota Community Access for Disability Inclusion (CADI) waiver and Minnesota State Plan services in an FFS environment.

Implementation Considerations

Implementing PACE requires the clinical, financial, and administrative capacity necessary to deliver comprehensive, integrated care. Projecting a timeline for PACE implementation is dependent upon various factors. The implementation must consider the time needed for CMS review and approval of the application and finalizing the three-way agreement. In addition, there are factors at the state level, which include the size of legislative appropriations for both administrative resources and capitated payments, as well as the time needed to onboard resources to manage the PACE implementation.

Operational considerations, such as state-specific requirements (e.g., licensure and financial solvency) and how many PACE locations/centers the state wishes to implement will impact the timeline. State-specific requirements may require updates to state law or administrative code and implementing PACE simultaneously with multiple organizations and sites may elongate initial implementation. Finally, the timeline will also be impacted by the readiness of organizations interested in PACE, for example:

- Experience in providing LTSS
- Ability to meet state-specific licensure requirements
- Readiness of systems to manage participant enrollment, capitation payments, and claims processing for network providers
- Resources, including financial, for start-up and initial cash-flow, and
- Strategies for a marketing program

Considering all of the variables involved from the State initiating efforts to move forward with PACE implementation, up through CMS approval and the enrollment of the first PACE participant, an implementation timeline could range from 18-24 months.

Report Purpose

Just as each Medicaid program is unique, implementing new programs and services within Medicaid needs to be approached in a way that allows the buildup of the infrastructure needed and supports the states vision for providing services. The information in this report can support Minnesota as it considers the feasibility of implementing PACE and help DHS and policy makers determine the best timeline and approach for a PACE program in Minnesota.

II. Legislation

Minnesota Statutes 2023, Chapter 61, section 37;

Sec. 37. DIRECTION TO COMMISSIONER; FUTURE PACE IMPLEMENTATION FUNDING.

(a) The commissioner of human services shall work collaboratively with community members to undertake an actuarial analysis of Medicaid costs for nursing home eligible beneficiaries for the purposes of establishing a monthly Medicaid capitation rate for the program of all-inclusive care for the elderly (PACE). The analysis must include all sources of state Medicaid expenditures for nursing home eligible beneficiaries, including but not limited to capitation payments to plans and additional state expenditures to skilled nursing facilities consistent with Code of Federal Regulations, chapter 42, part 447, and long-term care costs.

(b) The commissioner shall also estimate the administrative costs associated with implementing and monitoring PACE.

(c) The commissioner shall provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance on the actuarial analysis, proposed capitation rate, and estimated administrative costs by March 1, 2024. The commissioner shall recommend a financing mechanism and administrative framework by September 1, 2024.

(d) By September 1, 2024, the commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance on the commissioner's progress toward developing a recommended financing mechanism. For purposes of this section, the commissioner may issue or extend a request for proposal to an outside vendor.

III. Introduction

The Introduction is divided into three major subsections. The first, Project Background, details the context, need, and history of the PACE Implementation Analysis project. The second, Methodology, outlines BerryDunn's approach for the analysis. The third, Assumptions, specifies assumptions for the construction of this Report.

III.i Project Background

Overview

In 2023, the Minnesota DHS selected BerryDunn to conduct an analysis related to PACE administrative framework and considerations of program implementation. The project team also assisted DHS through the facilitation of community engagement on the program needs and eventual implementation plan. The project outcomes included the development of an Initial Report in spring 2024 regarding the implementation of PACE in Minnesota. The project culminated with this Final Report delivered in June 2024, which details the PACE administrative framework, implementation plan, and overview of actuarial analysis completed by the actuarial vendor. The outputs of the project and the information provided in the Final Report will help inform discussions at the legislature about whether to implement PACE in Minnesota.

Current Landscape

Minnesota has a growing aging population, with the latest U.S. Census finding that approximately 17.4% of the Minnesota population is now age 65 and older.[2] In addition, over 13% of the population in Minnesota is between ages 55 and 65.[3] The Minnesota State Demographic Center estimates that by 2030, the ratio of adults age 18 to 65 to those older than 65 will be 3:1, representing a growth from the ratio in 2010 which was 5:1.[4] A 2022 article noted that 90% of Minnesota adults age 65 and older live independently in their homes, and more than 1 in 4 Minnesota adults between ages 65 and 74 remain in the workforce.[5]

[2] U.S. Census Bureau. July 1, 2022. *QuickFacts Minnesota.* United States Census Bureau. Accessed December 10, 2023. www.census.gov/quickfacts/fact/table/MN/PST045222

[3] Neilsberg Research. September 17, 2023. *Minnesota Population by Age*. Neilsberg Research. Accessed January 30, 2024. https://www.neilsberg.com/insights/minnesota-population-by-age/

[4] Dayton, Megan and Lee, Mark. October 2020. *Long-term Population Projections for Minnesota*. Minnesota State Demographic Center, Department of Administration. Accessed October 31, 2023. https://tinyurl.com/5n8et758

[5] Chmielewski, Megan. April 29, 2022. *7 Things to know about Minnesota's older adults*. Wilder Research. Accessed September 26, 2023. https://www.mncompass.org/data-insights/articles/7-things-know-about-minnesotas-older-adults

The current model of care for adults age 65 years and older with both Medicare and Medicaid in Minnesota is MSHO. While MSHO is a Dual Eligible Special Needs Plan (D-SNP); MSHO is actually a special type of D-SNP called a Fully Integrated Special Needs Plan (FIDE SNP).

According to an April 2019 report from the *U.S. Department of Health and Human Services (HHS), Office of the Disability, Aging and Long-Term Care Policy* FIDE SNPs must coordinate and be at risk for coverage of both Medicare and Medicaid services, including LTSS. FIDE SNPs must also have procedures in place for administrative alignment of Medicare and Medicaid processes and materials. FIDE SNPs may be eligible to receive additional Medicare payments depending on the overall frailty level of their enrollees. Quoting a 2015 report from Mathematica, HHS noted in their report: "FIDE SNPs are the most integrated delivery model outside of the PACE and the Financial Alignment Initiative demonstrations." [6]

FIDE SNPs

FIDE SNPs such as MSHO are D-SNPs that fully integrate Medicare and Medicaid. To obtain CMS approval to operate as a FIDE SNP, a plan must:

- Provide access to Medicare and Medicaid benefits under a single managed care organization.
- Coordinate the delivery of covered health care and LTSS, using aligned care management and specialty care network methods.
- Have CMS and State-approved procedures to integrate member materials, enrollment, communications, grievances, and quality improvement.

Minnesota DHS, working with its community including the legislature, has begun the process of evaluating additional options that may complement MSHO and help manage the needs of the aging population. To help understand other dual integration models, the state has undertaken an actuarial and implementation analysis of PACE that will inform legislative discussions about whether to implement PACE in Minnesota.

First authorized by the federal Balanced Budget Act (BBA) of 1997, the PACE model was established within the Medicare program as permanent. The BBA authorized states, through Medicaid, the ability to cover PACE services for members as a state plan option. The primary objective of PACE is to deliver comprehensive healthcare and support services to eligible aging individuals wanting to maintain independence in the community rather than residing in nursing homes or other institutional settings. The PACE model integrates healthcare and activities of daily living (ADL) services, making it advantageous for serving aging individuals.[7]

While PACE offers members a community-based and a comprehensive model of care, the implementation and management of the program requires additional administrative capacity from states. The additional administrative needs may add complexity to state Medicaid systems that leverage managed care to provide LTSS. States are required to cover various program implementation costs, including modifications to information systems for claims processing and data reporting, establishing program criteria for PACE, efforts to establish

[6] Assistant Secretary for Planning and Evaluation (ASPE). 2019. *Integrating Care through Dual Eligible Special Needs Plans (D-SNPs): Opportunities and Challenges.* ASPE.HHS.gov. Accessed June 11, 2024. https://tinyurl.com/2pycakb8

[7] Medicaid. 2023. *Programs of All-Inclusive Care for the Elderly Benefits.* Medicaid.gov. Accessed October 30, 2023. https://www.medicaid.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html

clinical oversight and quality assurance, and managing the review and approval process for PACE center applications.

Because MSHO is a FIDE-SNP, it resembles the PACE model by integrating care for primary, acute, and LTSS. Further, like MSHO, PACE has voluntary enrollment and includes Medicare Part D. PACE differs from the MSHO model as it serves those over age 55 rather than 65, is based on an adult day health center model, and those enrolled in PACE can be Medicaid-only or may participate under a private payment arrangement.

Table 1: PACE and MSHO Comparison

	PACE	MSHO
Population	Individuals who are Medicaid-only, private pay, or those who are dual-eligible (Medicare and Medicaid), age 55+	Individuals who are dual-eligible, age 65+
Integrated Care	PACE center with Interdisciplinary Team (IDT)	Assigned Care Manager Care Coordinator for HCBS
Level of Care	Must meet nursing facility (NF) level of care	NF level of care not required
Enrollment	National PACE Association (NPA) indicates 9% as the average national PACE market penetration rate	>40,000 people enrolled in 2023[8]
Risk	Full risk for scope of services	Full risk for scope of services
Type of Care	Primary, acute, and LTSS	Primary, acute, and LTSS
Private Pay Allowed	Yes	No
Voluntary Enrollment	Yes	Yes
Medicare Part D Included	Yes	Yes
Provider	Potential entity types that could be PACE organizations include LTSS providers, non-profit or for-profit health and hospital systems, tribal nations, and federally qualified health centers (FQHCs)	MSHO must be a health maintenance organization (HMO) or county-based purchasing plan[9]

PACE History in Minnesota

[8] Minnesota Department of Human Services. 2023. *Managed Care Enrollment Figures*. Department of Human Resources County Link. Accessed October 9, 2023. https://tinyurl.com/ymbdxr6k

[9] Stitt, Tom, and Higgins, Colin. February 24, 2021. *Exploring Partnerships in PACE Development*. Health Dimensions Group. Accessed March 15, 2024. https://healthdimensionsgroup.com/insights/blog/exploring-partnerships-in-pace-development/

In 2004, Minnesota was one of eight original states to participate in a CMS and NPA study to evaluate the barriers and opportunities for developing and implementing PACE. Following this study, the legislature authorized DHS to develop and implement PACE in Minnesota in 2005.[10] One requirement was that DHS would need to secure sufficient grant funding to cover the administrative costs of program development. Ultimately, DHS was unable to obtain grant funding, which prevented implementation of PACE at that time.

Subsequently, in 2010, the legislature appropriated administrative funding to DHS to help facilitate implementation of PACE.[11] The funding was available for two years with the requirement that DHS work in the interim to develop more permanent financing mechanisms to support the ongoing actuarial and administrative costs. In March 2011, DHS published an RFP to secure an entity to serve as a viable PACE organization. While the RFP was amended to extend the proposal deadline from June 2011 to October 2011, no proposals were submitted to DHS.

In 2023, various community members advanced legislation for the state to conduct an actuarial and administrative analysis of PACE in Minnesota. The information in this report is designed to supplement concurrent actuarial analyses and help inform discussions at the legislature about whether to implement PACE in Minnesota.

III.ii Methodology

BerryDunn has developed this report through meetings with key DHS staff and community members, as well as through information collected from peer states, CMS, and external agencies. In addition, a literature review was performed on the administrative cost and needs for a PACE in Minnesota, peer reviewed by subject matter experts (SMEs) on Medicaid and PACE and presented to DHS in an iterative format.

Approach

To understand the current Minnesota LTSS environment, report authors sought insight from state staff and external entities.

Report authors conducted a review of the literature relating to PACE, the LTSS workforce, the MSHO program, and Medicaid benefits and services.

Report authors also conducted reviews of three peer states that have experience with PACE: Indiana, Michigan, and North Dakota.

[10] Minn. Laws, 1 Spl. Sess., Chap. 4, Art. 7, Sec. 46, 2005, Accessed December 4, 2023. https://www.revisor.mn.gov/laws/2005/1/Session+Law/Chapter/4/

[11] Minn. Laws, 1 Spl. Sess., Chap. 1, Art. 25, Sec. 3, Subd. 9, 2010, Accessed December 4, 2023. https://www.revisor.mn.gov/laws/2010/1/Session+Law/Chapter/1/

Peer states were chosen based upon distinct program characteristics to compare and contrast to the Minnesota environment. BerryDunn also had direct insight from members of our team working with these states on PACE in a variety of capacities in the past.

To assess the feasibility of PACE for Minnesota, the report authors also defined criteria and assumptions based on the literature review and discussions with key DHS staff.

III.iii Deliverable Assumptions

This section describes BerryDunn's assumptions regarding the development of the Final Report.

Key assumptions for the development of the Final Report include:

- BerryDunn's access to key project personnel from DHS, including a project sponsor, contract manager, project manager, and DHS project team
- Office/meeting space in Minnesota, as needed, during community engagement sessions
- Access to state project data repositories and necessary documentation, including state classification and compensation information
- Availability of the state's actuarial vendor to BerryDunn for questions and information pertinent to the project work

IV. PACE Administrative Framework

The Administrative Framework section details the structure that will inform planning for a Minnesota PACE model. It also includes components such as staffing, regulatory oversight, and compliance. This research includes both specific states and national resources.

IV.i PACE Overview

Congress first authorized a national PACE demonstration in 1986. In 1997, Congress authorized Medicare to pay for PACE services and added PACE as an optional Medicaid state plan benefit, giving joint administration and oversight of the program to CMS and states. To participate, states must designate an SAA to oversee the program.[12,13] PACE organizations provide all Medicare-covered services and all Medicaid-covered services included in the state's Medicaid plan, as well as other services and supports deemed necessary by the PACE organization's interdisciplinary team. Certain limitations built into Medicare benefits are waived for PACE, including limitations on coverage for institutional services, limitations on extended in-home care, and Medicare's three-day hospitalization requirement for accessing extended care services.[14]

Through prepaid, capitated payments from both Medicare and Medicaid, the PACE delivery model is designed to meet four primary objectives:

- Enhance the quality of life and autonomy for frail, older adults.
- Maximize dignity and respect for older adults.
- Enable frail, older adults to live in their homes and in the community as long as medically and socially feasible.
- Preserve and support the member and their informal caregivers.13F[15]

PACE Nationally

- Available in 33 state Medicaid programs
- 154 PACE organizations
- Over 300 PACE centers
- Serving approximately 70,000 members

[12] National PACE Association (NPA). 2023. *PACE History*. NPA. Accessed September 25, 2023. https://tinyurl.com/rcy9ysaj

[13] National PACE Association (NPA). 2023. *Find a PACE Program*. NPA. Accessed September 28, 2023. https://www.npaonline.org/find-a-pace-program

[14] 42 CFR §460.94(b), Oct. 1, 2002. Federal Register. Accessed November 20, 2023. https://tinyurl.com/2r8a5vs5

[15] Centers for Medicare and Medicaid Services (CMS). 2011. *Program for All-Inclusive Care for the Elderly (PACE) Manual, Chapter 1: Introduction to PACE*. CMS.gov. Accessed November 6, 2023. https://tinyurl.com/358nur5j

To support these objectives, PACE organizations are required to have enhanced care features, such as interdisciplinary teams, comprehensive assessments, and plans of care that integrate behavioral health, health-related social needs, and individual and caregiver preferences.[16]

PACE Administrative Framework

The administrative framework for PACE is centered around three key organizations: CMS, the SAA, and the PACE organization, detailed in Table 2 below. Each of the three organizations is responsible for distinct aspects of PACE governance, oversight, and program execution. The framework's hierarchy is necessary to provide multiple levels of administration and regulatory oversight for the care delivery model.

Table 2: Responsibilities by Organization

Organization	Key Responsibilities
CMS	Provides regulatory oversight and enforces program compliance Establishes program and performance standards Provides technical assistance to states and PACE organizations Conducts program audits Issues regulations and guidance documents Oversees program compliance and implementation for consistency across jurisdictions Makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicare participant in the payment area Approves the monthly Medicaid capitation amount to be paid to PACE organizations
SAA	Establishes NF level of care eligibility standard for the program Determines the process and state entity that conducts program enrollment Enforces compliance for eligibility and enrollment Establishes capitated rates in negotiation with PACE organization Oversees program quality monitoring and quality reviews Audits PACE organizations for effectiveness and member outcomes
PACE Organization	Responsible for employing or contracting the providers needed to ensure the provision of services to members

[16] 42 CFR §460.102. Oct. 1, 2002. Federal Register. Accessed November 20, 2023. https://tinyurl.com/2r8a5vs5

	Coordinates the IDT, which includes established teams of healthcare professionals such as physicians, nurses, social workers, and therapists Organizes the full spectrum of care, including primary and specialty healthcare, home care, adult day care, transportation, and social services Ensures financial viability/solvency of PACE organization Conducts outreach, engagement, and advocacy Engages members in care decisions Promotes health and wellness initiatives Provides encounter data to SAA, as required by contract

Medicaid- and Medicare-Only Programs

As of 2022, national PACE enrollment statistics show 90% of PACE members were dually eligible for Medicaid and Medicare; 9% were eligible for Medicaid only, being comprised of a relatively younger population. Finally, 1% were only eligible for Medicare or alternatively used private pay to access PACE services.[17] At least one state, Virginia, has established state code that restricts PACE enrollment to those individuals who participate in programs authorized pursuant to Title XIX (Medicaid) or Title XVIII (Medicare) of the United States Social Security Act, respectively.[18]

PACE is designed to serve those who are age 55 and older. The under age 65 group has primarily accessed PACE through Medicaid if they are not disabled or do not have ESRD or amyotrophic lateral sclerosis (ALS). Individuals under age 65 with the following diagnoses may not qualify for Medicare before the 24-month disability waiting period: early onset dementia, multiple sclerosis (MS), and chronic obstructive pulmonary disease (COPD).[19] Therefore, these individuals who would benefit from PACE could qualify for PACE through Medicaid only.

Medicare Eligibility

Most individuals age 65 and older who have been U.S. citizens or legal residents for over five years qualify for Medicare, provided they have 40 work quarters.

In addition, those under age 65 who have a qualified disability for at least 24 months, or who have end-stage renal disease (ESRD) or ALS qualify for Medicare.

[17] Harootunian, Laura et al. October 4, 2022. *Improving PACE: Improving Access to and Enrollment in Programs of All-Inclusive Care for the Elderly*. Bipartisan Policy Center. Accessed January 22, 2024. https://tinyurl.com/3c8y2tkc

[18] § 32.1-330.3. 2020.*Operation of a PACE plan; oversight by Department of Medical Assistance Services*. Accessed April 10, 2024. https://law.lis.virginia.gov/vacode/title32.1/chapter10/section32.1-330.3/

[19] AARP. March 23, 2021. *What Medical Conditions Qualify Someone for Social Security Disability Benefits?* AARP. Accessed January 22, 2024. https://www.aarp.org/retirement/social-security/questions-answers/medical-conditions.html

IV.ii Findings from the Literature Review

To gather background research relevant to PACE, the BerryDunn team reviewed a variety of sources to help survey a national landscape and best practices. The highlights of these findings are detailed below.

Program Outcomes

Studies have demonstrated specific health benefits of PACE access and enrollment. One study found that PACE members were less likely to be institutionalized than similar members under 1915(c) HCBS aged and disabled waiver programs based on available longitudinal data from 12 PACE participating states.[20] When the PACE participants did enter NF care, the participants had higher cognitive and physical impairment, demonstrating PACE organizations were able to maintain individuals in the community through higher levels of care.[21] However, the aforementioned study did not differentiate between non-integrated waiver programs and integrated Medicaid/Medicare models like MSHO, as fully integrated programs report improved outcomes and member satisfaction.[22]

PACE members appear to have fewer hospitalizations than dually eligible participants in other care settings requiring NF level of care. In addition, rates of potentially avoidable hospitalizations were substantially lower in PACE than dually eligible HCBS waiver for conditions such as COPD, asthma, congestive heart failure, dehydration, and urinary tract infections. [23]

In a 2018 caregiver survey, Vital Research surveyed 973 family caregivers of individuals enrolled in 30 PACE centers. Caregiver perceived stress level was surveyed before and after PACE enrollment. Overall, caregiver stress was reduced 58% after PACE enrollment.[24]

[20] Micah Segelman, Xueya Cai, Christine van Reenen, Helena Temkin-Greener. April 1, 2017. *Transitioning From Community-Based to Institutional Long-term Care: Comparing 1915(c) Waiver and PACE Enrollees*. The Gerontologist, Volume 57, Issue 2, 1 April 2017, Pages 300–308. Accessed December 10, 2023. https://doi.org/10.1093/geront/gnv106

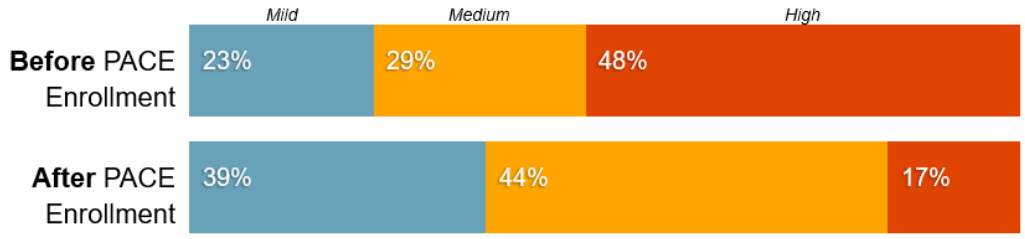
[21] Micah Segelman, Xueya Cai, Christine van Reenen, Helena Temkin-Greener. April 1, 2017. *Transitioning From Community-Based to Institutional Long-term Care: Comparing 1915(c) Waiver and PACE Enrollees*. The Gerontologist, Volume 57, Issue 2, 1 April 2017, Pages 300–308. Accessed December 10, 2023. https://doi.org/10.1093/geront/gnv106

[22] Anderson, Wayne, and Feng, Zhanlian. March 30, 2016. *Minnesota Managed Care Longitudinal Analysis*. Office of the Assistant Secretary for Evaluation and Planning (ASPE). Accessed January 20, 2024. https://tinyurl.com/dn88p8yc

[23] Segelman, Micah et al. January 13, 2024. Hospitalizations in the Program of All-Inclusive Care for the Elderly. Journal of the American Geriatrics Society (AGS). Accessed October 30, 2023. https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.12637

[24] Urman, Harold. 2019. *PACE Enrollment Reduces Burden On Family Caregivers.* Vital Insights. Accessed March 2, 2024. https://vitalresearch.com/insights/PACE-enrollment-reduces-burden-on-family-caregivers.html

Figure 1: Reductions in Burden Levels Following PACE Enrollment[25]



Case Study: PACE in Wyoming

Wyoming's Implementation timeline

- **2010** Legislature lays the groundwork for PACE
- **2011** CMS approves PACE SPA in September
- **2012** PACE provider submits its application in February
- **2012** Governing agreement signed in December

Wyoming Medicaid funded a PACE program in Cheyenne from 2013 until 2020, when the program was cut as part of budget reductions. In 2023, a legislatively required study sought to understand whether it would be cost-effective to reestablish PACE in the state. The study- developed internally by the Wyoming Department of Health- concluded that it would not be cost effective to restore PACE. Specifically, retiring PACE saved roughly $1.6 million in state General Funds per biennium, and a cost-effective rate for administration would actually be lower than the $2,250 per member per month (PMPM) paid previously.

The single PACE provider in Wyoming invested approximately $10 million in capital and staff and began services in 2012. The provider employed 45 staff and steadily grew to serve its peak of 140 members by 2018. Wyoming Medicaid employed two employees who also spent a percentage of their time working for the larger Community Choices waiver program.

In 2023, rather than reestablish PACE in the state, the Wyoming Department of Health proposed three alternatives to its legislature for consideration:

- Increasing rates for selected home-based Medicaid services with low utilization, like non-emergency transportation or adult day care
- Bundling core PACE services into a rate that could be billed on a per-diem basis
- Exploring the development of a state-operated Medicare Advantage plan[26]

[25] [25] Urman, Harold. 2019. *PACE Enrollment Reduces Burden On Family Caregivers.* Vital Insights. Accessed March 2, 2024. https://vitalresearch.com/insights/PACE-enrollment-reduces-burden-on-family-caregivers.html

[26] Wyoming Department of Health 2023. *Aging in Wyoming Part III: Reviewing the Program of All-Inclusive Care for the Elderly, and alternatives*. Accessed April 10, 2024. https://tinyurl.com/53t6xxvm

Feasibility in Minnesota

A unique challenge for Minnesota is the demand for older adult services in rural counties where there are fewer people of working age to provide care. In 2017, a report estimated that 21% of the rural Minnesotan population was 65 years old or older.[27] The Minnesota Department of Health (MDH) estimated that by 2033, 32% of the population in rural Minnesota counties is projected to be 65 years or older. Additionally, about 20% of the Medicaid-eligible adults age 65 and older reside in rural areas in Minnesota, nearly double the national average of 11.3%.[28] The higher proportion of aging adults in rural Minnesota presents opportunities and obstacles for the implementation of PACE.[29]

Hub and Spoke Model

- A hub and spoke model describes the arrangement in which a rural and a non-rural site within driving distance are connected operationally.
- An example of hub and spoke model is North Dakota's PACE (further discussed in Section 5.1)
- The Bismarck (non-rural) site was established first and subsequent Dickinson (rural) site benefited from the Bismarck PACE experience and shared administrative staff.

Rural areas have unique challenges including staffing shortages, availability of practitioners to contract with, and periods of low enrollment. At the time of a 2011 report to Congress, the most successful rural PACE centers were connected operationally to a non-

[27] Minnesota State Demographic Center, Department of Administration. January 2017. *Greater Minnesota, Refined and Revisited.* Accessed April 4, 2024. https://mn.gov/admin/assets/greater-mn-refined-and-revisited-msdc-jan2017_tcm36-273216.pdf

[28] Blewett, Lynn. N.d. *Demographic, Social, and Economic Characteristics of the General Population of Minnesotans aged 65 and Older.* State Health Access Data Assistance Center, University of Minnesota, School of Public Health. Accessed March 13, 2024. https://www.shadac.org/sites/default/files/resources/LTSS/Demographic-Social-Economic-Characteristics-Minnesotans-65+.pdf

[29] Minnesota Department of Health (MDH). November 18, 2021. *Rural Health Care in Minnesota: Data Highlights*. Division of Health Policy, MDH. Accessed October 1, 2023. https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmndata.pdf

rural PACE center within driving distance, referred to as the "hub and spoke" model.[30]

The NPA outlined key success factors for PACE center selection. These factors include sufficient demand for PACE in the community where the PACE center is located, strong referral sources, state support for PACE, the ability for the PACE sponsor to take on financial risk, and adequate capital investments into the physical PACE center, such as equipment, vans, and information technology (IT) hardware and software.[31]

In 2022, a study with PACE directors from across the country revealed that PACE has not avoided the workforce crisis, as 97% of PACE directors said they were experiencing a workforce shortage, particularly with filling open positions and higher-than-usual turnover. Direct care staff positions were hardest to fill, followed by nurses and drivers. However, direct care staff for PACE centers tended to have higher job satisfaction and felt more valued than direct care workers in other settings, particularly through the support of the IDT structure. PACE entities also have additional flexibility within the capitated rate structure for investment in the recruitment, retention, and pay of direct care staff. [32] Therefore, only 13% of PACE centers limited the number of newly enrolled members due to workforce shortages, compared to more than 50% of NFs.[33]

Minnesota has historically prioritized rebalancing LTSS toward HCBS through programs such as MSHO, MSC+, EW, and Alternative Care (AC). HCBS programs support people remaining in the community for longer periods of time, often avoiding the need for institutional care. At times, living independently with in-home supports can lead to feelings of isolation. PACE may specifically support and enhance the quality of life for people who reside in the community independently and help prevent isolation through the structure of the PACE center.[34]

Cost

A review of reports published over the past decade suggests that PACE costs less per member than comparable care provided in other care environments. In a 2021 report, CalPACE—an advocacy organization—estimated the state pays $130.8 million less for a year of PACE than if the current PACE participants were served in other

[30] Sebelius, Kathleen. 2011. *Report to Congress: Evaluation of the Rural PACE Provider Grant Program*. Secretary of Health and Human Services. Accessed October 5, 2023. https://tinyurl.com/3bx2tv6x

[31] National PACE Association (NPA). N.d. *Understanding the PACE Operating Experience and Critical Success Factors*. NPA. Accessed November 7, 2023. https://tinyurl.com/mryyc43m

[32] McCall, Stephen. February 16, 2023. *The Health Care Workforce Crisis Arrives at the PACE Model.* Altarum. Accessed March 2, 2024. https://altarum.org/news-and-insights/health-care-workforce-crisis-arrives-pace-model

[33] American Health Care Association (AHCA). 2023. State of the Nursing Home Industry: Survey of 425 nursing home providers highlights persistent and economic crisis. ACHA. Accessed March 2, 2024. https://tinyurl.com/3j86a8rv

[34] Blewett, Lynn. N.d. Demographic, Social, and Economic Characteristics of the General Population of Minnesotans aged 65 and Older. State Health Access Data Assistance Center, University of Minnesota, School of Public Health. Accessed March 13, 2024. https://www.shadac.org/sites/default/files/resources/LTSS/Demographic-Social-Economic-Characteristics-Minnesotans-65+.pdf

programs outside of PACE. Compared to the cost of institutional care, the 2021 monthly capitation rate for PACE was approximately 40% less for a dual-eligible member in California.[35]

According to the NPA in 2019, the PACE rates were 13% less than the cost of alternatives providing services to a similar population.[36]

In a 2022 report by the Bipartisan Policy Center, cost savings were noted per PACE member as compared to serving those individuals through a Medicaid waiver or NF. In a demonstration application to CMS, Oklahoma noted that with 100 participants, the Cherokee Elder Care PACE saved the state $103,587 per month and around $1.2 million per year. South Carolina predicted savings around $9,000 per PACE member annually. Wyoming operated a PACE in Cheyenne from 2013 to 2020, when the program was cut as part of significant budget reductions.[37] During the program's operation between 2015 and 2020, Wyoming paid approximately $12,000 per member less annually as compared to the amount paid for a nursing home resident.[38]

While these reports of cost savings are worth noting when evaluating various factors that influence a states' decision about implementing PACE, it should be noted that none of the studies cited compared a FIDE SNP, which is how MSHO is classified. Furthermore, because MSHO has more than twenty years of experience, which includes coordinating Medicare as well as Medicaid state plan and Medicaid waiver services, the expected savings to Minnesota Medicaid for members choosing PACE instead of MSHO will be less than savings that would be expected in a state that lacks a FIDE SNP model, primarily operating as FFS.

Adaptability

PACE was able to adapt to the COVID-19 pandemic in a way that NFs and assisted living providers were unable to. Though PACE relies heavily on day programming, PACE providers broadly were able to flex toward home-based care, reducing the risk of infection for participants.

According to an NPA article written in October 2020 based on data reported by 107 PACE organizations, 1.6% of PACE participants had died as a result of COVID-19. This figure was less than half the COVID-19-related death rate (3.4%) of individuals who had the same level of care in other service settings, such as NFs and assisted livings.[39]

---

[35] CalPACE. March 4, 2021. *PACE Cost-Effectiveness*. CalPACE. Accessed December 20, 2023. https://tinyurl.com/y24d5uzd

[36] National PACE Association 2019. *PACE: Frequently Asked Questions*. National PACE Association. October 2019. Accessed December 20, 2023. https://tinyurl.com/42e4j9pc

[37] Wyoming Department of Health 2023. *Aging in Wyoming Part III: Reviewing the Program of All-Inclusive Care for the Elderly, and alternatives*. Accessed April 10, 2024. https://tinyurl.com/53t6xxvm

[38] Harootunian, Lisa, et al. October 4, 2022. *Improving PACE: Improving Access to and Enrollment in Programs of All-Inclusive Care for the Elderly (PACE).* Bipartisan Policy Center. Accessed December 21, 2023. https://bipartisanpolicy.org/report/improving-pace

[39] Fitzgerald, Peter. October 20, 2020. *The PACE Response to COVID-19 Calls for Policy Actions Increasing Access and Affordability.* Better Care Playbook, National PACE Association. Accessed December 21, 2023. https://tinyurl.com/5a87n5re

A case study conducted by the University of California, Berkeley examined COVID-19 pandemic response by WelbeHealth, a California PACE provider, that, as of June 2021, served 750 participants. The provider experienced no COVID-19 related deaths for the first eight months of the pandemic, and experienced 10 COVID-19 related deaths from November 2020 through April 2021. The death rate of 2.4% was a significantly lower rate than comparable populations in NFs nationwide during the same period.[40]

A study published from Journal of the American Medical Directors Association in 2022 looked at the impact of COVID-19 on the structure and functions of PACE sites in North Carolina.[41] The report authors identified six themes from the study:

- New, unprecedented administrative challenges brought on by COVID-19
- Insufficient access to and integration with other healthcare providers
- Reevaluation of the core PACE model, resulting in a transition to home-based care
- Reorientation to be more family-focused in care provision
- Implementation of new, creative strategies to address participant and family psychological and social well-being in the home
- Major reconfiguration of staffing, including transitions to new and different roles and a concomitant effort to provide support and relief to staff

North Carolina PACE sites experienced increased costs in some areas (e.g., personal protective equipment); however, the steady capitated payments provided stability in funding as well as savings in some areas, and overall, the IDT and core staff members were able to adapt to meet the needs of participants. The authors concluded:

> "While facing many challenges that required major changes in care provision, PACE was successful in mounting a COVID-19 response that upheld safety, promoted the physical and mental well-being of participants, and responded to the needs of family caregivers. Administrators felt that, after the pandemic, the PACE service model is likely to remain more home-based and less reliant on the day

[40] Nitzberg, Mark, Zysman, John, and Michael, Amelia. June 25, 2021. *WelbeHealth: Case Study of Adapting PACE Under COVID-19.* University of California Berkeley. Accessed December 21, 2023. https://tinyurl.com/2fas27t4

[41] Aggarwal, N., Sloane, P. D., Zimmerman, S., Ward, K., & Horsford, C. (2022). Impact of COVID-19 on Structure and Function of Program of All-Inclusive Care for the Elderly (PACE) Sites in North Carolina. Journal of the American Medical Directors Association, 23(7), 1109–1113.e8. https://doi.org/10.1016/j.jamda.2022.05.002

center than in the past. As a result, PACE may have changed for the better and be well-positioned to play an expanded role in our evolving long-term care system."[42]

IV.iii PACE Operational Overview for States

Implementing PACE requires the clinical, financial, and administrative capacity necessary to deliver comprehensive, integrated care under the PACE capitated model. The operational requirements section details at a high level the policy design and oversight of PACE, as well as the key features and elements related to PACE organizations.

State Plan Overview

- The state plan is a formal, written agreement between DHS and the federal government
- Describes how the state administers its Medicaid program
- Provides assurances that the State will abide by federal requirements
- Allows the state to claim federal funds

Policy Infrastructure

While PACE is a three-way agreement between the federal government, the state, and the PACE organization, the program begins at the state level with a SPA. The state plan is the agreement with CMS and the federal government that governs the program and allows for receipt of federal funds to support payment of the PACE capitation. To implement PACE in Minnesota, PACE must be elected as an optional benefit through a SPA, which must be submitted by DHS and approved by CMS. CMS has a PACE preprint, which would be used to guide the content included in the SPA. The preprint includes selecting if coverage will be for both categorically-needy and medically-needy populations. Electing eligibility rules in the preprint include Social Security Insurance (SSI) and spousal-related provisions, assurances and details related to rates and payments, and assurances related to enrollment and disenrollment. Each state is required to have an SAA responsible for administering PACE and conducting the State Readiness Review during the application approval process to ensure the PACE center meets regulatory requirements. The SPA for PACE must be approved by CMS prior to a PACE organization submitting an application. Approval of PACE as a state plan option does not obligate the state to enter into a program agreement with a PACE organization.

[42] Aggarwal, N., Sloane, P. D., Zimmerman, S., Ward, K., & Horsford, C. (2022). Impact of COVID-19 on Structure and Function of Program of All-Inclusive Care for the Elderly (PACE) Sites in North Carolina. *Journal of the American Medical Directors Association*, *23*(7), 1109–1113.e8. https://doi.org/10.1016/j.jamda.2022.05.002

If the state chooses to implement PACE, the SAA establishes a process to review and select organizations that meet state and federal requirements. See Section 5.4 Program Design and Implementation for more information.

Selection of Entities to be PACE Organizations

The solicitation of entities for prospective PACE organizations is often initiated by the state using an RFP process, generally specifying one or more service areas. State RFPs vary, but common features include:

- A demonstrated need for PACE services
- Requirements for state licensure
- Experience in providing LTSS
- Fiscal soundness and solvency

IV.iv Financing and Payment Model

The Financing and Payment Model section provides an overview of the PACE payment model, including capitation and role of risk.

Capitation

PACE organizations follow a capitated payment model. Capitation refers to a set rate paid monthly to PACE organizations in advance for services rendered to enrolled PACE members. A capitated payment model differs from a FFS model in that there is a single rate paid to the PACE organization based on the number of participants and their corresponding cohorts (e.g. age, gender, rural/urban), as opposed to the FFS model where payments are made to providers based on the services provided.

PACE entities receive funding from Medicare, Medicaid, and, in certain cases, from individuals who are private pay. A PACE entity receives a capitated monthly payment from the state for each Medicaid participant, which is the only Medicaid payment made for a given month. Considerations of PACE capitation include:

- Medicare-eligible individuals enrolled in PACE who are not eligible for Medicaid pay the PACE entity a monthly premium equal to the Medicaid capitation amount.
- No deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies to Medicare or Medicaid participants.

- PACE entities are not allowed to bill the Medicaid agency or participants separately for PACE-covered services.
- PACE entities assume risk for the healthcare of the participants without limits on amount, duration, or scope of services needed.

PACE Payment

- For eligible members, the premium for PACE is covered by Medicare and Medicaid.
- While less common, PACE services can also be accessed through a private-pay arrangement.

Capitation payments and their soundness are based on actuarial analyses, estimating expenditures for a comparable population.

- The CMS PACE Manual describes the Medicare payments method. Additional information about this payment methodology is detailed in the CMS PACE Manual as well.[43] The manual references the PACE agreement, with a more descriptive narrative of the Medicare payment amount found in Appendix F.[44]
- The state, generally through a contracted actuary, calculates the Medicaid capitated rates based on utilization and cost of the array of services PACE-like Medicaid enrollees are expected to utilize. Federal regulations allow for the SAA and PACE entity to negotiate the capitated payment and affords authority for the rates to be renegotiated annually.[45] The Medicaid capitation rates are designed to be less than the amount that would otherwise be paid if the participants were not enrolled under PACE, but also sufficient for the population served by PACE.

Role of Risk in Capitation

Through the capitated payment model, the PACE organization assumes full financial risk for PACE members' healthcare needs, as defined in the integrated care plan, without limitations on the duration, amount, or scope of services. Upon receipt of a capitated payment, additional claims for Medicaid services on behalf of PACE participants are not allowed. The defining characteristics of the PACE financing model include:

- Obligation for payments is shared by Medicare, Medicaid, and private pay individuals who do not participate in Medicare and/or Medicaid.
- Medicare, Medicaid, and private payments for acute, LTSS, and other services are pooled.

[43] Centers for Medicare and Medicaid Services (CMS). 2011. *Program for All-Inclusive Care for the Elderly (PACE) Manual, Chapter 13: Payments to PACE organizations.* CMS.gov. Accessed November 6, 2023. https://tinyurl.com/358nur5j

[44] Centers for Medicare and Medicaid Services (CMS). 2011. *PACE Program Agreement.* Accessed April 10, 2024. https://www.cms.gov/medicare/health-plans/pace/downloads/programagreement.pdf

[45] 42 CFR §460.182, October 1, 2022. Federal Register. Accessed April 12, 2024. https://tinyurl.com/bddacm84

- The capitation rates paid by Medicaid are designed to result in cost savings relative to expenditures that would otherwise be paid for a comparable NF-eligible population not enrolled under PACE.[46]

Role of Risk with the PACE Organization and Payments

Under the PACE model, the PACE organization must remain at full risk. The state may not share risk with the PACE organization. Medicaid capitated PMPM rates are based on the costs of services for PACE-like members meeting an NF level of care or those already receiving NF care. The design of these rates is intended to blend costs from both NF and HCBS care for the frail elderly. The state must assure CMS that the capitated rates will be less than the cost to the agency of providing those same state plan services to a comparable population. Such assurances are required as part of the state electing PACE through a SPA.

PACE organizations enter the arrangement understanding they are at full risk and accept the capitation payment amount as payment in full for Medicaid participants. PACE organizations may not bill, charge, or receive any other form of payment from the SAA. There are exceptions for Medicaid members with spenddown liability and other amounts due under post-eligibility treatment of income.

Members with Medicaid-only eligibility cannot be charged premiums. Individuals who are private pay (not eligible for Medicare or Medicaid) may be charged a PACE premium, which is the combined cost of the Medicare and Medicaid capitation rates.

IV.v Requirements of the PACE Model for PACE Organizations

PACE organizations must provide all benefits covered under both Medicare and Medicaid, encompassing LTSS, including NF care when needed, and medications under Medicare Part D. One goal of PACE is to keep participants out of an NF as long as possible. If the participant needs to receive care in an NF, PACE organizations are prohibited from disenrolling individuals because of NF admission; therefore, the PACE organization must pay for the NF care and the IDT will continue to be involved in the PACE participant's care plan, including discharge planning and supports. While PACE participants may voluntarily disenroll from PACE, including as a result of NF admission, the NPA estimates that less than 10% of PACE participants who disenroll (for reasons other than death) do so as a result of NF admission.

Minnesota is nationally recognized for state-based health systems. Non-profit health systems and hospitals are most densely located in the metro area, around Minneapolis and St. Paul, followed by Duluth, Rochester, and St. Cloud. Furthermore, Minnesota has strong existing LTSS providers for a continuum of care for older adults. The established network of providers, health systems, and hospitals helps support a potential PACE. Some PACE organizations grow out of existing community-based or non-profit programs for aging individuals and started out as hospice, home health, or adult day care providers. Organization types which become PACE providers include not-for-profit health systems, for-profit health systems, area agencies on aging (AAAs), tribal nations, county

[46] Centers for Medicare and Medicaid Services (CMS). 2011. *Program for All-Inclusive Care for the Elderly (PACE) Manual, Chapter 13: Payments to PACE organizations*. CMS.gov. Accessed November 6, 2023. https://tinyurl.com/yckestz5

governments, FQHCs, and existing LTSS providers. In 2019, CMS published final regulations that allowed PACE entities to be for-profit organizations. The regulation expanded the types of organizations that can be PACE entities. However, the regulation requires the SAA to provide quality reporting demonstrating no major discrepancies between for-profit and not-for-profit entities to maintain the flexibility for the state.[47]

Key features of PACE include:

- **The PACE Center:** PACE entities are required to operate at least one PACE center where enrolled PACE members can receive a minimum set of services.[48] The PACE center serves as the hub of care coordination and delivery, providing day supports, meals, recreational activities and classes, field trips, and other social activities. The PACE center needs to be in or contiguous to the service area. In addition, it must have adequate capacity to ensure participants can receive services.

- **Services:** Services available at the PACE center must include primary care, nursing, personal care, restorative therapies, nutritional counseling, recreational therapy, meals, and social services. The PACE organization must also arrange transportation for PACE participants to and from the center. Services may also be provided in the home for individuals who are not able to go to the PACE center.

- **Integrated Care Teams and Care Planning:** PACE organizations must have an IDT that includes primary care providers, nurses, social workers, physical therapists, and other professionals as described in PACE regulation.[49] The IDT is responsible for assessment, development of a care plan, and coordination of care. Team members participate in performing a comprehensive assessment of participant needs, which incorporates physical and behavioral health as well as individual and family caregiver preferences, home environment, and cognitive function.[50]

- **Provider Networks:** PACE organizations must employ or contract with practitioners or healthcare systems to ensure the PACE provider network is sufficient to provide all Medicare- and Medicaid-covered services.

- **PACE Participant Rights:** PACE organizations must comply with participant rights, as required by federal regulation at 42 Code of Federal Regulations (CFR) 460, Subpart G – Participant Rights. These rights include:

[47] Department of Health and Human Services, Centers for Medicare, and Medicaid Services. June 3, 2019. *Final Rule: Medicare and Medicaid Programs: Program of All-Inclusive Care for the Elderly (PACE)* Federal Register, Vol. 84. Accessed April 4, 2024. https://www.govinfo.gov/content/pkg/FR-2019-06-03/pdf/2019-11087.pdf.

[48] 42 CFR § 460.98(c) January 1, 2021. Federal Register. Accessed December 15, 2023. https://tinyurl.com/49kpdaka.

[49] 42 CFR § 460.102 January 21, 2021. Federal Register. Accessed December 15, 2023. https://tinyurl.com/2sw6r89c

[50] 42 CFR§ 460.102. January 21, 2021. Federal Register. Accessed December 15, 2023. https://tinyurl.com/2sw6r89c

- Respect and nondiscrimination
- Information disclosure
- Choice of providers
- Access to emergency services
- Participation in treatment decisions
- Confidentiality in health information
- Ability to voice complaints and appeal treatment decisions

CMS has developed a sample PACE Member Rights template, which can be found in Appendix C of this report. PACE organizations are also expected to remain as restraint-free as possible, using the least restrictive restraints if medically necessary for the member's safety or the safety of others. The restraint must be determined necessary by the IDT and well documented in the participant's medical chart.

PACE Organization Startup

Prior to initiating the process to become a new PACE, organizations will typically conduct a needs assessment or market analysis to determine there is a need for services in the community. States may also require new PACE organizations to have a certificate of need, or may limit the number of PACE providers in a service area. Please see *Identification and Selection of Providers* in Section 5.4 Program Design and Implementation for additional information.

The SAA is responsible for overseeing the selection and startup of new PACE organizations and the expansion of existing PACE organizations. As part of the PACE organization enrollment process, the state will have certain processes and procedures in place, to help ensure compliance with federal regulations. These will include:

- Procedures for enrollment and disenrollment of PACE participants
- Processes for overseeing the PACE organization's administration of incident management and safety criteria for PACE participants
- Requirements for information to be provided to PACE participants, such as the state's fair hearings processes
- Processes for review of involuntary disenrollments
- Requirements for quality assurance reporting
- Procedures for monitoring the assessment and care planning processes
- Requirements for audit participation and financial reporting

- Methods for member outreach and marketing[51]

Fiscal Soundness

The federal regulations at 42 CFR §460.80 require PACE organizations to have:

- A fiscally sound operation
- An insolvency plan
- Arrangements to cover expenses

Some states add additional state-specific requirements, all of which will be monitored by the SAA and CMS on an ongoing basis. An example of a state-specific requirement could be that PACE organizations must submit independently audited financial statements to CMS on an annual basis.[52] The CMS Medicare Drug and Health Plan Contract Administration Group has also issued memos that clarify and refine requirements related to fiscal soundness of PACE organizations. See Appendix F for related memos.

Startup Funding

Prospective PACE organizations will need access to startup funding, which is necessary to rent, build, and/or renovate a facility to serve as the PACE center. Organizations may be able to secure grant funding for startup, undertake a capital campaign, or access investor funding or other private resources. Depending on state requirements, a new PACE organization may also need a certain amount of funds to demonstrate the organization can support operations for a specified period as enrollment and corresponding expenses (paid claims) ramp up. The NPA estimates startup costs for new PACE organizations average between $1.5 million and $5 million.[53]

Notice of Intent to Apply (NOIA)

An entity that intends to submit an initial application to become a PACE organization must file an NOIA; see Appendix E. The NOIA must be submitted early in the quarter in which the entity plans to submit the PACE Application. The NOIA must be submitted to the PACE portal (Imi.org). Upon receipt of the NOIA, CMS will issue a contract number and Health Plan Management System (HPMS) access information to the PACE entity.

---

[51] Department of Health and Human Services, Centers for Medicare, and Medicaid Services. June 3, 2019. *Final Rule: Medicare and Medicaid Programs: Program of All-Inclusive Care for the Elderly (PACE)* Federal Register, Vol. 84. Accessed April 4, 2024. https://www.govinfo.gov/content/pkg/FR-2019-06-03/pdf/2019-11087.pdf.

[52] Centers for Medicare and Medicaid Services (CMS). *Fiscal Soundness Reporting Requirements (FSRR).* CMS.gov. Accessed April 12, 2024. https://www.cms.gov/medicare/enrollment-renewal/health-plans/reporting.

[53] National PACE Association (NPA). 2023. *Understanding the PACE Operating Experience and Critical Success Factors*. Accessed October 1, 2023. https://tinyurl.com/mryyc43m.

PACE Entity Application

An entity that wants to become a PACE organization must submit the PACE Application.[54] The federal application process requires prospective PACE organizations to attest to and provide documentation that the organization meets the requirements contained in federal regulation at 42 CFR Part §460. The application includes sections that cover PACE requirements; for example: service area, governing body, fiscal soundness, marketing, enrollment and disenrollment, grievances, service requirements, interdisciplinary team and plan of care, program integrity, and medical records.

The application also includes a section of *Document Templates* to be used by the applicant PACE entity to provide supporting documentation for various sections in the application.

The PACE organization will also undergo a State Readiness Review (SRR), which will be completed by the SAA. The readiness review is discussed in further detail in Section 5.4. CMS requires a completed SRR before they will approve the application; however, the PACE entity may upload the SRR as part of the initial submission of the application or may upload the SRR after the initial application submission, subsequent to CMS's request for additional information. Note: Because the application must be submitted on the CMS-designated quarterly submission date and must be submitted in the same quarter that the NOIA was submitted, it may be necessary to submit the application before receipt of the completed SRR.

Waiver of PACE Model

PACE organizations may submit a waiver requesting reasonable flexibility for adapting the PACE model to the needs of particular organizations. Waivers may be particularly helpful for rural PACE centers. A waiver request must be reviewed by the SAA, and once complete, the SAA forwards the waiver request to CMS, and will include concurrence, concerns, or conditions regarding the waiver.

Three-Way Agreement

PACE organizations are approved to operate through a three-way agreement between the PACE organization, CMS, and the SAA. To enter these contracts, PACE organizations must first meet requirements described in federal regulation and any additional state-specific requirements, and successfully complete state and federal application processes. The three-way agreement is assembled by CMS after receipt and approval of the PACE Application. The current CMS template for the three-way agreement can be found at https://www.cms.gov/medicare/health-plans/pace/downloads/programagreement.pdf.

Marketing

[54] Department of Health and Human Services, Centers for Medicare, and Medicaid Services (CMS), Center for Medicare (CM), Medicare Drug and Health Plan Contract Administration Group (MCAG). *Programs of All-Inclusive Care for the Elderly: for all new applicants and existing PACE organizations seeking to expand a service*. CMS.gov. Accessed April 12, 2024. https://www.cms.gov/files/document/pace-initial-and-service-area-expansion-applicationupdated-2022-pdf.pdf

To promote program growth, PACE organizations will need to engage in ongoing marketing of their program. Federal regulations establish criteria for marketing, such as minimum requirements for marketing materials, including restriction of services; CMS approval of all marketing materials; special language considerations for marketing materials; and prohibited marketing practices.[55]

Enrollment and Disenrollment of Participants

To be eligible to enroll in PACE, an individual must meet the following requirements:

(1) Be 55 years of age or older

(2) Be determined by the SAA to meet NF level of care

(3) Reside in the service area of the PACE organization

Enrollment for a participant begins with the PACE organization initiating an intake process. The federal regulations detail the required elements of an intake process and define the process as "an intensive process during which PACE staff members make one or more visits to a potential participant's place of residence and the potential participant makes one or more visits to the PACE center."[56]

Individuals approved to enroll must sign an enrollment agreement with the PACE organization. The regulations establish a set of minimum criteria for the content of the participant enrollment agreement. If an individual is denied enrollment because his or her health or safety would be jeopardized by living in a community setting, the PACE organization must meet specific requirements for documentation, notification, and referral.[57]

Enrollment continues until the participant's death, regardless of changes in health status, unless either of the following actions occur:

(1) The participant voluntarily disenrolls

(2) The participant is involuntarily disenrolled[58]

A PACE participant may **voluntarily disenroll** from PACE without cause at any time. Voluntary disenrollment is effective on the first day of the month following the date the PACE organization receives the participant's notice of voluntary disenrollment. A PACE organization must ensure that its employees or contractors do not engage in

[55] 42 CFR § 460.82 – Marketing. June 3, 2019. Federal Register. Accessed April 15, 2024. https://tinyurl.com/mta9aahw

[56] 42 CFR § 460.460 Subpart I – Participant Enrollment and Disenrollment. June 3, 2019. Federal Register. Accessed April 15, 2024. https://tinyurl.com/4befpjce

[57] 42 CFR § 460.460 Subpart I – Participant Enrollment and Disenrollment. June 3, 2019. Federal Register. Accessed April 15, 2024. https://tinyurl.com/4befpjce

[58] 42 CFR § 460.460 Subpart I – Participant Enrollment and Disenrollment. June 3, 2019. Federal Register. Accessed April 15, 2024. https://tinyurl.com/4befpjce

any practice that would reasonably be expected to have the effect of steering or encouraging disenrollment of participants due to a change in health status.[59]

A participant may be **involuntary disenrolled** by the PACE organization, which is effective on the first day of the next month that begins 30 days after the day the PACE organization provides notice of the disenrollment to the participant. Before an involuntary disenrollment is effective, the SAA must review and determine that the PACE organization has adequately documented acceptable grounds for disenrollment. A participant may be involuntarily disenrolled for any of the following reasons:

(1) The participant, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any premium due the PACE organization.

(2) The participant, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any applicable Medicaid spend down liability or any amount due under the post-eligibility treatment of income process, as permitted under §§ 460.182 and 460.184.

(3) The participant or the participant's caregiver engages in disruptive or threatening behavior, as described in paragraph (c) of this section.

(4) The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(5) The participant is determined to no longer meet the state Medicaid NF level of care requirements and is not deemed eligible.

(6) The PACE program agreement with CMS and the SAA is not renewed or is terminated.

(7) The PACE organization is unable to offer healthcare services due to the loss of state licenses or contracts with outside providers.[60]

Monitoring and Oversight of PACE Organizations

As PACE organizations become Medicaid-participating providers, the state will work with CMS to oversee PACE operations. Federal regulations at 42 CFR §460 Subpart K describe the SAA obligations for oversight when a state

[59] 42 CFR § 460.460 Subpart I – Participant Enrollment and Disenrollment. June 3, 2019. Federal Register. Accessed April 15, 2024. https://tinyurl.com/4befpjce

[60] 42 CFR § 460.460 Subpart I – Participant Enrollment and Disenrollment. June 3, 2019. Federal Register. Accessed April 15, 2024. https://tinyurl.com/4befpjce

approves a PACE entity to implement the program in one or more centers.[61] These requirements are also built into the three-way agreement and include the following:

- **Monitoring during trial period:** During the first three contract years (trial period), the state must conduct an annual review of PACE operations and programming, which include center visits, assessment of fiscal soundness and solvency, assessment of provider's ability to provide all PACE services, and a detailed analysis of the PACE organization's compliance with state and federal regulations. The first three contract years may be longer than three calendar years, given that the first contract year can extend from 19 to 30 months for purposes of the review period.
- **Ongoing monitoring:** At the conclusion of the trial period, CMS, in cooperation with the SAA, will continue to conduct PACE organization reviews, as appropriate, considering the quality of care furnished and the organization's compliance with program requirements.[62]
- **Corrective Action:** A PACE organization must take action to correct any findings resulting from monitoring, complaints by PACE participants or caregivers, or identified by CMS or the SAA. Corrective actions will be monitored by CMS and/or the SAA.[63]
- **Other:** Additional state oversight requirements include review of the PACE organization's marketing materials and areas where consultation with CMS is required, such as changes to the PACE service area, organizational structure, or imposition of sanctions.

Provider Network and Care Delivery

PACE organizations must employ or contract with practitioners and providers to offer all required services. The PACE regulations establish qualifications for staff who have direct participant contact.[64] The network of providers must be sufficient for participants to have a choice of healthcare providers and to ensure access to appropriate high quality care. PACE participants must utilize PACE network providers, except for emergency situations when out-of-network services are necessary. PACE organizations must provide information to PACE participants on the procedure for obtaining emergency out-of-network services.

Network adequacy must be determined so PACE organizations can provide all required services directly, or through contracts with external providers. Recent federal regulations require PACE organizations have contracts in place with the following medical specialties. The contracts must be executed prior to enrollment of

[61] 42 CFR § 460 Subpart K. June 3, 2019. Federal Register. Accessed December 10, 2023. https://tinyurl.com/4z6sseac

[62] 42 CFR § 460.192. June 3, 2019. Federal Register. Accessed December 10, 2023. https://tinyurl.com/4z6sseac

[63] 42 CFR § 460.194. June 3, 2019. Federal Register. Accessed December 10, 2023. https://tinyurl.com/4cdz9hbb

[64] 42 CFR §460.64. June 3, 2019. Federal Register. Accessed December 10, 2023. https://tinyurl.com/bddafbyh

participants and must be maintained on an ongoing basis to ensure participants receive appropriate and timely access to all medically necessary care and services.

- Anesthesiology
- Audiology
- Cardiology
- Dentistry
- Dermatology
- Gastroenterology
- Gynecology
- Internal Medicine
- Nephrology
- Neurosurgery
- Oncology
- Ophthalmology
- Oral surgery
- Orthopedic surgery
- Otorhinolaryngology
- Palliative Medicine
- Plastic surgery
- Pharmacy consulting services
- Podiatry
- Psychiatry
- Pulmonology
- Radiology
- Rheumatology
- General Surgery
- Thoracic and vascular surgery
- Urology[65]

PACE Representation

If PACE is implemented in Minnesota, incorporating a PACE representative into community engagement groups like Aging Councils, Minnesota Leadership Council on Aging, American Association of Retired Persons (AARP) Minnesota, and Medicaid advisory groups may be beneficial. Additionally, PACE should be included in the Minnesota State Plan on Aging to emphasize community options for the state's aging population.

[65] Department of Health and Human Services, Centers for Medicare, and Medicaid Services. April 12, 2023. *Medicare Program; Contract Year 2024, Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly*. Federal Register, Vol. 84. Accessed April 4, 2024. https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf

V. PACE Actuarial Analysis

The PACE Actuarial Analysis prepared by Milliman analyzed Medicaid costs to propose a monthly Medicaid capitation rate for Minnesota PACE.

On February 23, 2024, Milliman, Minnesota's contracted actuary, released their actuarial analysis for PACE in Minnesota. The report summarizes the development of the illustrative CY 2024 amount that would otherwise have been paid (AWOP) for a potential PACE and the resulting CY 2024 capitation rate for a potential PACE program. Milliman's report for a potential PACE can be found in Appendix I.

VI. Minnesota PACE Implementation Plan

The PACE Implementation Plan outlines implementation approaches from other states that offer PACE. The analysis includes research of Minnesota's current LTSS landscape, national resources, and implementation efforts in comparable states.

VI.i Insights from Other States

State Experiences

The national presence of PACE and the program's flexibility toward the unique needs of aging adults has provided benefits to states that have implemented the program. PACE continues to grow nationally, with seven new PACE organizations started since 2022. These newer programs join 155 operating PACE organizations in the U.S., in addition to the 2023 launch of PACE in the state of Illinois.[66,67] New PACE organizations include PACE Southeast Michigan (PACE SEMI), where seven centers serve over 1,000 beneficiaries and are run by a partnership between Henry Ford Health and Presbyterian Villages of Michigan. To be considered along with program growth, a 2015 report noted that the needs of PACE members is shifting in the younger population of members age 55 to 64, where an increased proportion of members reported behavioral health and substance use disorder (SUD) needs.[68]

California

Other states have experienced challenges in PACE implementation, including slow expansion of the PACE model as well as fraud and abuse among PACE providers. PACE first emerged in California and has been highly praised nationally for its quality care results. However, the state's PACE model was initially slow to expand proportionally to the Californian Medicaid population. The California Healthcare Foundation identified reasons for the lag in PACE expansion, including high startup costs and low initial investment recoupment, staffing capacity, and caps on enrollment.[69] PACE did expand in California after caps on enrollment were removed in 2013 through a SPA.[70] In 2014, state legislation was enacted requiring that PACE capitation payments could not

[66] Pritzker, JB. August 15, 2022. *Gov. Pritzker Announces Program of All-Inclusive Care for the Elderly to Expand Choices in Care for Illinois Seniors*. Office of the Governor. Accessed January 8, 2024. https://tinyurl.com/3svbvt33

[67] National PACE Association (NPA). December 2023. *PACE in the States Report*. NPA. Accessed January 18, 2024. https://www.npaonline.org/pace-operations/research-data/pace-in-the-states

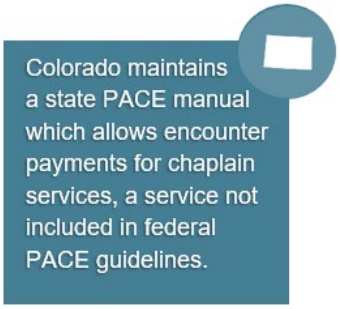
[68] Mercer. May 4, 2015. *Program of All Inclusive Care for the Elderly.* Commonwealth of Massachusetts. https://tinyurl.com/ytetvu6b. Accessed January 5, 2024.

[69] California Healthcare Foundation. July 2010. *Aging in PACE: The Case for California Expansion*. San Diego County. Accessed October 12, 2023. https://www.chcf.org/wp-content/uploads/2017/12/PDF-AgingPACECaseExpansionCalifornia.pdf

[70] California Healthcare Foundation. July 2010. *Aging in PACE: The Case for California Expansion*. San Diego County. Accessed October 12, 2023. https://www.chcf.org/wp-content/uploads/2017/12/PDF-AgingPACECaseExpansionCalifornia.pdf

be less than 95% of the FFS equivalent in a comparable population.[71] In 2016, the cap on the number of PACE providers was removed from law and regulatory flexibilities were added, which grew the number of PACE centers from 10 in 2015 to 30 in 2017.[72] As opposed to trends in NFs, PACE expanded in California following COVID-19, and additional funds were provided by the American Rescue Plan Act (ARPA) that allowed for direct care worker incentive payments. As a result, the policy changes regarding PACE allowed for program expansion in California's particular LTSS landscape.[73]

Colorado



The Colorado Department of Health Care Policy and Financing (HCPF) ceased enrollment for the state's largest PACE organization, InnovAge, in December 2021.[74] InnovAge, based in Denver, lost Medicare funding and received corrective action from the HCPF after audits revealed a series of problems where members were left without basic care services. InnovAge shifted its model after a 2019 CMS ruling that for-profit companies could become PACE entities. To recoup more funds and maintain a profit, InnovAge was found enrolling ineligible members to receive more reimbursement. InnovAge bought out smaller non-profit PACE entities and tried to enroll the greatest number of members possible, leading to quality issues that later resulted in legal recourse.[75] However, the sanctions were lifted on InnovAge in June 2023 after InnovAge was found to be compliant with the corrective action, allowing the company to resume operations in Colorado.[76] This instance reveals the importance of auditing PACE organizations, particularly as PACE organizations serve older adults with significant care needs. For this reason, other care settings such as NFs are heavily regulated and audited at least annually.[77]

---

[71] SB 870.3. June 20, 2014. *California Senate Bill 870.* California Secretary of State. Accessed January 10, 2024. https://tinyurl.com/3zw9an7y

[72] SB 833. June 27, 2016. California Senate Bill 833. California Secretary of State. Accessed January 10, 2024. https://tinyurl.com/3zw9an7y

[73] CalPACE. 2023. *History.* CalPACE. Accessed January 15, 2024. https://calpace.org/about-us/history/

[74] Colorado Department of Health Care Policy and Financing (HCPF). December 23, 2021. *InnovAge Frequently Asked Questioned – Members & Families.* Accessed January 18, 2024. https://tinyurl.com/axr5x9we

[75] Wingerter, Meg. July 3, 2022. *Denver's InnovAge was struggling long before Medicare stopped paying.* The Denver Post. Accessed October 12, 2023. https://tinyurl.com/mr37zk9h

[76] Eastabrook, Diane. October 2, 2023. *PACE could expand amid possible nursing home closures: InnovAge CEO.* InnovAge. Accessed January 20, 2024. https://www.innovage.com/innovage-news/innovage-blair-pace-nursing-home-shortage-seniors

[77] Stevenson D, Bramson J. "Regulation of long-term care in the United States. In: Mor V, Leone T, Maresso A, eds. Regulating Long-Term Care Quality: An International Comparison." *Health Economics, Policy, and Management.* Cambridge: Cambridge University Press; 2014:289-323. Accessed January 5, 2024. doi:10.1017/CBO9781107323711.016

PACE Action Network

According to the National Academy for State Health Policy (NASHP), one of the most significant barriers to access for PACE is geography. Around two-thirds of the population which may be eligible for PACE lacks access to PACE due to living in areas where no PACE organization is operating. In 2022, five states convened in the NASHP State PACE Action Network to improve PACE implementation and expansion. These states included Iowa, Maryland, Massachusetts, New Jersey, and Louisiana. These states shared with each other their PACE-related innovations. Louisiana in 2021 released a Request for Information (RFI) specifically for a PACE organization to serve adults with severe mental illness (SMI), resulting in two new PACE organizations. Massachusetts invited existing PACE organizations to apply for expansion into other zip codes. Massachusetts also analyzed the enrollment process for PACE and implemented changes to reduce the number of days between the consumer decision to enroll and the start of services.[78] The NASHP State PACE Action Network also found that the opening process of a PACE is likely take longer than a calendar year, considering the significant lift of contracting care, along with implementing all necessary policies for compliance.[79]

Peer State Experiences

The experiences of other states can offer insight into the process of PACE implementation. BerryDunn leveraged subject matter expertise from Indiana, Michigan, and North Dakota to provide information on each state's PACE implementation experience.

Table 3: State Experience Considerations

Category	Questions
Implementation	What was the timeline of PACE implementation? When was the SPA effective date? What were the goals and objectives of PACE implementation in the state?
Eligibility and Enrollment	What are the eligibility groups? What is the process for member enrollment? What is the enrollment trend?

[78] Kaye, Neva. May 3, 2022. *Five States' Progress toward Expanding Access to PACE Services. National Academy for State Health Policy (NASHP).* Accessed January 23, 2024. https://nashp.org/five-states-progress-toward-expanding-access-to-pace-services/

[79] Kaye, Neva. May 3, 2022. *Five States' Progress toward Expanding Access to PACE Services. National Academy for State Health Policy (NASHP).* Accessed January 23, 2024. https://nashp.org/five-states-progress-toward-expanding-access-to-pace-services/

Administration	What is the number of statewide PACE entities? What is the level of staffing involved in PACE oversight? What is the payment process? What are the vendor types and roles? What is the process for PACE closures? What are state requirements for PACE organizations? Are there any notable sister programs?

Indiana

Indiana has six PACE organizations, all of which are hosted by or partner with a hospital health system. PACE of Northeast Indiana is a new PACE organization hosted by a partnership between Aging and In-Home Services of Northeast Indiana (AIHS) and Parkview Health System. AIHS is an AAA and is the first AAA in the nation to partner with a health system as a PACE organization.

Please see Table 4 below for additional information on Indiana PACE organizations. While some of the PACE organizations include rural zip codes in their catchment areas, none of the Indiana PACE centers are in a rural area.

Table 4: Indiana PACE Organizations

Organization Name	Location	Contract Start Date	Participants as of 10/2023
Ascension Living St Vincent PACE	Indianapolis, IN	7/1/2023	0
Franciscan Senior Health & Wellness	Indianapolis, IN Dyer, Indiana Lafayette, IN Michigan City, IN	1/1/2015	255
PACE of Northeast Indiana	Fort Wayne, IN	5/1/2021	57
Reid Health PACE Center	Richmond, IN	11/1/2020	60
Saint Joseph PACE, Trinity Health	Mishawaka, IN	9/1/2016	171
		Total	**543**

- While all PACE organizations in Indiana are hosted by a health system, they may be not-for-profit, for-profit, or public entities. Indiana requires all PACE organizations to be a risk-based managed care Medicaid and Medicare program. Indiana PACE organizations must provide hospice services as part of their state agreement, and several PACE organizations also provide ESRD services.

Indiana PACE includes Medicaid, Medicare, dual-eligible, and private pay options. The state rates are designed to consider age, geography, and payor criteria. The Medicaid-only rate is the highest state PACE rate. Dual rates are higher for urban areas and as age increases. Over 80% of PACE members are dual-eligible; less than 17% are Medicaid-only.

All PACE members with Medicaid and/or Medicare have an Indiana Health Coverage Program (IHCP) card that denotes PACE enrollment. PACE participants are required to sign an enrollment agreement indicating they understand that the PACE organization must be their sole service provider. Services must be preapproved and obtained from specified doctors, hospitals, pharmacies, and other healthcare providers that contract with the

PACE organization. Because PACE is a managed care entity (MCE) in Indiana, no FFS claims may be submitted for PACE members; IHCP denies payment if a claim is submitted.

- In Indiana, PACE organizations must provide hospice services as part of their state agreement. Several PACE organizations also provide ESRD services.

- Indiana is currently transitioning to managed long-term services and supports (MLTSS) for individuals age 60 and older who are Medicaid-eligible. During the transition, an AAA completes level of care assessments until July 2025. At that time, and if the individual qualifies, the AAA will provide a warm handoff to an enrollment broker for MCE selection. Because PACE organizations in Indiana are MCEs, the enrollment broker will discuss PACE as a LTSS option. Beginning in July 2025, the level of care assessment representative (LCAR) with the enrollment broker will complete the front-end level of care assessments. If the individual qualifies for PathWays, the enrollment broker will assist the member in selecting an MCE. Indiana's MLTSS program requires managed care organizations (MCOs) to have D-SNP agreements and contractually commit to integrated care management between the D-SNP and MLTSS participants includes electronic data-sharing, referrals, and benchmarks for care coordination discussion.

The SAA in Indiana consists of one full-time employee in a management-level position. The FTE dedicates all staff time to the Indiana PACE Program and is responsible for all functions of the SAA, including data reporting, application submissions, and site reviews. This position works closely with the Managed Care Oversight Team, Division of Aging Staff, and the Medicaid Audit Team where staff complete other duties like HCBS enrollment oversight, capitation payment/rate development, and managed LTSS monitoring which PACE is a part of and/or refers to for participant services including nursing facility stays. There are no licensing requirements for Indiana PACE organizations. Organizations must go through a state site review, which includes the PACE day center.

Michigan

In 1994, southeast Michigan launched PACE as part of the Henry Ford Health System, making it one of the first PACE organizations. By 2000, PACE became an optional service under Michigan's State Plan, providing comprehensive care for the elderly in a community-based setting. As of July 2023, the program has enrolled 4,589 members statewide and operates 14 programs across 24 centers. PACE Organizations are present in 53 of Michigan's 83 counties.

PACE in Michigan is overseen by four state employees from the MDHHS. These employees are responsible for the program's management and expansion, while other administrative duties like enrollment, capitation payments, encounter data submission and reporting are managed in other divisions within MDHHS.

Under Michigan's state code, PACE organizations can be non-profit, for-profit, or public entities. PACE organizations are not required to have Michigan healthcare licensure, but must meet federal PACE standards, enroll as Michigan Medicaid providers, and conduct a feasibility study. Additionally, a prospective PACE entity that submits a letter of intent must state in the application the proposed service area for PACE.

If the state determines that there is unmet need in a designated geographic area already covered by an existing PACE organization, the department must notify that PACE organization and afford them the opportunity to submit a plan to expand capacity sufficient to accommodate need. The state must give the existing PACE six

months from notice of the determination of unmet need to submit an expansion plan. If the existing PACE organization fails to submit a reasonable plan for expansion within six months, the state may allow proposals from additional PACE organizations. There have been no closures of either PACE centers or PACE entities.

In addition to addressing unmet needs within existing PACE organizations, the state is also responsible for setting capitation rates. Capitation rates are set by MDHHS Actuarial Division staff in collaboration with the state's actuary. PACE capitation rates are calculated by region, dual-eligible population, and Medicaid-only population. The table below provides the fiscal year (FY) 2023 PACE Capitation Rate PMPM.

Table 5: Michigan PACE Capitation

Michigan State FY 2023 PACE Capitation Rate PMPM		
PACE Region	**Dual-Eligible Population(s)**	**Medicaid-Only Population(s)**
1	$3,020.29	$5,976.90
2	$3,882.91	$5,976.90
3	$4,088.17	$5,976.90
4	$3,942.07	$5,976.90
5	$4,200.86	$5,976.90
6	$3,902.42	$5,976.90
7	$3,569.00	$5,976.90
8	$3,850.42	$5,976.90
9	$3,863.62	$5,976.90
10	$3,946.79	$5,976.90
11	$4,591.60	$5,976.90

Michigan's PACE has experienced positive outcomes, including consistent growth, high consumer satisfaction, reduced use of institutional care, managed utilization of medical services, and cost savings for Medicare and Medicaid.

North Dakota

North Dakota implemented PACE in 2008. Northland Healthcare Alliance, the PACE entity at the time of implementation, originally had centers in Bismarck and Dickinson. PACE centers were added in Minot in 2015

and Fargo in 2020. PACE enrollment in North Dakota has been slow since the inception of the program.[80] North Dakota reached 100 enrollees in 2014, and according to the North Dakota Department of Health and Human Services (NDHHS), there were 188 individuals enrolled in PACE as of September 2023. In January 2024, NDHHS reported the following participant enrollment across the four ND centers: 98 in Bismarck; 28 in Dickinson; 44 in Minot; and 22 in Fargo.[81]

Individuals or family members seeking information about North Dakota PACE or who may be interested in enrolling can utilize the ND Aging & Disability Resource Link or may contact any of the PACE sites directly. If individuals need assistance in applying for Medicaid eligibility, they will be referred to the NDHHS Medicaid long-term care eligibility unit, which specializes in assisting individuals who are applying for Medicaid eligibility related to LTSS.

The original goal of PACE was to offer an additional option for individuals seeking an alternative to NF care. North Dakota had an array of services in place through both state-funded HCBS as well as Medicaid-funded personal care and 1915(c) waivers; however, the PACE entity (Northland Healthcare Alliance) was committed to the PACE model and was instrumental in securing legislative support and funding to initiate the program. North Dakota received a Money Follows the Person (MFP) grant in 2007 and started transitions to MFP in 2008. While there was not a direct correlation between MFP transitions and PACE enrollment, the two efforts were complimentary by continually enhancing community-based options.

In August 2020, NDHHS testified that "…DHS pays Northland PACE between $4,784 and $5,683 PMPM, depending on the participant's age group and urban/rural location." The following chart represents the State FY (July - June) 2024 rates, according to information obtained from NDHHS in January 2024.

Table 6: North Dakota State FY (July - June) 2024 Rates

	Urban/Rural	Age	Monthly PMPM
Duals	Urban	55 - 64	$5,291.45
Duals	Urban	65 - 74	$5,134.69
Duals	Urban	75+	$5,481.75
Duals	Rural	55 - 64	$5,020.27
Duals	Rural	65 - 74	$4,871.02
Duals	Rural	75+	$5,200.62
Non-Duals (Medicaid Only)	Either	55+	$5,786.50

[80] Fisher, Annette. January 13, 2022. *Program of All-Inclusive Care for the Elderly (PACE).* North Dakota Human Services. Accessed January 30, 2024. See slide 2. https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/pace-overview.pdf

[81] North Dakota Department of Health and Human Services. 2023. *Quarterly Budget Insight.* North Dakota Department of Health and Human Services. Accessed January 30, 2024. https://tinyurl.com/58x795fn

Most of the day-to-day administrative responsibilities fall to one FTE (PACE administrator) within the Medical Services Division of the NDHHS. The requirements of the position call for the individual to be a registered nurse. The decision to require a nurse in this role was intentional so the individual would have the background to participate in discussions about level of care and individual care plans, and to oversee quality assessments and participant appeals.

The PACE administrator is supported by others throughout the department in the areas of budgeting, financial management, and federal reporting; encounter data and actuarial rate setting; and on-site visits. The non-federal share of the Medicaid-funded PMPMs is included in the Medicaid Long-Term Care Budget, and the legislative process and testimony is generally managed by department and division leadership. Several external contracts, including level of care and actuarial services, are also necessary to support PACE.

There are no specific licensing requirements of a PACE entity in North Dakota; however, they must enroll as a North Dakota Medicaid provider. Once the PACE entity has established a day center, the North Dakota SAA conducts a review of the center utilizing a compliance checklist that is used for Adult Day Care and Adult Family Foster Care (see Appendix D).

After Northland Healthcare Alliance implemented PACE at the first two centers, they requested an exception to North Dakota State Law (Century Code, or NDCC) regarding “Protection against insolvency”. Per NDCC Chapter 26.1-18.1-01, Definitions, PACE is excluded from the definition of an HMO:

> *1. "Health maintenance organization" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both. However, a qualified PACE is not a health maintenance organization.*

Therefore, when NDCC Chapter 26.1-18.1-12, Protection Against Insolvency, establishes net worth requirements for HMOs, PACE organizations are excluded:

> *1. Net worth requirements.*
>
> > *a. Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization have an initial net worth of one million dollars and shall thereafter maintain the minimum net worth required under subdivision b.*

Even with the relatively small enrollment in North Dakota, since its inception 15 years ago, PACE has been a positive option for many individuals and there have been no closures of either PACE organizations or centers.

VI.ii Participant Outreach and Enrollment

As aging individuals and caregivers need assistance with medical services and home supports, they are introduced to components of LTSS. LTSS can include medical care; home-based services such as attendant care, home healthcare, or home modifications; community programs such as adult day health centers; and institutional care such as NF care.

Options Counseling and Enrollment Navigation

Accessing LTSS can be overwhelming with unfamiliar eligibility criteria and enrollment processes, as well as lack of awareness about how to gain access or obtain referrals. Aging individuals and caregivers may turn to emergency departments or private pay services to meet urgent needs. The Administration on Community Living (ACL), CMS, and Veteran's Health Administration (VHA) developed the No Wrong Door (NWD) model to support states in providing uniform and consistent access to a full range of services, including LTSS, for any individual.

Minnesota's NWD model includes several access points to long-term care consultants, including Senior LinkAge Line, county health or human services agencies, tribal nation resources, and Medical Assistance care coordinators if the member is enrolled in a health plan. County or tribal resources can be located using the County and Tribal Directory for Minnesota Health Care Programs/Minnesota DHS.

The Senior LinkAge Line® is a free statewide service of the Minnesota Board on Aging in partnership with Minnesota's AAA's. The Senior LinkAge Line can help Minnesotans with many age-related and caregiving issues, such as:

- Health insurance counseling—including Medicare, long-term care planning, and prescription drug costs
- Forms assistance, including help applying for Medicaid and Medicare Extra Help
- Long-term care insurance and planning
- Comparing housing options
- Connecting with help and services in the community
- Moving out of a NF and back into the community
- Pre-admission screening for NF

VI.iii MSHO, MSC+, and Special Needs Basic Care (SNBC) Landscape

Minnesota's LTSS environment supports a range of programs, many of which focus on keeping aging adults in the community. The Minnesota EW Program serves adults age 65 and older, who meet NF level of care, and who are eligible for payment of long-term care under Medical Assistance. Most members enrolled in the EW receive HCBS services and other Medicaid services through a Managed Care Organization (MCO) contracted by either the MSC+ or MSHO. Some aging adults not eligible for managed care receive their EW services through the FFS system, with case management from a county or tribal lead agency. The state also provides an AC program which supports individuals age 65 and older who are not financially eligible for Medicaid but are expected to be Medicaid-eligible within 135 days of entering a NF, and who meet NF level of care.

MSHO and MSC+ are the current managed care programs under Medicaid for aging adults in Minnesota. MSHO is a fully integrated dual-eligible special needs plan (FIDE SNP), which incorporates benefits for both Medicaid and Medicare, including LTSS, in a managed care model. MSC+ does not include Medicare benefits; however, a member may qualify and receive benefits for Medicare separately.

MSHO and MSC+ are entitlement programs, which means all applicants who meet eligibility requirements must receive benefits regardless of the number of people enrolled. Though someone who qualifies for MSHO or MSC+

may also qualify for the EW and have their EW services paid for by managed care, the EW is able to set enrollment caps and establish waitlists; however, the EW in Minnesota has never done so and plans to maintain the program without caps.

The MSHO plan operates under two separate contracts, one with CMS (for Medicare), and another with the state (Medicaid). If an MCO contracts to provide services to MSHO enrollees, they must also be contracted to provide services for MSC+ and must accept MSC+ enrollees. MSHO members require varied services; a portion live and receive care in an NF, and around half of members are enrolled in EW, receiving care from EW at home or in an assisted living environment.

MSHO has been a longstanding program in Minnesota for the past 25 years and has seen considerable success. MSHO members were less likely to be hospitalized, have emergency department visits, or be admitted to a long-term care facility than MSC+ members; they also were more likely to receive preventive care services, remain at home, and receive hospice care than MSC+ members.[82] As of May 2024, there are 45,553 members enrolled in MSHO spread across eight MCOs.[83]

An additional benefit that MSHO provides in Minnesota is the ability to reach dual-eligible members in areas where a PACE center and proximity to PACE providers may not be feasible. PACE provides the benefit of an array of services at a PACE center, additional support for members to remain at home, and the opportunity for members younger than 65 years of age to receive integrated care. MSHO and PACE differ, and thus would remain separate and complementary programs in Minnesota, where enrollees who qualify for either could select the program that best fits their needs, geographic location, and future care goals.

As Minnesota considers PACE, it may also consider the feasibility of expanding current managed care options to include HCBS for Medicaid-eligible individuals ages 55 through 64. Currently, this age group may receive HCBS through the Minnesota CADI waiver and Minnesota State Plan services in an FFS environment. Expanding managed care HCBS options may allow individuals to become familiar with supports that may prevent hospitalization or entrance into an NF. The care coordination of medical services, HCBS, and caregiver or natural supports is a significant advantage provided by MSHO/MSC+ and PACE, which is not currently provided to individuals receiving services through CADI and FFS. Further alignment of HCBS services in other managed care arrangements may help with future care navigation and service coordination.

Alternative Considerations

As Minnesota considers PACE, it may also consider the feasibility of expanding current managed care options to include HCBS for Medicaid-eligible individuals ages 55 through 64.

[82] Anderson, Wayne, Feng, Zhanlian, Long, Sharon. March 30, 2016. *Minnesota Managed Care Longitudinal Data Analysis*. Office of the Assistant Secretary for Planning and Evaluation (ASPE). Accessed October 1, 2023. https://tinyurl.com/7net858f

[83] Department of Human Services (DHS).. *Enrollment Figures*. DHS. Accessed May 14, 2024 https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&dDocName=MNDHS-066630

In addition to MSHO and MSC+, Minnesota also offers a voluntary managed care program for individuals with disabilities ages 16 through 64, called Special Needs Basic Care (SNBC). The benefits offered through SNBC are the same as those for the Minnesota Medicaid FFS program, plus a care coordinator and access to a 24-hour nurse phone line. HCBS waiver and home care services are provided on a FFS basis. The various waiver programs for people under 65 needing nursing facility level of care are carved out of SNBC as are State Plan personal care services. Members who turn 65 while enrolled in SNBC will be disenrolled on the last day of the month they turn 65 and, if able to enroll in a senior managed care plan, will be enrolled in MSC+ unless they choose to enroll in MSHO (Medicare- and Medicaid-eligible).

VI.iv Program Design and Implementation

Prior to enrolling entities as PACE organizations and initiating operations, there are various considerations for the SAA. SAAs must ensure compliance with federal regulations (42 CFR Part §460), as well as with the requirements of the three-way CMS/SAA/PACE agreement.

Areas for SAA consideration include:

- Process for determining how initial PACE organizations will be identified and selected
- Establishing any state-specific criteria for the PACE entity
- Actuarial rate setting for the PMPM, with cohorts considering:
    - Age of beneficiary
    - Urban or rural
    - Dual-eligible or Medicaid-only
- Providing technical assistance to a potential PACE entity and preparing for the SRR of the PACE center
- Procedures PACE organizations will need for enrollment and disenrollment of individuals as PACE participants, including involuntary disenrollments
- Processes for overseeing the PACE organization's administration of incident management and safety criteria for enrollees living in the community
- Requirements for information to be provided, such as the participant rights
- Requirements for quality assurance reporting by PACE organizations
- Procedures for monitoring care planning
- Requirements for PACE organization for audit participation and financial reporting
- Methods to be used by PACE organizations for member outreach and marketing

Identifying the SAA

Federal PACE materials and guidance reference SAAs. PACE regulations at 42 CFR §460.6 define the SAA as the state agency responsible for administering the PACE agreement. The SAA may be the Medicaid agency or another agency. Even if a sister agency is selected as the SAA, the Medicaid agency, as the single state Medicaid agency, remains responsible for Medicaid expenditures and needs to be involved in certain aspects of administration, such as the Medicaid SPA and federal financial reporting.

State Staffing Considerations for PACE

The SAA will also need to develop an allocation plan for other staff who will contribute to program oversight. Staff typically providing input or additional support but who are not full-time with PACE will be individuals with expertise in HCBS, facility licensing, rate setting, data, contracting or procurement, or survey analysis for Consumer Assessment of Healthcare Providers and Systems (CAHPS). Staff will be responsible for and have authority over the following program components:

- Technical assistance for the PACE organization application submission to CMS
- PACE organization readiness review
- Clinical services, NF, and HCBS provider auditing to the extent that the SAA requires the providers to follow statutorily required processes such as public health department audits or surveys
- Financial eligibility process for Medicaid and Medicare
- Functional eligibility for PACE (level of care)
- Eligibility (financial and functional) denial and appeal processes
- PACE organization closure requirements
- Contract execution and monitoring with the PACE organization and CMS
- Capitation rate setting
- Data reporting and analysis, including CAHPS survey

After reviewing other state staffing models and Minnesota's Management and Budget job classification specifications, the following staff positions may be considered for the implementation, management, and evaluation of PACE:

Table 7: Management and Budget Job Classification Specification 003913

Title	**Human Services Supervisor 2, Class Code 003913**
Classification	https://mn.gov/mmb-stat/hr-toolbox/002-class-and-compensation/001-classification/class-specs/h/3913-hum-serv-supr-2.pdf[84]
Description	The class specifications indicate the nature and purpose of the Human Services Supervisor 2 position is as follows: An employee in this class supervises development of healthcare, monetary, and non-monetary assistance programs, as well as the management and investigative services that enhance their operation. The work involves translation of state and/or federal mandates into operational rule, policy, procedure, technical assistance, and monitoring through professional staff. Incumbents are responsible for one or more portions of the following: planning, development, assessment/evaluation, and modification. Responsibilities extend to establishing standards of performance and service, hiring, training, directing, evaluating, and disciplining employees. Considerable latitude is given to the employee for use of independent judgment in carrying out assigned duties and responsibilities.

Table 8: Management and Budget Job Classification Specification 002393

Title	**Nurse Specialist, Class Code 002393**
Classification	https://mn.gov/mmb-stat/hr-toolbox/002-class-and-compensation/001-classification/class-specs/n/2393-nurse-specialist.pdf
Description	The class specifications indicate the nature and purpose of the Nurse Specialist position is as follows: An employee in this class exercises considerable independent judgment in development of program standards, training, and evaluation in an area of specialization such as pediatrics, family planning, perinatal, or geriatrics. This employee may direct in a leadwork capacity other nursing specialists and/or other people who are employed or contracted by the state.

[84] Minnesota Department of Management and Budget. N.d. *Job Class Specifications*. Accessed January 25, 2024. https://mn.gov/mmb/job-class-specs/.

	The Clinical Nurse Specialist reports administratively to a unit supervisor and technical direction is received upon request from a physician. The position must have current licensure as a registered nurse in compliance with the Minnesota Nurse Practice Law.

Other areas where a portion of SAA staff or contract time may be needed for PACE administration include:

- Special Needs Purchasing
- Actuarial Services for rate development
- Capitation payment policy
- HCBS policy
- MCO quality
- Encounter data
- Contract attorney
- Contract manager
- Enrollment staff

Coordination with State Units on Aging

The premise of PACE is consistent with the efforts of State Units on Aging, funded through the Older Americans Act (OAA), which support programs and services that help aging adults live independently. Supporting caregivers is a priority of OAA efforts, which is also a foundational principle of PACE. While braiding of OAA and PACE funding streams and service locations may pose challenges, the PACE SAA can benefit from ongoing collaboration with the State Units on Aging. Minnesota has a strong history of developing state-specific solutions that address gaps in service and promote well-being. A collaboration with OAA may offer ideas for developing a PACE that best meets the needs of PACE participants and their families.

Identification and Selection of Providers

When determining how to proceed with PACE design and implementation, the SAA will need to decide how to identify and select entities who are qualified and interested in developing PACE. An RFI could be used early in the process to test interest from potential PACE entities. If the RFI results show significant interest, the SAA may:

- Develop an RFP to solicit entities to operate a PACE. The NPA maintains a repository of State PACE RFPs that could be of interest should Minnesota use this approach.
- Seek legislative designation of prospective PACE centers, including potential timeline for program and/or center expansions.

Regardless of the approach taken to identify prospective PACE entities, the SAA will want to consider establishing criteria that can be used to evaluate organizational capacity, readiness, solvency, and related experience. For example:

- Would the SAA require potential applicants to assess community needs prior to consideration as a PACE provider?
- Proof of financial reserves, solvency, and ability to operate within a fully capitated arrangement
- Which provider types will the SAA consider as PACE entities? (See Section 5.4 for information on potential PACE entity provider types)
- Expectation for use of electronic health records or case management systems
- Capacity to submit reports to the SAA regarding participant health outcomes, satisfaction levels, provider network capacity, encounter claims, and/or other quality and service delivery metrics

In addition, the RFP or legislative process will need to determine the initial number of PACE organizations and/or centers to be established and may wish to stager implementation in recognition of the SAA effort to launch each program and/or center.

Eligibility Groups

As part of the design of the PACE, the SAA, in consultation with Medicaid eligibility staff, will want to review current Medicaid eligibility criteria and evaluate if changes will be proposed for PACE member eligibility. Any eligibility changes will need to be coordinated with Medicaid staff who manage the eligibility process, systems, and the Medicaid state plan, to establish the infrastructure is in place to support any eligibility variations. As noted in the letter contained in Appendix G, at least one community member group discouraged DHS from considering an income eligibility level for PACE that is lower than for others who qualify for Medicaid under existing eligibility categories or groups:

> *Some states have established a lower income threshold for beneficiaries compared to the federally allowed guidelines. Similarly, some states have carved out beneficiaries who receive certain types of housing benefits. It would be inadvisable to exclude people from benefitting from this program if they otherwise meet federal guidelines.*

Infrastructure and Administrative Considerations

Any change to Medicaid requires advanced and careful consideration of the impacts that can be viewed as "behind the scenes" of the work stream directly related to implementation. If Minnesota moves forward with PACE implementation, the considerations in this section can be used to construct a project outline and schedule that can support the implementation approach, including operationalizing parallel work streams in various areas. Implementation considerations are outlined in Table 8 below:

Table 9: Implementation Considerations

Business Area	Consideration
Administrative Framework	How will DHS assess, plan for, and provide ongoing support for the administrative considerations for implementing and managing a PACE program, such as level of care determinations/member assessments, establishing process for state-specific licensing or fiscal solvency criteria, training new or existing state or county staff regarding process changes and program requirements?
Medicaid Management Information System (MMIS)	Are updates needed for claims processing, encounter claims processing, federal reporting (e.g., financial; CMS-64 and data; Transformed Medicaid Statistical Information System [T-MSIS]); interfaces (such Eligibility and Enrollment [E&E], level of care vendor, quality oversight vendor, or Medicare)?
E&E System	Are updates needed for categories of eligibility, federal match codes, or other data field changes to track urban/rural, dual/Medicaid-only, age cohort, etc.?
MCO Contracts	Would MCO contracts be impacted with PACE implementation? Are there considerations for partial-month eligibility, or coverage in the case of PACE disenrollment?
State Law	Are there state law references that need to be reviewed and updated to ensure the SAA has the appropriate authority to administer PACE? Does Minnesota wish to develop state-specific criteria, such as licensing or fiscal solvency? Are there operational authorities needed for the SAA to provide the necessary support and oversight to PACE and to ensure services are provided within the quality framework established?

As with most Medicaid changes that involve new services and provider types as well as changes to the Medicaid administrative structure, there are additional areas that should be considered with the implementation of PACE:

- Will updates to the Public Assistance Cost Allocation Plan be required?
- Will existing contracts that support administrative activities need to be updated (e.g., Prior Authorization, External Quality Review, Actuarial Services, Third-Party Liability, Waste, Fraud and Abuse, or Level of Care)?
- What training will new or existing staff need to fulfill expected PACE support functions?
- How will the MnCHOICES assessment/reassessment/support planning processes change with PACE implementation, and what impact will there be to the current lead agencies performing these roles?

- How will existing outreach, resource, and referral efforts need to be modified so consumers, caregivers, and the public can access information regarding PACE?
- Will there be ongoing legislative reporting? If so, consider building reporting frameworks as the program is designed and implemented.
- What information will be needed for future fiscal projections and budget development, including any program and center expansions?
- What additional provider designation and enrollment considerations including potential impacts to the MMIS as well as other enrollment processes and systems?

VI.v State-Specific Criteria and Licensing

It is not uncommon for SAAs to align their state requirements for PACE entities to those found in 42 CFR §460, detailed above in Section 3.3 PACE Operational Overview for States. This alignment includes adopting the language from 42 CFR §460 into their state administrative rules or similar Code structure. However, some states have adopted state-specific requirements. These requirements may include enhancements to the PACE care model, such as specific care management or access requirements, and/or cultural competency requirements. In addition, some states have adopted certificate of need, financial, and/or licensing requirements, some of which are detailed in the following subsections. Should Minnesota wish to consider state-specific requirements for PACE, considering the following examples and asking potential entities, as part of a PACE RFI, may provide the state with a structure that best balances oversight and access.

SAA Oversight of Fiscal Soundness

The federal regulations governing PACE provide a foundation of requirements regarding fiscal soundness of PACE organizations. Specifically, 42 CFR §460.80 requires PACE organizations to have fiscally sound operations, an insolvency plan, and arrangements to cover expenses. Some states have built on this foundation by clarifying how fiscal soundness will be determined, or by adding additional state-specific requirements. Such considerations around program oversight will impact the design of PACE in Minnesota and impact the resources needed for program operation for both the SAA as well as PACE organizations.

Virginia Code § 32.1-330.3. Operation of a PACE plan; oversight by Department of Medical Assistance Services requires the PACE entity to "… demonstrate that it has arrangements in place in the amount of, at least the sum of the following to cover expenses in the event of insolvency:

- One month's total capitation revenue to cover expenses the month prior to insolvency; and
- One month's average payment of operating expenses to cover potential expenses the month after the date of insolvency has been declared or operations cease.

Appropriate arrangements to cover expenses shall include one or more of the following:

- Reasonable and sufficient net worth
- Insolvency insurance

- Letters of credit, or parental guarantees

- **California** has developed a New Applicant Financial Requirements document to aid PACE entities in understanding federal and state requirements regarding financial status for new applicants. In addition, to federal requirements, California requirements for PACE entities include:
  - Maintaining a tangible net equity equal to one month's capitation
  - Maintaining an organizational structure sufficient to conduct the proposed operations and ensure its financial resources are sufficient for sound business operations

- If the organization conducting the day-to-day PACE operations is a subsidiary entity within a larger parent company, a separation of duties must be clearly established between the two entities in the PACE organization's operating policies and procedures and its financial record-keeping. A separate financial statement must be maintained for the PACE entity, which includes the balance and income statements. The financial reserve requirements must be held in a separate bank account clearly designated as the PACE reserve account. The funds in this account shall not be commingled with the reserves for any other program.

- In addition, California requires that PACE organizations ensure an annual audit is performed to include working capital and current ratio of one of the following:
  - Demonstration of currently meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; OR
  - Evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.[85]

South Carolina requires PACE organizations (not parent organization) to submit quarterly (unaudited) balance sheets that detail the performance of the program.[86]

In addition to the above examples that are related to initial and ongoing operational fiscal soundness, Minnesota could consider requiring potential PACE entities to provide proof of available funding for startup costs. See Section 3.5 Startup Funding for additional information on startup costs.

Certificate of Need and Program Licensure

[85] California New Applicant Financial Requirements. Accessed April 11, 2024. https://tinyurl.com/54avbwjk

[86] South Carolina Department of Health and Human Services. April 18, 2022. *Program of All-Inclusive Care for the Elderly (PACE) Provider Manual.* Accessed April 12, 2024. Accessed April 12, 2024. https://tinyurl.com/2ddp7r2w

Michigan requires the entity wishing to become a PACE organization to submit a feasibility assessment for PACE for new/expanding programs.[87] **Maryland** requires PACE applicants to be licensed as an Adult Medical Day Care Facility[88], and **New Jersey** requires Ambulatory Care Facility licensure.[89]

Texas and South Carolina require PACE entities to be licensed as adult day care centers.[90],[91]

Kentucky has the following requirements for an entity to secure approval to operate as a PACE organization:[92]

- **Certificate of Need:** The PACE organization shall apply for a non-substantive review certificate of need. Kentucky defines non-substantive as a PACE organization that has met the requirements of the SRR, seeks to provide a healthcare service not exempt from certificate of need, and ensures that all services are provided exclusively to its members who reside in the service area.[93]
- **Adult Day Health Center Licensure:** The PACE organization must apply for Adult Day Health Center Licensure.[94]
- **Home Health Licensure:** After signing the three-way agreement, the PACE organization must apply for Home Health Licensure.[95] At start date of the first PACE participant, the PACE organization must notify the Kentucky Office of Inspector General to request an initial, unannounced licensure survey.[96]

---

[87] Michigan Department of Health and Human Services (MDHHS). April 1, 2024. *Michigan Medicaid Provider Manual*. Accessed April 12, 2024. ://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

[88] Maryland Department of Health, Maryland Office of Long-Term Services and Supports. September 1, 2021. *Provider Solicitation – Request for Responses, Program of All-Inclusive Care for the Elderly*. Accessed April 15, 2024. https://tinyurl.com/4b2z6err

[89] *Subchapter 33- Programs of All-Inclusive Care for the Elderly (PACE) Organizations. April 1, 2024.* New Jersey Administrative Code. Accessed April 12, 2024. https://tinyurl.com/mr3xu82w

[90] Texas Administrative Code. September 1, 2014. *Social Services and Assistance Department of Aging and Disability Services Contracting to Provide Programs of All-Inclusive Care for the Elderly (PACE) Contracting Requirements.* Texas Title 40, Part 1, Chapter 60. Accessed April 12, 2024. https://tinyurl.com/tx8zk4av

[91] South Carolina Department of Health and Human Services. April 18, 2022. *South Carolina PACE Provider Manual*. Accessed April 12, 2024. https://www.scdhhs.gov/sites/default/files/pace/SCDHHS%20PACE%20Manual.%204.18.2022_FINAL.pdf

[92] Kentucky Office of Inspector General, Division of Health Care. June 12, 2023. Kentucky Guidance on CON HH ADH Licensure for PACE. April 12, 2024. https://tinyurl.com/yzmf3hx3

[93] Title 900 | Chapter 006 | Regulation 075. March 26, 2024. Kentucky General Assembly. Accessed April 12, 2024. https://apps.legislature.ky.gov/law/kar/titles/900/006/075/

[94] Title 902 | Chapter 20 | Regulation 066. *Kentucky Adult Day Health Center Licensure*. Kentucky Administrative Regulations. December 15, 2021. Accessed April 12, 2024. https://apps.legislature.ky.gov/law/kar/titles/902/020/066/

[95] Title 902 | Chapter 20 | Regulation 081. *Operations and Services, Home Health Agencies.* December 15, 2021. Kentucky Administrative Regulations. Accessed April 12, 2024. https://apps.legislature.ky.gov/law/kar/titles/902/020/081/

[96] Kentucky Office of Inspector General, Division of Health Care. June 12, 2023. Kentucky Guidance on CON HH ADH Licensure for PACE. April 12, 2024. https://tinyurl.com/yzmf3hx3

VI.vi PACE Approval Process

As noted in Section 3.1, PACE must be elected as an optional service for Medicaid, which is done through a SPA. Assuming CMS has approved the PACE SPA, and the SAA has identified and selected one or more PACE entities, the process necessary for PACE approval will include an NOIA, a PACE Entity Application, and a three-way agreement, each detailed further in this section.

NOIA

Entities that will be submitting an initial application to become a PACE organization must file an NOIA; see Appendix E. The NOIA must be submitted by the PACE entity early in the quarter in which the entity plans to submit the PACE Application. The NOIA must be submitted to the PACE portal (Imi.org). Upon receipt of the NOIA, CMS will issue a contract number and HPMS access information to the PACE entity.

PACE Entity Application

According to the regulations at 42 CFR §460.12, an entity that wants to become a PACE organization must submit the PACE Entity Application. The application includes sections that cover PACE requirements; for example: service area, governing body, fiscal soundness, marketing, enrollment and disenrollment, grievances, service requirements, interdisciplinary team and plan of care, program integrity, and medical records.

The application also includes a section of Document Templates to be used by the applicant PACE entity to provide supporting documentation for various sections in the application. The SAA is required to provide attestations and assurances as part of the application, which certify:

- The entity is qualified to be a PACE provider and has been selected to operate in the geographic service area
- The SAA is willing to enter into a program agreement with the PACE entity
- The state has elected PACE in the Medicaid State Plan
- Any enrollment caps for the PACE organization/center
- Its agreement to make capitated payments
- The SAA will verify the qualifications of PACE-program-employed or contracted staff, prior to service initiation
- Participants will have access to the state's Fair Hearing process
- Agreement with various processes and requirements related to the participation of dual-eligible individuals in PACE

The completed SRR is a required element before CMS will approve the application; however, the SRR may be uploaded as part of the initial submission of the application, or may be uploaded after the initial application submission, subsequent to CMS's request for additional information. Note: Because the application must be

submitted on the CMS-designated quarterly submission date and must be submitted in the same quarter that the NOIA was submitted, it may be necessary to submit the application before receipt of the completed SRR.

In accordance with 42 CFR 460 Subpart B, PACE organizations may submit a waiver requesting reasonable flexibility for adapting the PACE model to the needs of particular organizations. Waivers may be particularly helpful for rural PACE centers. A waiver request must be reviewed by the SAA, and once complete, the SAA forwards the waiver request to CMS, and will include concurrence, concerns, or conditions regarding the waiver.

Three-Way Agreement

The three-way agreement is assembled by CMS after receipt and approval of the PACE Application. The current CMS template for the three-way agreement can be found at https://www.cms.gov/medicare/health-plans/pace/downloads/programagreement.pdf.

Timelines for PACE Application Review and Approval

According to the federal regulations at 42 CFR §460.20, within 90 days of a PACE entity submitting a complete application to CMS, CMS takes one of the following actions:

(1) approves the application;

(2) denies the application and notifies the entity in writing of the basis for denial and the process for requesting reconsideration of the denial; or

(3) requests additional information needed to make a final determination.

If more than 12 months elapse between the date of the initial submission and the entity's response to the CMS request for additional information, the entity will be required to update the application and related materials.[97]

State Readiness Review

Before the new PACE organization can start providing services, the state must conduct an SRR of the proposed PACE center. CMS has developed a tool that the SAA may use to complete the most recent version of the CMS SRR tool.[98]

The SRR includes physical inspection of the PACE center and assessment of the organization's compliance with criteria, such as:

- **Federal Compliance:** Policies and procedures that cover all required domains in 42 CFR Part §460

[97] 42 CFR § 460.20. *Notice of CMS Determination.* June 3, 2019. Federal Register. Accessed April 11, 2024. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-E/part-460/subpart-B/section-460.20

[98] Centers for Medicare and Medicaid Services (CMS). 2019. *Readiness Review Report*. CMS.gov. Accessed April 12, 2024. https://www.medicaid.gov/sites/default/files/2019-12/3-33b-readiness-review.pdf

- **Physical Infrastructure:** Design and construction of the PACE center, including fire inspections, safety, and accessibility standards, etc.
- **Additional Requirements:** Additional requirements that states may include are state licensing requirements, PACE staffing requirements, emergency preparedness, and adherence to Life Safety Code

The PACE entity submits the SRR either with its application or in a request for additional information from CMS.

VI.vii SAA Ongoing Administration and Oversight

As with all Medicaid-covered services, there are ongoing administrative responsibilities, including oversight. Some of the administrative responsibilities are described in this section. See Monitoring and Oversight of PACE Organizations in Section 3.5 for additional information on requirements specific to monitoring and oversight.

Level of Care

As a requirement for enrollee eligibility, the SAA is responsible for determining level of care for individuals who want to enroll with PACE. In addition, federal regulations require annual recertifications of level of care and afford SAAs options related to waiving the annual recertification and utilizing deemed continued eligibility.[99]

Involuntary Disenrollments

The SAA is required to review involuntary disenrollment and determine that the PACE organization has adequately documented acceptable grounds for disenrollment.[100] See Enrollment and Disenrollment of Participants in Section 3.5 for additional information.

Member Transition Between MSHO/MSC+/SNBC and PACE

- As the SAA monitors PACE enrollment and member transition between programs, the following criteria should be reviewed with a standard level of frequency:
  - Members may change between a PACE organization and MSHO MCOs as allowed by Medicare regulation
  - Members may change between a PACE organization and MSHO or MSC+ upon request to the MCO during the MCO open enrollment period; similarly, as allowed by Medicare regulation and under Minnesota Rules, Part 9500.1453, subparts 5, 7, and 8, and 42 CFR §438.56(c)(2)

[99] 42 CFR § 460.460 Subpart I – Participant Enrollment and Disenrollment. June 3, 2019. Federal Register. Accessed April 15, 2024. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-E/part-460/subpart-I

[100] 42 CFR § 460.460 Subpart I – Participant Enrollment and Disenrollment. June 3, 2019. Federal Register. Accessed April 15, 2024. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-E/part-460/subpart-I

- Individuals enrolled with SNBC, ages 55 through 64, who otherwise meet the PACE eligibility criteria, may find the additional benefits of PACE attractive and transition between PACE enrollment and SNBC

Appeals

The SAA must review and monitor the PACE organization's grievance and appeal processes to ensure they are consistent with 42 CFR §460.120 (grievance process) and 42 CFR §460.122 (PACE organization's appeal process), respectively. The PACE organization must have written processes for both grievances and appeals, and must notify participants at least annually of the processes. In addition, the regulations require the PACE organization to maintain and analyze information related to grievance and appeals and use the information for quality improvement efforts.

Incident Reporting

The commissioner for DHS has statutory authority over the MN HCBS standards. The applicability and scope of authority is outlined in Section 245D.03 (Sec. 245D.03 MN Statutes). Protection and safety standards are outlined in Section 245D.06 (Sec. 245D.06 MN Statutes) and include incident reporting, prohibited procedures, and restricted procedures. To ensure the protection and safety standards and incident reporting for PACE are aligned with other HCBS programs, DHS would need to take action to ensure the applicable Sections of Minnesota statute are updated. In addition, these protection and safety standards and processes should be included in the agreement between the PACE organization and SAA.

Quality Assurance Reporting

The SAA is responsible for overseeing a quality assurance reporting process. Because DHS has experience implementing the CAHPS, DHS should expect the Minnesota PACE organizations to participate in the survey. Current participants in the CAHPS are MSHO, clinicians and groups, hospitals, and adult health plans.

VI.viii PACE Implementation Checklist

Table 10 below details, at a high level, the tasks involved with establishing and operationalizing a PACE in Minnesota. The approximate durations noted are high level estimates of timeframes for the tasks based on the experiences of peer states, research, and subject matter expertise. There is a checklist of tasks for the SAA, as well as a checklist of tasks for the PACE Organization. The tasks and durations are intended as a starting point for implementation considerations. Some of the tasks can be accomplished concurrently.

Legislative appropriation for PACE operations, including administrative costs, is a prerequisite for initiating task on the checklist. Upon receipt of Legislative appropriation, a thorough workplan incorporating these elements would be the first step in the implementation process.

Table 10: PACE Implementation Checklist

#	Implementation Task	Approximate Duration (Months)
PACE Implementation Checklist for the SAA		

#	Implementation Task	Approximate Duration (Months)
1.1	Inform CMS of intention of PACE implementation, establishing contact with point person in regional office as well as Medicare	2
1.2	Identify State staffing needs and onboard PACE program staff	6
1.3	Develop SPA	1-2
1.4	Negotiate SPA with federal partners at CMS	3-6
1.5	Develop PACE capitation rates and Upper Payment Limit (UPL) for payments to PACE organizations	2
1.6	Establish program guidelines including member eligibility, provider types, expected systems use, number of organizations, urban/rural mix, age, reports, and network needs as well as state-specific licensure and financial solvency requirements.	3
1.7	Develop RFP for PACE organizations	3
1.8	Finalize PACE procurement and solicit proposals from prospective PACE organizations	3-4
1.9	Identify State IT impacts for PACE including MMIS and E&E systems	3
1.10	Identify policy and program impacts such as impacts to the state plan and managed care and PACE contracts	2
1.11	Update existing contracts for administrative activities such as level of care, external quality review, actuarial services, and third-party liability	3
1.12	Remediate State IT impacts for PACE including MMIS and E&E systems	9-12
1.13	Remediate policy and program impacts across all impacted areas, including managed care and PACE contracts	3-6
1.14	Develop manual or other documentation for PACE organizations inclusive of participant rights, reporting, enrollment/disenrollment, and quality assurance	3
1.15	Design and conduct training for new or existing staff to fulfill expected PACE support functions	1
1.16	Facilitate changes to outreach, resource, and referral processes to include information on PACE for consumers, caregivers, and the public	2
1.17	Develop and implement contracts with PACE organizations	2
1.18	Develop PACE organization application process	2

#	Implementation Task	Approximate Duration (Months)
1.19	Review and award PACE organization contracts for service operations	3
1.20	Verify and enroll entities as PACE organizations	2
1.21	Develop and provide attestations and assurances as part of the application process	1
1.22	Perform PACE organization readiness review	3
1.23	Develop waiver process for PACE organizations and process any initial waivers	2
1.24	Providing technical assistance to selected PACE organization(s)	6
Implementation Checklist for PACE Organizations		
2.1	Conduct a needs assessment or market analysis	3
2.2	Develop infrastructure for at least one PACE center and services	4
2.3	Establish provider network and ensure written contracts are in place for all outside organizations/practitioners	3
2.4	Establish interdisciplinary team	3
2.5	Develop process for participant assessments and plan of care	3
2.6	Establish methods for member outreach and marketing and develop materials	3
2.7	Establish procedures and agreements for enrollment and disenrollment of PACE participants, including written participant rights	3
2.8	Establish processes for administration of incident management and safety criteria for PACE participants	2
2.9	Establish grievance and appeal processes	2
2.10	Establish processes and ensure systems are in place to collect data, maintain records and complete required reporting	2
2.11	Establish processes for audit participation and general reporting	1
2.12	File an NOIA with CMS	1
2.13	Submit PACE Application to CMS	2
2.14	CMS review and approval	3

#	Implementation Task	Approximate Duration (Months)
2.15	Determine and facilitate supporting documentation for various sections in the PACE Entity Application	3
2.16	Submit the PACE Entity Application to DHS	1
2.17	Finalize three-way agreement	1

VII. Results of Community Engagement

The Results of Community Member Engagement Section of the PACE Implementation Program Analysis Initial Report covers the three community engagement sessions, summarizes notes, and identifies key themes gathered during the sessions.

VII.i Background

DHS collaborated with BerryDunn to host internal and community engagement sessions. The Community member engagement sessions offered valuable contextualization to the feasibility analysis research, including potential benefits and challenges of PACE implementation in Minnesota. DHS community members provided information on how PACE may influence the member experience, administrative landscape, and program operation within the state government. External community members reported a demand for PACE and its services in Minnesota and discussed considerations for providers. Through the community engagement sessions, key themes emerged, which will be enumerated in the sections below. Questions were prepared for each session, specific to the community member group and phase of feasibility analysis development.

Table 11: Community Member Engagement Session Questions

Community Member Group	Questions Asked
Internal (DHS and Minnesota State Employees, December 7, 2023)	Which program area do you represent and why are you interested in a discussion about PACE? From your perspective, do you see a problem or gap for PACE to address? What are the potential risks and opportunities of this project? What other changes are happening within the organization that may affect the ability to implement PACE? What would success look like for Minnesota PACE? Are there agency changes that would need to be considered for PACE to be implemented and successful in Minnesota?

Community Member Group	Questions Asked
	Do DHS staff members have the necessary resources to support implementation of PACE in Minnesota?
Community Members (December 7, 2023)	From your perspective, do you see a problem or gap for PACE to address? What would you like PACE to accomplish? What would success look like for Minnesota PACE? What concerns, if any, do you have about Minnesota implementing PACE? Is there anything else you would like DHS to consider as Minnesota is studying implementation of PACE? Are there other key community members that should be consulted? If so, what individuals need to be involved as key community members in addition to the ones already identified?
Community Members (April 4, 2024)	The April 2024 community member session focused on DHS and Milliman explaining the actuarial analysis prepared for PACE. Community members provided questions and feedback.
Community Members (May 2024)	Outstanding Policy Considerations ▪ Considering the outstanding policy considerations for the Department of Human Services (DHS), are there items that you noted from the report that could be particularly helpful as MN considers PACE implementation? Implementation and Timeline ▪ What considerations would be helpful for MN when considering a timeline for PACE implementation? ▪ If MN initially implements PACE with a limited number of organizations and/or service areas, what considerations could be used to selecting organizations and/or service areas? ▪ Are there major tasks that are not represented in the report and/or implementation checklist? State Landscape ▪ From the Peer State Comparison, are there items that you noted that could be particularly helpful for MN as MN considers PACE implementation? ▪ What is unique about the MN long term supports and services (LTSS) landscape that should be considered as MN evaluates PACE implementation?

Community Member Group	Questions Asked
	Oversight ▪ Through the detail provided about state-specific licensure and fiscal solvency requirements, which approaches align best with MN's overall approach to program oversight and provider accountability? ▪ Similarly, what types and levels of LTSS should be considered as "experience in providing LTSS"?

VII.ii Minnesota Agency Engagement Session

The Minnesota Agency Engagement Session occurred on December 7, 2023. It was a one-hour session with 25 participants, including six BerryDunn team members. Most Minnesota state employees present in the meeting were employed directly by DHS, but there were also employees from the MDH. The internal community members worked for a variety of units, including HCBS, managed care, MFP, quality, eligibility, contract management, disability services, healthcare research, rate setting, and aging services.

Table 12: Key Themes from Minnesota Agency Engagement Session

Theme	Comments
Equity	Community members expressed interest that PACE allows for members between the ages of 55 and 65, which may help prevent institutionalization for younger populations. Community members noted that though Minnesota has positive average health metrics as a state, there are large disparities in health outcomes between white residents and Black, Indigenous, and People of Color (BIPOC) residents in Minnesota. If PACE was tailored to be culturally relevant for specific cultural communities, PACE could potentially reduce disparities in older adults in terms of health outcomes. A program goal would be for PACE to assist with care for older adults in rural parts of Minnesota; however, this may be challenging given the limited workforce in Greater Minnesota.
Financial Risk and Oversight	With PACE, the financial risk lies with the PACE organizations; it may be difficult to find PACE organizations prepared to manage the financial risk of PACE over the time it takes to recoup initial investments in the program. The role of financial risk and the PACE organization reimbursing providers for services raises the question of how PACE organizations will be licensed and overseen. It is unclear whether the PACE organization would be treated like a provider organization in terms of oversight and regulation.

Theme	Comments
Complexity	DHS employees expressed that Minnesota has a variety of existing programs for older adults, including dual-eligibles, such as the MSHO program. Another option may confuse members in terms of navigating the healthcare and LTSS system. The enrollment process and decisions for which program to enroll in may become more difficult with another program like PACE in the LTSS space. Concerns about complexity are present at every level, from the end user, to families, to lead agencies and providers. DHS is working on numerous initiatives concurrently alongside PACE feasibility and implementation and therefore will need to rely on hiring additional staff members.
Flexibility	DHS employees expressed that MSHO is a successful program for keeping members in their homes; however, post-COVID-19, there is increased isolation in older adults. PACE allows the flexibility for a member to both age in place while also having frequent contact with the community through the day center model, which can assist in preventing or reducing isolation.

Potential Challenges

The key themes above indicate that potential challenges include:

- Finding entities who can manage the level of financial risk that PACE assumes
- Tailoring PACE organizations to improve equity in health outcomes for BIPOC older adults, adults between the ages of 55 and 65, and those in Greater Minnesota
- Attaining staff capacity for the PACE organization and DHS to implement and oversee the program
- Implementing PACE without adding additional difficulty for members, providers, and lead agencies in connecting older adults with the correct services for their needs

VII.iii Community Member Engagement Session 1: Fall 2023

The community member session, which also occurred on December 7, 2023, shared themes with the internal engagement session. One shared theme was PACE's benefit to health equity, particularly for underserved communities in Minnesota. As the community represented lobbyists and potential PACE entities, community members were eager for the swift implementation of PACE, whereas the DHS internal community members were more conscious of the time-consuming administrative load of PACE implementation. While the internal community members voiced the importance of streamlining the complexity of programs, the community focused more on member choices and offering a wide variety of supports to older adults.

Table 13: Key Themes from Community Member Engagement Session 1

Theme	Comments
Equity	Community members expressed that the ability for PACE to serve younger populations is appealing, particularly people who have early onset dementia. One member mentioned that there is increased cultural diversity in older adults in Minnesota, particularly those who do not speak English as their first language. PACE can be more easily adapted to meet the needs of specific communities, for example, Somali and Hmong communities who have a large presence in the Twin Cities Metro area. Providing care options for older adults in rural areas was repeatedly mentioned as a critical area of focus for Minnesota. PACE may be able to provide an efficient supplementary option for care in Greater Minnesota. One member mentioned that rural PACE centers are rarer and more difficult to maintain. Community members present noted the need for participants from Hmong, Hispanic, and East African backgrounds, as well as rural providers, to be included in future conversations.
Member Choice and Caregiver Support	There was an emphasis on member choice for those on Medicaid beside the standard options of staying at home without as much direct support or living in an institutional setting. Community members shared that PACE offers caregiver support, where the caregiver or family member can still be engaged in the member's care without needing to do everything themselves, for example, driving the member to appointments.
Provider Readiness	Community members expressed that there are providers in Minnesota who have operated PACE organizations in other states and who are eager to begin the work of implementing PACE in Minnesota. Community members expressed that PACE is a program that can endure into the future changing environment of Minnesota. Community members, including those representing providers, shared the desire for PACE implementation to be as fast as feasible, and for DHS to collaborate with providers on an ongoing basis. Providers expressed their desired timeline for PACE implementation, including an RFP being issued no later than December 1, 2024, and services beginning by January 1, 2027. The providers suggested that there be two to three urban centers and one to two rural centers from the sponsoring PACE organization.

Theme	Comments
Flexibility	It was noted that if PACE has enough participants, the program is efficient in terms of cost and staffing, PACE works for the sponsor organization because of the flexibility, and the member can age in place while also maintaining connected relationships. Community members expressed that the flexibility of PACE and its ability to care for the individual can potentially prevent acute care usage. Community members noted that PACE was more flexible during the COVID-19 pandemic in responding to the crisis, versus institutional settings like NFs.
Cost	Community members shared that the rates must be high enough to incentivize providers to take on the level of financial risk that PACE requires. This was noted to not be the case in the past attempts to implement PACE in Minnesota. It was mentioned that PACE should not be treated as a pilot program; if there is a cap on participation, it makes it more difficult for PACE providers to make the program work financially. Community members encouraged DHS to consider the need for PACE providers to build service volume to achieve economies of scale. Providers request working collaboratively with the actuarial vendor to ensure that rates are accurate for the 55-65 age group, as well as incorporating administrative and startup costs, and factoring in the cost savings PACE provides in comparison to NF level of care. It was suggested that rates be updated on an annual basis to reflect inflationary cost increases.

Potential Challenges

Community members acknowledged specific challenges with PACE implementation, including:

- The ability for PACE organizations to be accessible to members in terms of language accessibility, systems navigation, paperwork, and cultural understanding
- Having enough community buy-in with the model of care
- Implementing PACE in rural areas, which have the greatest need
- Having capitated rates that are high enough to attract providers and allow providers to take on the financial risk that PACE requires

VI.iv Community Member Engagement Session 2: April 2024

The second community-focused engagement session occurred on April 4, 2024. The session was primarily focused on the results of the actuarial report prepared by Milliman. DHS presented on the report for community members. The session included both internal staff to DHS and external community members. The one-hour long session primarily focused on explaining the actuarial report, so community members could better understand the illustrative PACE capitated PMPM rate prepared by Milliman. Additional feedback was submitted regarding the actuarial report from Health Dimensions Group (HDG) and NPA, which provided letters in response to DHS ahead of the community member session.

Table 14: Key Themes from Community Member Engagement Session 2

Theme	Comments
Timeline	Community members expressed a strong desire to see PACE implemented in Minnesota quickly. One member asked if the SPA could be actively developed for PACE while DHS was deciding upon final policy decisions. Another member expressed hope for parallel tracks of work occurring for PACE so that progress and implementation may happen more quickly. The community member expressed that PACE may help with labor shortages, NF pressure, and in addressing the pressure of a growing aging population.
AWOP Development	Milliman and DHS explained in the community member session the requirement for PACE rates to be based off the AWOP model the assumptions used to calculate the illustrative rates in the report, including how MSHO, MSC+, and the SNBC programs help to inform the costs of the population. One community member asked about the prospective nature of the rates, as the rates determined will impact future payments to providers, while the illustrative rates in the actuarial report are based off of AWOP values from 2022. The community member stressed the upward wage pressure from direct care workers. DHS and Milliman clarified that the final rates would factor in wages, legislative impacts, and policy decisions that are still undetermined. A community member expressed concerns about PACE being compared to programs such as MSHO and MSC+, given that the programs have different operating models. Several community members, including the letters from Health Dimensions Group and NPA, expressed concerns that additional costs of individuals eligible for PACE were not included in calculating the AWOP. There was particular concern that the 95% and 5% split between HCBS and institutional

Theme	Comments
	care for participants that was assumed for rate development would not be accurate for the population served. Milliman explained that the 95% and 5% split was based on other states that have a highly mature managed care program like MSHO already covering much of the PACE-eligible population. In addition, PACE has high rates of community living rather than institutionalization. So, the 95/5 split is based on Minnesota's mature HCBS environment and supportive data from other states. There was support from community members for collapsing the rate cells into fewer categories.
Assumptions regarding the duration of NF care	One community member noted that the assumption of PACE participants disenrolling after long-term NF stays has not been the case, especially for participants with dementia. Another person shared that limits on NF stays may be helpful to incentivize PACE to assist participants in staying in the community. The letter from NPA stated: "Page 5 of the report indicates that the AWOP was not adjusted to account for institutional costs for services because of the assumption 'that most or all members will disenroll from PACE during NF stays expected to be long-term at similar patterns to those seen under MSHO/MSC+ and SNBC.' NPA strongly disagrees with the assumption. We understand that like the SNF/HCBS blend, it is hard to predict if – and how many – participants may disenroll from PACE. But in general, NPA has not observed 'most or all' participants disenrolling in PACE after a nursing home placement." The letter shared research suggesting that less than 10% of PACE participants disenrolled from PACE due to the NF stay. Health Dimensions Group expressed a similar concern regarding the assumption of disenrollment after NF stays.

Community members acknowledged specific challenges with the actuarial component of PACE implementation, including:

- PACE rate calculation assumptions being inclusive of the significant healthcare needs of the population, including outside of HCBS programs and the MSHO, MSC+, and SNBC programs
- The PACE rate being high enough to incentivize quality in an all-inclusive program such as PACE
- The PACE rate being flexible enough to support longer-term NF stays for participants who choose not to disenroll from PACE

VII.v Community Member Engagement Session 3: Spring 2024

The third community-focused engagement session occurred on May 30, 2024. The session was primarily focused on the initial report on the PACE implementation analysis prepared by BerryDunn. BerryDunn presented a PowerPoint focused on the methodology of the implementation analysis, and possible steps towards implementing PACE in Minnesota. The Community Member session included both internal staff to DHS and external community members. The session was two hours long, providing opportunities for community members to discuss question prompts as well as ask additional questions to BerryDunn and DHS related to the report or PACE implementation generally. Additional feedback was submitted after the session through letters written by HDG, and LeadingAge in collaboration with NPA.

Table 15: Key Themes from Community Member Engagement Session 3

Theme	Comments
Report Methodology	Community members expressed a desire to understand the rationale for selection of the peer states. One community member suggested another metro-centric State to be included in the analysis. There was additional feedback from HDG, LeadingAge, and NPA regarding the inclusion of the case study regarding Wyoming, given the comparability of the State to Minnesota. Community members expressed that PACE could be further differentiated from MSHO in the report and additional sources were encouraged.
Timeline for PACE Implementation	Community members expressed urgency about PACE implementation on a shorter timeline. Community members expressed their perspectives on the 2023 legislation and if implementation could commence based on the language in the 2023 legislation. DHS expressed concern with implementing PACE without additional legislation for an appropriation and the administrative resources for DHS. DHS indicated they planned to issue a request for information (RFI) to solicit input and potential interest from providers, and this was favorably received by community members. Community members expressed interest in passing legislation as quickly as possible and inquired about whether PACE would be included in the Governor's budget. Community members suggested parallel implementation as much as possible and providing potential PACE providers with a basic facts sheet to understand the opportunity. Community members commented on the FTE levels identified for peer states and noted that since DHS has successfully administered MSHO, there should

Theme	Comments
	be some knowledge and expertise transfer to support PACE implementation and operations.
Provider Procurement	Community members reiterated their preference to not implement PACE with a pilot program. There was discussion about the possibility of identifying one or more geographic areas where PACE could begin. DHS noted this could be something included in the RFI.
Regulatory Structure	Fiscal solvency was a topic of conversation, regarding what the fiscal solvency requirements should be and how the State will determine fiscal solvency requirements. Community members expressed a desire for the State to regulate the right components of PACE, so that the regulations keep member's safe, without overburdening new providers.
Equity	One community member suggested start-up grant opportunities. One community member suggested providing support for rural providers. One community member suggested considering what the effects of PACE could be for people with early onset dementia.

Community members acknowledged specific activities related to the implementation of PACE that can continue to move forward, including:

- Issuing an RFI
- Providing general information to potential PACE organizations
- Continued dialogue between DHS and interested PACE parties
- Determining the fiscal solvency and oversight requirements
- Considerations for legislation (appropriation) needed for operations and administration

VIII. Conclusions and Considerations

The Conclusion of the PACE Implementation Program Analysis Initial Report summarizes project themes and details considerations for next steps.

The information in this report can support Minnesota as it considers the feasibility of implementing PACE and help DHS and policy makers determine the best timeline and approach for a PACE program in Minnesota. Just as each Medicaid program is unique, implementing new programs and services within Medicaid will need to be approached in a way that allows the buildup of the infrastructure needed and supports the states vision for providing services.

Considerations for Program Administration

In building this report, BerryDunn performed a national scan and collected in-depth research on three identified peer states' PACE models: Indiana, Michigan, and North Dakota. BerryDunn found that the size of the programs varied among the three peer states. Similarly, the administrative burden on the states varied as well. For example, North Dakota and Indiana, with smaller program had one dedicated staff position dedicated to PACE managing the program and drawing on additional internal expertise such as contracting staff, fiscal staff, quality staff, HCBS staff, legal, and federal relations staff. Michigan followed a similar model with four dedicated staff that drew on additional internal expertise.

Staffing needs varied throughout the lifecycle of the program with more staff time needed for the start of the program. Overall, we estimate that the total staffing equivalent need for Indiana and North Dakota was approximately 2-3 FTEs across all needs, while Michigan we estimate as many as 7 FTEs across all needs. In Minnesota, DHS will need to determine current staff capacity to manage the program and may need to anticipate a blend of hiring additional dedicated staff along with internal experts in supporting departments. For implementation of PACE, additional support may be needed in the short term to design, develop, and implement the program in Minnesota.

Outstanding Policy Considerations

As part of gathering information in the December 2023, April 2024, and May 2024 community member sessions there have been multiple policy and program areas identified by community partners for solutioning. These areas for further consideration while considering PACE for implementation included:

- **Managing risk:** Finding entities who can manage the level of financial risk that PACE assumes
- **Equity and inclusion:** Tailoring PACE organizations to improve equity in health outcomes for BIPOC older adults, adults between the ages of 55 and 65, and those in Greater Minnesota
- **Attaining staff capacity:** Establishing the workforce for the PACE organization and DHS to implement and oversee the program
- **Coordination of programs:** Implementing PACE without adding additional difficulty for members, providers, and lead agencies in connecting older adults with the correct services for their needs

- **Accessibility:** The ability for PACE organizations to be accessible to members in terms of language accessibility, systems navigation, paperwork, and cultural understanding
- **Regional considerations:** Such as implementing PACE in rural areas, which may have the greatest need
- **Rates:** Having capitated rates that are calculated correctly, high enough to attract providers, incentivize quality, and allow providers to take on the financial risk that PACE requires
- **Flexibility:** The PACE capitated rate being flexible enough to support longer-term NF stays for participants who choose not to disenroll from PACE
- **Dialogue:** Continued conversation between the State and community members, particularly around fiscal solvency and oversight topics
- **Appropriation:** Including considerations for legislation and allocations for program operations and ongoing administration

Considerations for Implementation

Implementing PACE requires the clinical, financial, and administrative capacity necessary to deliver comprehensive, integrated care. Projecting a timeline for PACE implementation is dependent upon various factors. The implementation must consider the time needed for CMS review and approval of the application and finalizing the three-way agreement. In addition, there are factors at the state level, which include the size of legislative appropriations for both administrative resources and capitated payments, as well as the time needed to onboard resources to manage the PACE implementation.

Operational considerations, such as state-specific requirements (e.g., licensure and financial solvency) and how many PACE locations/centers the state wishes to implement will impact the timeline. State-specific requirements may require updates to state law or administrative code and implementing PACE simultaneously with multiple organizations and sites may elongate initial implementation. Finally, the timeline will also be impacted by the readiness of organizations interested in PACE, for example:

- Experience in providing LTSS
- Ability to meet state-specific licensure requirements
- Readiness of systems to manage participant enrollment, capitation payments, and claims processing for network providers
- Resources, including financial, for start-up and initial cash-flow, and
- Strategies for marketing program

Considering all of the variables involved from the State initiating efforts to move forward with PACE implementation, up through CMS approval and the enrollment of the first PACE participant, an implementation timeline could range from 18-24 months.

VIII.i Additional Considerations

As the state develops its regulatory framework, DHS should consider how and if PACE fits into other state Medicaid priority initiatives, such as reentry services for justice-involved individuals, expanded SUD services, value-based purchasing, quality measurement, and addressing health disparities and health-related social needs. States' policies generally track to the federal PACE regulations at 42 CFR Part §160; however, some states impose additional criteria and requirements, such as more stringent solvency requirements—Wisconsin requires PACE organizations to operate under a state licensed HMO.

PACE Representation

If PACE is implemented in Minnesota, incorporating a PACE representative into community member engagement groups like Aging Councils, Minnesota Leadership Council on Aging, AARP Minnesota, and Medicaid advisory groups may be beneficial. Additionally, PACE should be included in the Minnesota State Plan on Aging to emphasize community options for the state's aging population.

Recent Policy Considerations

On April 22, 2024, CMS issued a final rule regarding staffing standards for NFs. The rule requires of a minimum total of 3.48 hours of nursing care per day, including at least 0.55 hours per resident per day of direct care from a for registered nurse (RNs) and 2.45 hours of care per resident per day from a nurse aide. The final rule also requires an RN on-site 24 hours a day, seven days a week; and requires an enhanced facility assessment.[101] Over 80% of NFs need to hire additional staff in a competitive direct care market to meet the staffing requirement.[102] The rule may impact the availability of direct care workers for PACE, or increase the need for PACE if NFs decide to limit admissions or operations due to the inability to meet the new staffing requirements. The rule includes effective dates, some extending to May 2028.

[101] Centers for Medicare and Medicaid Services (CMS). June 10, 2024. Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting *(CMS 3442-F).* CMS.gov. Accessed April 23, 2023. https://public-inspection.federalregister.gov/2024-08273.pdf

[102] George, Kelsie. October 23, 2023. *Update on State and Federal Long-term Care Staffing Requirements*. National Conference of State Legislatures (NCSL). Accessed March 13, 2024. https://tinyurl.com/2brfmsch

Minnesota legislators authorized legislation in June 2023 for NFs to create a regulatory board that sets the compensation for NF staff. The Minnesota Nursing Home Workforce Standards Board will decide upon wage and working hour limits by August 1, 2024, for an effective date of January 2025. The board will additionally set minimum employment standards, certify worker organizations to provide training, and create curriculum training requirements.[103] The staffing and wage changes to NFs may inform similar policies for HCBS and impact Medicaid payment rates to attract the direct care workforce.

In October 2023, Minnesota completed an assessment of its LTSS environment. One of the recommendations was for the state to enhance care navigation and support services by developing a state-initiated care navigation collaboration with all aging services providers. The recommendation would increase awareness and education, provide stronger support to informal caregivers, and leverage and braid service resources. A care navigation initiative developed along these lines may increase community awareness of PACE and its benefits.

Many informal caregivers experience significant isolation, burnout, and stress. If PACE is implemented and made accessible to people navigating community-based care options, informal caregivers, especially those who may be adult children providing support for parents, may benefit from PACE. PACE can offer the caregiver support, a team environment, and an overall sense of relief in balancing informal caregiving for parents.[104,105]

Minnesota's Olmstead Plan

The state's plan encompasses goal areas including:

- Person-centered planning
- Transition services
- Housing and services
- Employment
- Lifelong learning and education
- Timeliness of waiver funding
- Transportation
- Healthcare and healthy living
- Positive supports
- Crisis services
- Assistive technology
- Preventing abuse and neglect
- Community engagement

Overarching System Considerations

In a landmark decision in 1999, the U.S. Supreme Court found in Olmstead v. L.C. that the unjustified segregation of people with disabilities was a form of discrimination under the Americans with Disabilities Act (ADA). The Court required community-based services to be accessible for individuals entitled to institutional services if the placement is medically appropriate and the individual does not oppose the placement. Further, the placement must be reasonably accommodated when considered alongside the resources available to the state and the

[103] Minn. Stat. §1621.1-14. June 20, 2023. Accessed April 4, 2024. https://tinyurl.com/3wz4m7au

[104] FTI Consulting, Inc, and the Altarum Institute. October 2023. *The Own Your Future LTSS Funding and Services Initiative: Options to Increase Access to Long-term Care Financing, Services, and Supports in Minnesota.* Prepared for the Minnesota Department of Human Resources (DHS). Accessed December 11, 2023. https://tinyurl.com/2semb4tw

[105] Urman, Harold. 2019. PACE Enrollment Reduces Burden On Family Caregivers. Vital Insights. Accessed March 2, 2024. https://vitalresearch.com/insights/PACE-enrollment-reduces-burden-on-family-caregivers.html

needs of other individuals with disabilities.[106] Minnesota created a State Olmstead Plan in 2015, which was updated in April of 2022.[107]

[106] U.S. Department of Human Services (DHHS). July 31, 2023. *Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead.* DHHS. Accessed on October 31, 2023. https://tinyurl.com/yytsrc4h

[107] Olmstead Implementation Office. April 2022 Revision. *Putting the Promise of Olmstead into Practice: Minnesota's Olmstead Plan.* State of Minnesota. Accessed October 20, 2023. https://tinyurl.com/4v3rnreh

IV. Appendices

Appendix A: List of Acronyms

Table 15 lists the acronyms that appear throughout this DED.

Table 16: Acronym List

Acronym	Description
AAA	Area Agency on Aging
AARP	American Association of Retired Persons
AC	Alternative Care
ACL	The Administration on Community Living
ADA	The Americans with Disabilities Act
ADL	Activities of Daily Living
AIHS	Aging and In-Home Services of Northeast Indiana
ALS	Amyotrophic Lateral Sclerosis
ARPA	American Rescue Plan Act
BBA	Balanced Budget Act
BIPOC	Black, Indigenous, and People of Color
CADI	Community Access for Disability Inclusion
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CFR	The Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nursing Assistant
COPD	Chronic Obstructive Pulmonary Disease
CY	Calendar Year
DED	Deliverable Expectation Document
DHHS	United States Department of Health and Human Services
DHS	Minnesota Department of Human Services
DME	Durable Medicaid Equipment
D-SNP	Dual-Eligible Special Needs Plan
EMR	Electronic Medical Record
ESRD	End-stage Renal Disease

Acronym	Description
EW	Elderly Waiver
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FTE	Full-time Equivalent
FQHC	Federally Qualified Health Center
HCBS	Home and Community-Based Services
HCPF	The Colorado Department of Health Care Policy and Financing
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HPMS	Health Plan Management System
IDT	Interdisciplinary Team
IHCP	Indiana Health Coverage Program
IT	Infrastructure Technology
LOE	Level of Effort
LCAR	Level of Care Assessment Representative (LCAR)
LTSS	Long-Term Supports and Services
HIT	Health Information Technology
MCD	Minnesota Council on Disability
MCE	Managed Care Entity
MCO	Managed Care Organization
MDH	Minnesota Department of Health
MDHHS	Michigan Department of Health and Human Services
MES	Medicaid Enterprise Systems
MFP	Money Follows the Person
MITA	Medicaid Information Technology Architecture
MLTSS	Managed Long-term Services and Supports
MMIS	Medicaid Management Information System
MPR	Market Penetration Rate
MS	Multiple Sclerosis
MSC+	Minnesota Senior Care Plus

Acronym	Description
MSHO	Minnesota Senior Health Options
MOU	Memorandum of Understanding
NACRHHS	National Advisory Committee on Rural Health and Human Services
NASHP	National Academy for State Health Policy
NDHHS	North Dakota Department of Health and Human Services
NF	Nursing Facility
NOIA	Notice of Intent to Apply
NPA	National PACE Association
NWD	No Wrong Door
OAA	Older Americans Act
PACE	Program of All-Inclusive Care for the Elderly
PACE SEMI	PACE Southeast Michigan
PBP	Plan Benefit Package
PCP	Primary Care Provider
PMPM	Per Member Per Month
QAPI	Quality Assurance and Program Improvement
RFI	Request for Proposal
RFP	Request for Information
RN	Registered Nurse
SAA	State Administrating Agency
SME	Subject Matter Expert
SMI	Severe Mental Illness
SPA	State Plan Amendment
SRR	State Readiness Review
SUD	Substance Use Disorder
T-MSIS	Transformed Medicaid Statistical Information System
TPA	Third-Party Administrator
UPL	Upper Payment Limit
VHA	Veteran's Health Administration

Appendix B: List of Community Member Engagement Session Attendees

Table 17: Community Member Meeting Attendee List

Attendee	Description
Kristi Kane	Arrowhead Area Agency on Aging
Lori Kangas-Olson	Arrowhead Area Agency on Aging
Sam Smith	Alzheimer's Association
Robert Freeman	Alzheimer's Association
Dena Register	Bold Age PACE
Mary Austin	Bold Age PACE
Russell Hilliard	Bold Age PACE
Daniel (Dan) Pollock	Bold Age PACE, (Lock Law)
Toby Pearson	Care Providers of Minnesota
Angela Garin	Care Providers of Minnesota
Nicole Mattson	Care Providers of Minnesota
Laurie Brownell	Hiawatha Homes
Dave Beijer	Kinship Health
Mark Anderson	Knute Nelson
Matt DeBoer	Knute Nelson
Kayla Khang	LeadingAge Minnesota
Erin Hubbert	LeadingAge Minnesota
Kari Thurlow	LeadingAge Minnesota
Nathalie Squire	LeadingAge Minnesota
Nikki Peterson	Minnesota DHS
Pamela (PJ) Weiner	Minnesota DHS
Rachel Shands	Minnesota DHS
Lynn Shannon	Minnesota DHS
Sue Kvendru	Minnesota DHS
Ashley Hilbelink	Minnesota DHS
Jeff Provance	Minnesota DHS
Julie Erickson	Minnesota DHS
Gina Smith	Minnesota DHS

Attendee	Description
Mark Foresman	Minnesota DHS
Jen Gerber	Minnesota DHS
Chris Gibson	Minnesota DHS
Matt Knutson	Minnesota DHS
Ibha Kumari	Minnesota DHS
Lisa Luckhardt	Minnesota DHS
Debra Maruska	Minnesota DHS
Amy Peterson	Minnesota DHS
Jeff Provance	Minnesota DHS
Lynnette Provost	Minnesota DHS
Elaine (Ellie) Schmidt	Minnesota DHS
Nicole Stockert	Minnesota DHS
Reginal (Reggie) Wardoku	Minnesota DHS
Darci Buttke	Minnesota DHS
Paige Anderson	Minnesota DHS
Liz Reyer	Minnesota House of Representatives
Lauren Sabes	Minnesota House of Representatives, Administrative Assistant to Rep. Liz Reyer
Liz Parry	National PACE Association
Maureen O'Connell	O'Connell Consulting, Health Access MN
Tony Albright	Poul Haus Lobbying
Janna Severance	Presbyterian Homes
Wayne Olson	Presbyterian Homes
Mike Bingham	Presbyterian Homes
Barbara Klick	Sholom/Leading Age
Jim Newbrough	Sholom
Mark Cullen	Trellis
Joe Gaugler	University of Minnesota, School of Public Health
Eric Nilsen	Volunteers of America
Chris Johnson	West Metro Medical Foundation

Appendix C: PACE Member Rights

Your Rights in the Programs of All-Inclusive Care for the Elderly

When you join a PACE program, you have certain rights and protections. [Insert name of PACE organization], as your PACE program, must fully explain and provide your rights to you or someone acting on your behalf in a way you can understand at the time you join.

At [Insert name of PACE organization], we are dedicated to providing you with quality healthcare services so that you may remain as independent as possible. This includes providing all Medicare-covered items and services and Medicaid services, and other services determined to be necessary by the interdisciplinary team across all care settings, 24 hours a day,7 days a week.

Our staff and contractors seek to affirm the dignity and worth of each participant by assuring the following rights:

You have the right to be treated with respect.

You have the right to be treated with dignity and respect at all times, to have all of your care kept private and confidential, and to get compassionate, considerate care.

You have the right:

- To get all of your healthcare in a safe, clean environment and in an accessible manner.
- To be free from harm. This includes excessive medication, physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, and any physical or chemical restraint that is used on you for discipline or convenience of staff and that you do not need to treat your medical symptoms.
- To be encouraged and helped to use your rights in the PACE program.
- To get help, if you need it, to use the Medicare and Medicaid complaint and appeal processes, and your civil and other legal rights.
- To be encouraged and helped in talking to PACE staff about changes in policy and services you think should be made.
- To use a telephone while at the PACE center.
- To not have to do work or services for the PACE program.

You have a right to protection against discrimination.

Discrimination is against the law. Every company or agency that works with Medicare and Medicaid must obey the law. They cannot discriminate against you because of your:

- Race
- Ethnicity

- National Origin
- Religion
- Age
- Sex
- Mental or physical disability
- Sexual Orientation
- Source of payment for your healthcare (For example, Medicare or Medicaid)

If you think you have been discriminated against for any of these reasons, contact a staff member at the PACE program to help you resolve your problem.

If you have any questions, you can call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

You have a right to information and assistance.

You have the right to get accurate, easy-to-understand information and to have someone help you make informed healthcare decisions. You have the right:

- To have someone help you if you have a language or communication barrier so you can understand all information given to you.
- To have the PACE program interpret the information into your preferred language in a culturally competent manner, if your first language is not English and you cannot speak English well enough to understand the information being given to you.
- To get marketing materials and PACE participant rights in English and in any other frequently used language in your community. You can also get these materials in Braille, if necessary.
- To have the enrollment agreement fully explained to you in a manner understood by you.
- To get a written copy of your rights from the PACE program. The PACE program must also post these rights in a public place in the PACE center where it is easy to see them.
- To be fully informed, in writing, of the services offered by the PACE program. This includes telling you which services are provided by contractors instead of the PACE staff. You must be given this information before you join, at the time you join, and when you need to make a choice about what services to receive.
- To be provided with a copy of individuals who provide care-related services not provided directly by [**Insert name of PACE organization**] upon request.

- To look at, or get help to look at, the results of the most recent review of your PACE program. Federal and State agencies review all PACE programs. You also have a right to review how the PACE program plans to correct any problems that are found at inspection.

You have a right to a choice of providers.

You have the right to choose a healthcare provider, including your primary care provider and specialists, from within the PACE program's network and to get quality healthcare. Women have the right to get services from a qualified women's healthcare specialist for routine or preventive women's healthcare services.

You have the right to have reasonable and timely access to specialists as indicated by your health condition.

You also have the right to receive care across all care settings, up to and including placement in a long-term care facility when the [**Insert Name of PACE organization**] can no longer maintain you safely in the community.

Appendix D: Adult Day Compliance Checklist

COMPLIANCE CHECK LIST ADULT DAY CARE STANDARDS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING SERVICES/HCBS
SFN 1703 (6-2023)

Clear Fields

Facility Name:			Provider's Name:
Address:			
City:	State:	Zip Code:	Provider's Telephone Number:

ADULT DAY CARE CENTERS

I. PROVIDER STANDARDS

1. ☐ Yes ☐ No	1. STAFF/PARTICIPANT RATIO MET.

II. FACILITY STANDARDS

1. ☐ Yes ☐ No	1. WAIVER FOR HOSPITALS, NURSING HOMES AND BASIC CARE FACILITIES - LICENSED
2. ☐ Yes ☐ No	2. HANDICAPPED ACCESSIBLE.
3. ☐ Yes ☐ No	3. ILLUMINATION LEVELS ADEQUATE.
4. ☐ Yes ☐ No	4. SOUND TRANSMISSION CONTROLLED.
5. ☐ Yes ☐ No	5. HEATING, COOLING, AND VENTILATION SYSTEMS PERMIT COMFORTABLE CONDITIONS.
6. ☐ Yes ☐ No	6. DESIGN FACILITATES PARTICIPANT'S MOVEMENT AND INVOLVEMENT.
7. ☐ Yes ☐ No	7. SUFFICIENT FURNITURE IS AVAILABLE TO ACCOMMODATE NUMBER OF PARTICIPANTS.
8. ☐ Yes ☐ No	8. FURNITURE AND EQUIPMENT ARE SELECTED FOR COMFORT AND SAFETY.
9. ☐ Yes ☐ No	9. A TELEPHONE IS AVAILABLE FOR PARTICIPANT USE.
10. ☐ Yes ☐ No	10. FACILITY IS ACCESSIBLE AT STREET LEVEL.
11. ☐ Yes ☐ No	11. ADULT DAY CARE CENTER HAS ITS OWN SEPARATE IDENTIFIABLE SPACE WHEN CO-LOCATED IN A FACILITY HOUSING OTHER SERVICES.
	12. THE FACILITY:
a) ☐ Yes ☐ No	a) Provides at least 35 square feet of program space per Adult Day Care participant.
b) ☐ Yes ☐ No	b) Is flexible and adaptable for large and small groups as well as individual activities.
c) ☐ Yes ☐ No	c) Provides toilets for male and female participants (one toilet per gender for each 15 participants).
d) ☐ Yes ☐ No	d) Has rest areas which provide privacy and/or able to isolate participants who become ill.
e) ☐ Yes ☐ No	e) Has a parking area for safe daily arrival and departure of participants.
f) ☐ Yes ☐ No	f) Has space available for outdoor activities.
g) ☐ Yes ☐ No	g) Has space, such as closets or separate locker, for outer garments and private possessions of participants.
h) ☐ Yes ☐ No	h) Complies with all applicable local, state, and federal health and safety regulations.
i) ☐ Yes ☐ No	i) Provides for appropriate and locked storage of medications.
j) ☐ Yes ☐ No	j) Provides for two exits to outside of building.
k) ☐ Yes ☐ No	k) Provides for non-slip surfaces or carpets on stairs, ramps, and interior floors.
l) ☐ Yes ☐ No	l) Provides for adequate outside lighting at facility entrances and grounds.
m) ☐ Yes ☐ No	m) Is free of hazards, such as high steps, steep grades, etc.

12. THE FACILITY:
(Continued)

n) ☐ Yes ☐ No — n) Assures the safe and sanitary handling, storing, preparation, and serving of food.
o) ☐ Yes ☐ No — o) Provides that fire safety procedures are posted.
p) ☐ Yes ☐ No — p) Has had a representative of the local fire department or state fire marshal's office conduct a fire and safety inspection of the center.
q) ☐ Yes ☐ No — q) Provides that emergency first aid kits are visible and accessible.
r) ☐ Yes ☐ No — r) Has written policies on assisting participants in taking and management of medications and emergency medical care plans.
s) ☐ Yes ☐ No — s) Provides for maintenance and housekeeping to be carried out on a regular schedule and in conformity with generally accepted standards.

II. FACILITY STANDARDS

1. ☐ Yes ☐ No — 1. WAIVER FOR ADULT FAMILY FOSTER CARE HOME-LICENSED
2. ☐ Yes ☐ No — 2. THE ADULT DAY CARE HOME:
a) ☐ Yes ☐ No — a) Is clean and well maintained.
b) ☐ Yes ☐ No — b) Has a rest area separate from activity areas.
c) ☐ Yes ☐ No — c) Has the telephone numbers of local police, fire department and ambulance service posted near every telephone located in areas where services are provided.
d) ☐ Yes ☐ No — d) Provides for safe storage of medications.
e) ☐ Yes ☐ No — e) Provides for an adequate central heating system or equivalent to permit comfortable conditions.
f) ☐ Yes ☐ No — f) No dead bolt-style locks are on interior doors.
g) ☐ Yes ☐ No — g) Illumination levels are adequate in participant occupied areas.
h) ☐ Yes ☐ No — h) Provides that all participant occupied rooms have window screens to keep out flies and mosquitoes.
i) ☐ Yes ☐ No — i) Food and cooking utensils are properly stored.
j) ☐ Yes ☐ No — j) Trash and garbage is kept in plastic or metal containers with properly fitted covers and disposed of regularly.
k) ☐ Yes ☐ No — k) Has a community or rural fire department available to serve the area.
l) ☐ Yes ☐ No — l) Has no accumulation of highly combustible material.
m) ☐ Yes ☐ No — m) Has covered or screened fireplaces, steam radiators, and hot surfaces to guard against accidental contact.
n) ☐ Yes ☐ No — n) Participant occupied areas shall have at least two means of exit, each being at least 30 inches wide, at least one of which must be a door providing a means of unobstructed travel to the outside of the building.
o) ☐ Yes ☐ No — o) Provides for the initial inspection and once every three years thereafter of heating units; date of inspection posted.
p) ☐ Yes ☐ No — p) Shall not have a stove or combustion heater so located as to block escape in case of fire from the malfunctioning of the stove or heater.
q) ☐ Yes ☐ No — q) Has as a minimum, a five-pound class "ABC" all-purpose fire extinguisher.
r) ☐ Yes ☐ No — r) Has photo-electric or ionization type smoke detectors.
s) ☐ Yes ☐ No — s) Trains participants upon enrollment how to exit the home in an emergency.

1. THE ADULT DAY CARE HOME: (Continued)

t) ☐ Yes ☐ No	t) Has had a representative of the local fire department or State Fire Marshal's office conduct a fire and safety inspection of the home.
u) ☐ Yes ☐ No	u) Stores all dangerous household products, flammable liquids, and chemicals in a safe manner.
v) ☐ Yes ☐ No	v) Supervises any participants use of potentially hazardous materials and tools.
w) ☐ Yes ☐ No	w) Has no exposed light bulbs used in the immediate area any participant uses.
x) ☐ Yes ☐ No	x) Assures that fuses in light circuits do not exceed recommended amperes.
y) ☐ Yes ☐ No	y) Assures any house pets have had all required shots.

III. PROGRAM STANDARDS

1. THE ADULT DAY CARE CENTER'S/HOME SERVICE PROGRAM INCLUDES:

a) ☐ Yes ☐ No	a) Self care activities.
b) ☐ Yes ☐ No	b) Social, leisure, and educational activities.
c) ☐ Yes ☐ No	c) Nutrition services which
1) ☐ Yes ☐ No	1) provide a nutritious meal to each participant in attendance during mealtime
2) ☐ Yes ☐ No	2) have meals prepared and served in a sanitary manner
3) ☐ Yes ☐ No	3) provide a nutritious mid-morning and mid-afternoon snack
4) ☐ Yes ☐ No	4) make fluids available as needed by participants
5) ☐ Yes ☐ No	5) make available a modified diet for participants requiring a restricted diet.
2. ☐ Yes ☐ No	2. A WRITTEN PROCEDURE FOR HANDLING EMERGENCIES IS POSTED IN THE CENTER/HOME.

Valid through (date not to exceed two years from date of issuance):

Signature of Potential Adult Day Care Provider:	Date:
Adult Day Care Provider: ☐ Meets Standards ☐ Does Not Meet Standards	
Aging Services Signature:	Date:

Appendix E: NOIA

CENTERS FOR MEDICARE AND MEDICAID SERVICES	
Organization's Legal Entity Name: Trade Name (if different):	
Parent Organization:	Organization's Mailing Address:
Application Contact's Name and Title: Application Contact's Mailing Address: Application Contact's Phone Number: Application Contact's Email:	
CEO or Executive Director's Name and Title: CEO or Executive Director's Mailing Address: CEO or Executive Director's Phone Number: CEO or Executive Director's Email:	

Appendix F: Clarification of Fiscal Soundness Memos

DATE: November 17, 2015

TO: Medicare Advantage Organizations
Prescription Drug Plans
1876 Cost Plans
Medicare-Medicaid Plans
PACE Organizations

FROM: Kathryn A. Coleman
Director

SUBJECT: Clarification of Fiscal Soundness Requirements

The purpose of this memorandum is to clarify fiscal soundness requirements for Medicare Advantage Organizations (MAOs), Medicare-Medicaid plans (MMPs), Programs of All-Inclusive Care for the Elderly (PACE) organizations, 1876 Cost Plans, and Prescription Drug Plans (PDPs) that contract with the Centers for Medicare & Medicaid Services (CMS). These organizations are required to satisfy all applicable state licensure, state and CMS financial requirements, and to submit their independently audited financial statements to CMS on an annual basis.

CMS contracts with legal entities whose financial statements are evaluated on their own merit. If the Domestic State permits organizations to submit financial statements that include other lines of business with the legal entity, CMS will accept these financial statements. However, the organization's resources included in the financial statements submitted, must support and back the line of business contracted with CMS.

In March of each year CMS announces the release of the current year's Fiscal Soundness Module (FSM), which is part of the Health Plan Management System (HPMS), along with the Fiscal Soundness Reporting Requirements (FSRR). Instructions for existing and new organizations are provided in the FSRR located at http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/FSRR.html.

Requirements

MAOs, PDPs, and Medicare-Medicaid Plans
Pursuant to 42 C.F.R. §§422.504 and 423.505 organizations must maintain a fiscally sound operation and must provide CMS audited annual financial statements demonstrating a fiscally sound operation. Audited annual financial statements must be prepared in accordance with generally accepted accounting principles (unless the Domestic State requires otherwise) and are due to CMS within 120 days of the end of its fiscal year, unless an extension has been granted by CMS.

In order to maintain a fiscally sound operation the organization must, at a minimum, maintain a positive net worth (total assets exceed total liabilities).

1876 Cost Plans

Pursuant to 42 C.F.R. §§417.120 and 417.126 Cost plans must maintain a fiscally sound operation. Audited annual financial statements must be prepared in accordance with generally accepted accounting principles (unless the Domestic State requires otherwise) and are due to CMS within 120 days of the end of its fiscal year, unless an extension has been granted by CMS.

In order to maintain a fiscally sound operation the organization must demonstrate:

1. Total assets greater than total unsubordinated liabilities;
2. Sufficient cash flow and adequate liquidity to meet obligations as they become due;
3. A net operating surplus; and,
4. An insolvency protection plan for the protection of enrollees.

PACE Organizations

Pursuant to 42 C.F.R. §§460.80 and 460.208 PACE organizations must maintain a fiscally sound operation and must provide CMS audited annual financial statements demonstrating a fiscally sound operation. Audited annual financial statements must be prepared in accordance with generally accepted accounting principles (unless the Domestic State requires otherwise) and are due no later than 180 days after the organization's fiscal year ends. PACE organizations operating within their trial period (3 years) must also submit quarterly financial statements. For purposes of fiscal soundness, the trial period ends when CMS has reviewed independently audited annual financial statements covering three full 12-month financial reporting periods.

In order to maintain a fiscally sound operation the PACE organization must, at a minimum, maintain:

1. Total assets greater than total unsubordinated liabilities;
2. Sufficient cash flow and adequate liquidity to meet obligations as they become due; and,
3. A net operating surplus or a financial plan for maintaining solvency that is satisfactory to CMS and the State Administering agency

As stated in the HPMS memo titled, "Attestation of Subordinated Debt Arrangements" issued August 11, 2011 and clarified in this memo, CMS contracts with the PACE legal entity. Therefore, all fiscal soundness requirements must be met by the individual PACE legal entity, not the parent organization, and any substitutions are unallowable. If the PACE organization is a line of business of the parent organization, and audited annual financial statements are not available at the PACE legal entity level, audited annual financial statements may be provided for the parent organization. However, the PACE organization must report the required financial data elements: Assets, Liabilities, Subordinated Debt (if applicable), Net Income/Loss, and Cash Flow from Operations and provide supporting annual financial statements for the corresponding period at the PACE legal entity level.

Total unsubordinated liabilities are used to determine a PACE organization's net worth. PACE organizations must identify the subordinated debt portion of their reported total liabilities. CMS will calculate total unsubordinated liabilities by subtracting subordinated debt from total liabilities prior to making the final fiscal soundness determination.

Subordinated debt is defined as an unsecured debt whose repayment to its parent organization ranks after all other debts have been paid when the subsidiary files for bankruptcy. PACE organizations that report subordinated debt with a parent organization must complete a subordinated debt arrangement attestation form and upload a signed version into the Health Plan Management System (HPMS) Fiscal Soundness Module (FSM)

with all annual and quarterly financial statements submissions. The PACE Organization Attestation of Subordinated Debt Arrangement form can be located under the documentation section of the FSM in HPMS.

Compliance

Organizations are also subject to compliance notices and/or past performance points for failure to meet fiscal soundness requirements (see HPMS Memo titled "2016 Application Cycle Past Performance Review Methodology Final" issued February 11, 2015). PACE organizations are not subject to past performance points at this time. If an organization's financial status does not improve following a compliance notice, CMS may issue additional notices or increase the severity of the notice.

Below are specific conditions that will result in a "Does Not Meet" fiscal soundness review that may result in a compliance action. For organizations that find themselves possessing both a negative net worth (liabilities greater than assets) and a negative net income (net loss), CMS may increase the severity of the notice.

MAOs, PDPs, and Medicare-Medicaid Plans

1. A negative net worth (liabilities greater than assets) and/or
2. A negative net income (net loss) which is greater than one-half of the entity's total net worth.

1876 Cost Plans

1. A negative net worth (unsubordinated liabilities greater than assets) and/or
2. A negative net income (net loss) which is greater than one-half of the entity's total net worth.

PACE Organizations

1. A negative net worth (unsubordinated liabilities greater than assets). CMS will provide technical assistance to PACE organizations failing to meet fiscal soundness requirements, specifically, negative net worth. PACE organizations must ensure financial statements and financial information is submitted at the appropriate organizational level and any subordinated debt arrangements with the parent organization are properly reported to CMS. Following a reasonable period of technical assistance, CMS may take further action including compliance notices to ensure PACE organizations comply with fiscal soundness requirements.

Note: PACE organizations that report a negative net income (net loss) which is greater than one-half of the entity's total net worth will continue to receive a "Does Not Meet" fiscal soundness review and CMS will continue to monitor on a quarterly basis.

For questions concerning this memo please contact the Financial Review mailbox at **FinancialReview@cms.hhs.gov.**

Appendix G: Community Member Feedback Letters

December 21, 2023

To: Ethan Wiley, Project Manager; Berry Dunn, on behalf of DHS CC: Pamela Weiner, DHS

RE: PACE stakeholder engagement feedback Greetings Ethan,

We appreciated the opportunity to discuss the value and possibilities for the program of all- inclusive care for the elderly (PACE) in Minnesota on December 7th, 2023. We would like to provide the following for consideration in the evaluation and ultimate implementation of PACE.

The value of PACE has been demonstrated for decades, in over 30 states nationwide. With the significant growth of the senior population in Minnesota over the next decade we know PACE can assist with managing an escalating demand for high quality long-term care services and supports.

Actuarial and Financial Considerations

While we recognize that the actuarial analysis is not in your scope of work, we hope that you are in communication with Milliman, to ensure the analysis is a comprehensive as practicable. This coordination would also inform where your implementation recommendations reflect actuarial limitations, should any exist. Further, we respectfully ask that you encourage Milliman to include stakeholders in its process. Doing so would be a strong signal of collaboration among all invested parties, and increase the likelihood of broad buy-in for moving PACE forward in Minnesota.

Successful implementation of the new program, as directed by the Legislature, require steady and intentional movement for preparation and planning. The Department of Human Services (Department) should work collaboratively with stakeholders to complete the actuarial analysis of Medicaid costs for nursing home eligible beneficiaries, 55 years of age or older, for the purposes of establishing Medicaid capitation rates for PACE. The analysis should include all sources of state Medicaid expenditures for nursing home eligible beneficiaries including, but not limited to, capitation payments to plans and additional state expenditures to skilled nursing facilities consistent with Chapter 42 Code of Federal Regulations (CFR) part 447.

It will be necessary to also estimate the administrative costs associated with implementing and monitoring PACE. Administrative costs will be driven by the level and type of monitoring that the State chooses to implement, in addition to the base CMS process. Many states with PACE programs use a full monitoring approach. The actuarial analysis should include an estimation of the savings to the State, with negotiated PACE rates as a potential offset for administrative costs. In addition, we request that early rate setting will recognize the need to build service volume to archive economies of scale.

Other budgetary considerations

- PACE services should be funded through budget allocations and payments determined by the Legislature, and in a similar amount as other Medicaid managed care plans serving similar eligible individuals.
- On an annual basis the Department should adjust the PACE capitated payments to reflect inflationary cost increases associated with providing care to PACE enrollees.
- Some states have established a lower income threshold for beneficiaries compared to the federally allowed guidelines. Similarly, some states have carved out beneficiaries who receive certain types of housing benefits. It would be inadvisable to exclude people from benefitting from this program if they otherwise meet federal guidelines.

The Department is required to provide a report by March 1, 2024 of the proposed capitation rates to the chairs and ranking minority members of the legislative committees with jurisdiction, per 2023 session laws. For comparative purposes the report shall also include a comprehensive account of total per beneficiary Medicaid expenditures for MSHO enrollees determined to be eligible for a nursing home level of care, including capitation payments paid to the plans, and additional state expenditures paid to nursing facilities for enrollees residing in nursing homes in excess of 90 days. The final report should include an estimate for administrative costs for PACE as well.

Implementation & Operational Considerations

We believe that a mechanism to determine the market allocation approach for PACE services areas is critical and should be shared with stakeholders by August 1, 2024. The Department should conduct an informational session to disclose the number and regions for future PACE contracts, and the prospective markets to be served. For comparison, Ohio recently awarded PACE contracts to seven areas across the state.

From the viewpoint of providers who have served PACE clients in other states, we offer a suggested timeline and key deliverables important to bringing PACE to Minnesota beneficiaries. This timeline should be concurrent and aligned with planned MSHO procurement in 2024 and thereafter.

- **Issue an RFP no later than December 1, 2024 for services beginning on January 1, 2027.** The Department should issue a request for proposals from organizations interested in sponsoring one or more PACE organizations in no fewer than 2-3 urban and 1-2 rural viable markets.
    - Viable markets are defined as those in which no fewer than 1,500 community- based nursing home eligible older adults aged 55 years of age and older reside.
    - Responses from interested sponsors could be due on or before March 1, 2025.
- **Selection of PACE sponsors.** The Department shall select one PACE sponsor for each of the designated markets that satisfy criteria that is developed in conjunction with the Department and stakeholders. Potential sponsors should have experience providing services in the geographic areas to be served, experience with PACE or similar proven senior business capacity. Other criteria could be determined by the Department.
    - The Department should choose successful PACE sponsors by June 1st, 2025.
- **PACE Enrollment**. It is common for PACE sponsors to need up to 18 months to become operational after being awarded a state contract. Under that time frame, enrollment could begin with open enrollment for Fall, 2026 and services beginning on January 1, 2027.
    - After an organization is authorized to provide PACE services in a specific market, such organization has three years to provide access to PACE services for all eligible individuals throughout the market.

- Extreme caution should be made in allowing another prospective PACE organization to operate PACE in an existing PACE market where all individuals eligible for enrollment in PACE have access to PACE services.
- The Department should authorize PACE organizations to undertake efforts to determine clinical and financial eligibility determinations for individuals seeking to enroll in PACE in a manner used by skilled nursing facilities.

Stakeholder Outreach Considerations
We support continuing efforts to reach out and engage with potential vulnerable populations, caregivers and community organizations who would benefit from PACE. DHS and its agency partner, MDH have robust public engagement processes that are well-suited for this task.

Thank you for the opportunity to provide additional feedback. We look forward to discussion and collaboration to bring PACE to reality in Minnesota.

Respectfully,

Wayne Olson
Presbyterian Homes

Mark Anderson
Knute Nelson

Barbara Klick
Sholom

Mary Austin
BoldAge

March 18, 2024

To: Jodi Harpstead, Commissioner of Human Services
Attn: Pamela Weiner, Director of Managed Care Contracting & Enrollment
PO BOX 64976
St. Paul, MN 55164

Dear Ms. Harpstead and Ms. Weiner:

On behalf of the National PACE Association (NPA), thank you for the opportunity to offer comments on the draft PACE capitation rates. We know there are a lot of considerations and challenges when developing draft rates, especially in a state that is new to PACE. We appreciate the efforts and hope the comments below are informative as you move forward with the rate setting process. If it would be helpful, we would be happy to meet and discuss these comments in more detail.

AWOP Development

While NPA was able to review the tables showing the Amount Would Otherwise be Paid (AWOP) and the PACE rates, we did not see the specific AWOP calculation. Without access to that level of detail, it is challenging to offer specific comments about the rates and how they were developed. Moreover, given the lack of detail, it is unclear to what extent all Medicaid expenditures for a PACE-like population outside of Minnesota Senior Health Options (MSHO) capitated payments were considered. It also appears that the AWOP is more focused on modeling the cost experience of a PACE enrollee rather than a comparable population outside of PACE. Assuming that observation is correct, we urge the state to include a PACElike comparable population in the AWOP and rate calculations. We also respectfully request that the state provide additional details about the AWOP calculation and all the Medicaid expenditures – beyond the MSHO capitation payment – that were considered in rate setting. Finally, we request clarity on how the rate development reflects specific characteristics of the PACE program, as noted on page 2.

Home and Community Based Services (HCBS)/Skilled Nursing Facility (SNF) Blend

The report indicates that the institutional percentages of MSHO/Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC) as well as information from other states were used to determine the 95% HCBS/5% SNF care mix. NPA does not have comprehensive data on this, and it does vary from state to state, but NPA often sees a blend that is closer to 65% HCBS/35% SNF in rate development. We recognize it is a challenge to establish the appropriate proportion, especially when there is no specific PACE data. However, we urge the state to reconsider and have a more balanced blend. In addition, after reviewing the following sections relating to MSHO rates, including SNF "add-ons," and the undisclosed additional fee-for-service costs, the AWOP seems to have been calculated in a manner that is fundamentally flawed, failing to reflect the actual rates of SNF/HCBS beneficiaries outside of PACE.

Nursing Home Placement

Page 5 of the report indicates that the AWOP was not adjusted to account for institutional costs for services because of the assumption “that most or all members will disenroll from PACE during NF stays expected to be long-term at similar patterns to those seen under MSHO/MSC+ and SNBC.” NPA strongly disagrees with the assumption. We understand that like the SNF/HCBS blend, it is hard to predict if – and how many – participants

may disenroll from PACE. But in general, NPA has not observed "most or all" participants disenrolling in PACE after a nursing home placement.

In 2016 and 2017, the NPA Clinical and Operational Data Analysis Committee (CODAC) looked at various reasons for disenrollments. CODAC found that of the 45,000 total PACE enrollees, about 17,000 experienced a nursing home admission (NPA does not know if these admissions were short or long-term stays.). During that timeframe, we know that about 5,700 disenrolled from PACE for reasons other than death. Of those 5,7000 individuals, 1,300 experienced a nursing home admission within 45 days prior to disenrollment. Even if we assume that all 1,300 participants who experienced a nursing home admission disenrolled from PACE directly because of that admission (which we do not believe is the case, but the worst-case scenario), then less than 10% of participants disenrolled from PACE due to the nursing home admission.

Finally, while some individuals may disenroll from PACE after a long-term SNF placement, it would be a financial disservice to PACE to assume that all PACE participants will disenroll. Many participants stay enrolled in PACE and PACE must pay the SNF rate. Therefore, it is critical that the rates reflect that inherent risk in the PACE model of care.

Other Comments

NPA generally supports states using the most recent data to help establish rates as it appears the state did by using 2022 information. However, given that COVID was still prevalent, and individuals may have been staying out of nursing homes due to fears of COVID, we wonder if the SNF data could be skewed, and thereby diluting the AWOP.

NPA also noticed the AWOP and rates are very close to the 65-74 age bracket. Given that the average age of a PACE participant is 76, we encourage the state to reexamine the AWOP and rates to ensure that the 75-84 age bracket is appropriately reflected.

Again, I would like to express NPA's appreciation for the state's work in developing these draft rates. We hope these observations are useful as you begin to finalize the rates. NPA welcomes the opportunity to discuss these comments in more detail.

Sincerely,
Shawn Bloom
President and CEO
National PACE Association

March 22, 2024

Jodi Harpstead, Commissioner of Human Services
Attn: Pamela Weiner, Director of Managed Care Contracting & Enrollment
P.O. BOX 64976
St. Paul, MN 55164

Dear Ms. Harpstead and Ms. Weiner,

On behalf of Health Dimensions Group (HDG), I am writing to provide some comments on the Legislative Report, Program of All-inclusive Care for the Elderly (PACE) Actuarial Analysis dated March 1, 2024. HDG has been a PACE Technical Assistance Center for over 20 years. During that time, we have assisted over a third of the PACE programs nationally in feasibility analysis, development, and operations. We are enthusiastic supporters of this fully-integrated care delivery model and strongly encourage the State of Minnesota to continue on its path toward adding this option to Minnesota's long-term care system.

We have reviewed the legislatively required report. We recognize and understand that the rate contained in the report is for illustrative purposes only and only represents one potential rate setting methodology. We offer the following comments in that spirit.

Compared to our experience in other states, the Final Capitation Rate Blended amount of $3,742 per member per month (PMPM) appears low. This result may be occurring for a variety of reasons. From our preliminary review, the issues may include:

- **Lack of inclusion of all the nursing facility costs**, as the report indicates that typical managed care disenrollment is assumed. Considering the design of the Minnesota Senior Health Options (MSHO) and Special Needs Basic Care (SNBC) programs, which exclude nursing home payments after a certain period of time vs. the all-inclusive nature of PACE, this hardly seems justifiable. Nor does it comport with our experience with PACE regarding disenrollments. We recommend carefully examining the nursing home disenrollment issue, as well as ensuring that all applicable fee-for-service or managed care costs for a Nursing Facility Level of Care (NFLOC) population are included in the rate-setting process.
- A separate, but related issue, is that the report incorrectly cites the federal PACE regulations as requiring the State to mimic the current Minnesota managed care rate-setting approach of amortizing nursing facility costs in the community-based rate cells. We reviewed the 2015 Federal PACE rate-setting guide and see no support for that position. In fact, the federal guide instructs states not to construct rate cells that cross-subsidize other rate cells. This is important for transparency and accuracy.
- **Lack of full exclusion of non-NFLOC costs.** For instance, the rate cells for the age 55–64 groups seem to have very low PMPMs and high member months, out of sync with what a PACE program might actually experience.

- **The assumed 95/5 blend between home- and community-based services (HCBS) and nursing facility care for PACE rates.** This is a very tight ratio that does not provide much room for PACE programs to grow. In the early days of a PACE program, enrollment is typically small and costs per member month are high. Over time that phenomenon levels out, but the odds of nursing home placement increase. Thus, it is very important to take an evolutionary approach to rate-setting that is cognizant of these dynamics.

We strongly concur with the suggestion to collapse the rates into a manageable number of federally permitted rate cells.

The "Final AWOP1 Blended Total" amount of $3,805 PMPM is suspiciously close to the "Final Capitation Rate Blended" amount of $3,742. We say suspicious because this is not typically the case in other states, and it led us to investigate the AWOP calculation further.

The conceptual frame of the AWOP calculation is to arrive at the amount that otherwise would have been paid if participants were not enrolled in PACE. The ratio of HCBS to nursing facility spending in states such as Minnesota for a NFLOC population is likely to be around 65/35. The ratio used in the PACE rate-setting was 95/5. As a hypothetical exercise, using standard amounts for HCBS and nursing facility spending PMPM and applying 65/35 and 95/5 ratios, a much larger differential between PACE rates and the AWOP would be observed. It does not appear that all of the elements that should go into the AWOP calculation are present, but it is hard to discern from the data presented in the report.

Regarding AWOP, we recommend that the rate-setting be more clearly separated from the AWOP calculation and that more detail on the assumptions going into the AWOP is provided. A more transparent and accurate AWOP provides policymakers with clearer guidance on how much PACE programs can save the Medicaid program compared to where participants otherwise would be. It is also an option for rate-setting.

We hope that these comments are useful. If you have any questions, we would be pleased to discuss this with you at your earliest convenience.

Sincerely,

Health Dimensions Group

Erin Shvetzoff Hennessey, MA, CPG, NHA
Chief Executive Officer and Principal
erinh@hdgi1.com
612.889.2802

May 28, 2024

To: Jodi Harpstead, Commissioner of Human Services

Attn: Pamela Weiner, Director of Managed Care Contracting and Enrollment PO BOX 64976
St. Paul, MN 55164

Dear Ms. Harpstead and Ms. Weiner:

I am writing on behalf of Volunteers of America National Services (VOANS) to express concern with the current rate setting methodology employed by the Minnesota Department of Health Services (DHS) for the Program of All-Inclusive Care for the Elderly (PACE). It is imperative that OHS re-evaluates its approach to ensure that the rates are accurate, equitable, and reflective of the unique nature of PACE. Below, I outline several critical reasons why the current methodology is insufficient and should be reconsidered.

1. **Comprehensive AWOP Calculations**
   The calculation of the Amount That Would Otherwise be Paid (AWOP) is a fundamental component in rate setting. However, the current AWOP calculations primarily focus on modeling the cost experience of a PACE enrollee rather than a comparable population outside of PACE. This approach overlooks key expenditures and characteristics specific to Medicaid populations. It is essential to include detailed Medicaid expenditures beyond existing capitated payments to ensure a comprehensive understanding of cost structures. Incorporating a comparable PACE-like population would provide a more accurate reflection of potential costs.
2. **Appropriate HCBS/SNF Blend**
   Determining the right mix of Home and Community-Based Services (HCBS) and Skilled Nursing Facility (SNF) care is vital. The current practices by other states with PACE use blends that more accurately represent the typical PACE participant's experience. A blend closer to 65% HCBS and 35% SNF would be more representative of other state's approaches to this assumption than the 95% HCBS and 5% SNF blend currently being applied. This adjustment is crucial for creating rates that better reflect the actual service utilization patterns of PACE participants. Given the need for PACE to cover all care and services regardless of the setting, it's essential that capitation rates are sufficient. This ensures PACE can provide the comprehensive range of home and community-based services, including services which may not be provided through the usual Medicaid HCBS funding streams, to support individuals in their communities and prevent significant declines in their health and functional status. It is the comprehensive nature of the program and, subsequently, the capitation rates which are essential to the program's success.
3. **Considerations of Nursing Home Placement Assumptions**
   Assumptions regarding disenrollment from PACE during long-term nursing home stays significantly affect rate calculations. Evidence suggests that only a small percentage of PACE participants disenroll due to nursing home placements. Therefore, it is crucial to account for the financial responsibility PACE

organizations bear for participants who remain enrolled during such placements. Rates should reflect this inherent risk and the ongoing financial commitment required to provide comprehensive care.

4. Impact of COVID-19 on Data

The ongoing impact of COVID-19 has altered healthcare utilization patterns, particularly in nursing home settings. Data from recent years may not accurately represent typical usage, as many individuals avoided nursing homes due to pandemic-related fears. It is essential to adjust AWOP calculations to account for these anomalies and ensure that rate setting reflects more typical conditions.

5. Age Bracket Considerations

PACE participants tend to be older, with the average age around 76 years. The current modeled rates appear closely aligned with the 65-74 age bracket, potentially underrepresenting the costs associated with the older demographic. Revisiting these age brackets is necessary to ensure that rates more accurately reflect the healthcare needs and costs of the actual PACE population.

The current rate setting methodology employed by DHS falls short and fails to address the unique needs of PACE participants. Developing PACE capitated Medicaid rates requires a nuanced approach that takes into account the distinct characteristics and needs of PACE participants. By considering alternative approaches and additional factors, we can create rates that are more accurate, equitable, and reflective of the comprehensive care provided by PACE programs.

We urge DHS to seriously consider these adjustments to its current methodology and work collaboratively with stakeholders to develop a robust rate-setting process which more closely addresses the unique needs of PACE participants.

Thank you for your attention to these critical considerations. We look forward to discussing these points in more detail and exploring how we can improve the rate-setting methodologies together.

Sincerely,

Paul F. Soczynski

Paul F. Soczynski
Senior Vice President, Healthcare
Volunteers of America National Services

June 4, 2024

Jodi Harpstead, Commissioner of Human Services
Attn: Pamela Weiner, Director of Managed Care Contracting & Enrollment
P.O. BOX 64976 St. Paul,
MN 55164

Dear Ms. Harpstead and Ms. Weiner,

On behalf of Health Dimensions Group® (HDG®), I am writing to provide some comments on the *Legislative Report, Program of All-inclusive Care for the Elderly (PACE) Implementation l Analysis* Initial Report dated May 22, 2024. These comments are provided as a follow-up to our comments previously provided on the *Legislative Report, Program of All-inclusive Care for the Elderly (PACE) Actuarial Analysis* dated March 1, 2024.

HDG has been a PACE Technical Assistance Center (TAC) for over 20 years. During that time, we have assisted over a third of PACE programs nationally in feasibility analysis, development, and operations. We have also assisted several states on long-term care policy matters, as well as development and feasibility of long-term care for veterans. We strongly encourage the State of Minnesota to continue on its path toward adding this option to Minnesota's long-term care system.

We have reviewed the implementation report and offer the following high-level comments for consideration for inclusion in the final report

- **Previous Comments Partially Acknowledged:** We appreciate the acknowledgement of HDG's previously stated concerns about the nursing home disenrollment assumption and the 95/5 HCBS/nursing facility blend. We continue to encourage the State to examine the entirety of the issues raised in our comments about the Actuarial Analysis.
- **Comparable States:** While it is important to examine other states and learn from their experiences, care needs to be taken to ensure that selected states are comparable and that issues are assessed in the appropriate context. Specifically, we are concerned that Wyoming and Indiana are likely not comparable due to the size of the state (Wyoming) and size of the programs (Indiana). There are other states that have other characteristics that are worthy of comparison, including ones that provide both Managed Long-Term Services & Supports (MLTSS) and PACE.
- **Administrative Staffing:** Related to the comment above about comparability of states, it is important to note that Minnesota's long history with Minnesota Senior Health Options (MSHO) is likely to serve it well in terms of implementing many of the administrative systems necessary for PACE.
- **Additional State Licensure Requirements:** We advise the State to be careful in considering which additional state-specific requirements to layer onto PACE above and beyond federal regulations, especially at the outset. In some states, licensure rules for other settings have been appropriated to PACE, and this can create unintentional barriers to development and administrative complexity due to

inapplicable or duplicative regulatory requirements from those settings. There should be a clearly defined need for any additional state-only requirements, and we would advise an evolutionary approach to considering such add-ons.

All of that noted, we appreciate the report's acknowledgement of the unique facets of PACE, including the prospect that these programs can provide culturally competent care to under- served frail elderly and disabled citizens.

If you have any questions, we would be pleased to discuss this with you at your earliest convenience.

Sincerely,

Health Dimensions Group

Brian Ellsworth, MA
Vice President for Public Policy and Payment Transformation
bellsworth@hdgi1.com
860.874.6169

June 4, 2024

To Whom It May Concern:

On behalf of the National PACE Association (NPA), I would like to express our appreciation for the work Berry Dunn has done on the PACE implementation report for the state of Minnesota. We believe, once finalized, the report will be a helpful guide to the state of Minnesota as they implement PACE.

As you work to finalize the report, we urge you to consider the following items.

Differentiating PACE from MSHO – We recognize that Minnesota already offers Minnesota State Health Option (MSHO), which has a long track record of providing primary, acute, and long-term services and supports (LTSS). However, we believe the final report should more clearly outline how PACE and MSHO differ and that many states across the country successfully offer both PACE and Medicaid managed care. These states have made this choice because they recognize that PACE has expertise in serving a subpopulation with very high needs by supporting their ability to live at home and in other noninstitutional settings. In addition, PACE sites have implemented key features of integrated care, including person- centered planning, interdisciplinary teams, comprehensive services, full-risk capitated payments, and emphasis on both quality of life and quality of care. PACE is a provider-based managed care model that offers beneficiaries a known local provider as an alternative to insurer-based managed care. Offering both PACE and MSHO enables eligible consumers to choose the best option to meet their health care needs. It may be helpful to examine a couple states that offer both PACE and Medicaid managed care. For example, both California and New Jersey offer both options, and PACE has successfully grown in both states since the implementation of managed care.

Literature Review – NPA appreciates the initial report includes a literature review. However, we believe the final report should also include information from the 2021 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning (ASPE) report "Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care." The ASPE report determined that PACE was a "consistently high performer." In addition, PACE participants did not have a higher mortality rate risk and were "significantly less likely to be hospitalized, to visit the ED, or to be institutionalized."

We also urge BerryDunn to remove the reference to the Wyoming state report. NPA has significant concerns with the report, which have been outlined in the attached letter. If for some reason, reference to the Wyoming report remains, we respectfully ask that NPA's letter is included in the appendix.

Costs and Capitation Rates – NPA urges BerryDunn to outline in the final report that PACE costs are fixed and do not change based on utilization. Alternatively, MSHO's costs are variable and more unpredictable due to limited risk imposed on the plans for nursing facility care. In addition, the report on page 13 speculates about how PACE will not save as much compared to other states that do not have MSHO models. As previously noted, other states offer both Medicaid managed care and PACE, and the states still find a financial benefit. The final report should compare the proposed PACE rate and MSHO's capitation plus any additional costs for nursing facility care for MSHO for a long-term care eligible enrollee.

Staffing – NPA understands that the state of Minnesota needs to determine the appropriate staffing to implement and oversee PACE, and looking at other states is a helpful guide. The number of PACE organizations can impact how many people the state will need. The initial report cites 7 FTEs in Michigan, however, it is NPA's understanding that there are only 4 FTEs who oversee the 14 programs. We acknowledge that there could be other people who spend a portion of their time on PACE, but not necessarily FTEs. To ensure that the state of Minnesota is clear about staffing in other states, it would be helpful for BerryDunn to include a definition of FTE in the final report. Depending on that definition, the FTE figure for Michigan may also need to be adjusted.

Other comments

- Market penetration – NPA recently looked at PACE market penetration, and we found that it was closer to 11% not 9% as noted in the initial report.
- Number of PACE organizations in the U.S. – the report indicates that there are 154 PACE organizations in the country. However, as of May 2024, there are 163 PACE organizations in the country.
- Number of PACE Organizations in Indiana – As of May 2024, the state of Indiana has six PACE organizations, not eight as noted in the report. A PACE organization may have additional centers, but since those are not reflected in the North Dakota or Michigan count, for consistency's sake, we ask that they are not included in the Indiana count.
- Implementation timeline – While it can take several months for CMS to approve a state plan amendment, it is NPA's understanding that is not the norm. We believe making this clear in the report would be helpful, so readers have a better expectation for the SPA approval process.
- Fiscal soundness – NPA does not have complete information about how each state handles fiscal soundness. However, based on the limited information we have, many states follow the federal CMS requirements for fiscal soundness and do not have additional requirements.

Sincerely,

Shawn Bloom President and CEO
National PACE Association

October 20, 2023

Mr. Franz Fuchs
Wyoming Department of Health
401 Hathaway Building
Cheyenne, WY 82002

Dear Mr. Fuchs,

Thank you for the opportunity to review the draft report "Aging in Wyoming Part III: Reviewing the Program of All-Inclusive Care for the Elderly and Alternatives." The National PACE Association (NPA) is a national organization representing all 155 PACE organizations (POs) in 32 states and the District of Columbia. We also represented PACE Wyoming when it was an operating PACE organization.

POs serve among the most vulnerable of Medicare and Medicaid populations— medically complex older adults over age 55 who are state certified as requiring a nursing home level of care. The objective of PACE is to safely maintain the independence of older adults and people with disabilities in their homes and communities for as long as possible. PACE is a capitated care model that assumes full financial risk and receives a monthly per person payment to deliver all necessary medical, biopsychosocial and long-term care for enrolled frail elders. PACE payments are predictable and do not change based on service use.

NPA appreciates that the state of Wyoming wanted to reexamine what would be required to restart PACE in terms of the monthly capitation rate and if there are possible providers that would be interested in operating PACE. While this report takes a comprehensive look at PACE in Wyoming, there are several areas of the report that NPA does not agree with or has questions. Below are general comments about the overall report as well as specific comments regarding various sections within the report. NPA would be happy to discuss these points in more detail if that would be useful.

General comments
We value and appreciate the time and effort associated with drafting this important report, especially in light of legislative consideration of re-establishing PACE as service option for frail older adults in need of long-term services and supports. As such, NPA strongly recommends that areas of the report containing opinions, general statements and recommendations be either substantiated by research, facts or data, or entirely removed. We are concerned that many of the inferences or observations leading to the recommendation to not "'re-start" PACE are either inaccurate, in conflict with federal and state requirements, or lack factual merit.

NPA has a comprehensive bibliography of research on PACE services, outcomes, and participants we are willing to share as a resource to assist the state in obtaining facts and details for various sections within the report. Without substantiation, we are concerned that many statements in the report will understandably and unfortunately likely lead to an erroneous conclusion to not re-establish PACE in the state of Wyoming.

Specific Section Comments
Section 2.5 – PACE revenue comes through fixed premiums – In this section, the report includes the following language: "While their services are community-based, PACE programs are therefore (in theory) also liable for the cost of institutional care, ranging from assisted living facility (ALF) services, to skilled nursing facility (SNF), memory care, and even lock-down units." NPA objects to the wording "in theory" because POs are responsible for providing and paying for institutional placement should a PACE participant need that level of care. In fact,

when PACE Wyoming closed in 2021, they reported having nine participants living in a SNF for which they made contractual payments, as required under federal statue and regulation. An individual not fully aware of the PACE model may read "in theory" and get the impression that POs do not actually provide this level of care.

This section includes the first of many references to "cherry picking" and "dumping." NPA strongly objects to this language anywhere in the document. Later in the report, cherry picking is defined as "…when plans selectively recruit members by designing their benefit plan to attract healthy people and repel the sick." Under federal law, POs cannot "cherry pick." Federal statute mandates that to enroll in PACE an individual must:

- Be 55 years of age or older;
- Be determined by the State Administering Agency to need the level of care required under the State Medicaid plan for coverage of nursing facility services;
- Reside in the PACE organization's service area;
- Be able to live in a community setting at the time of enrollment without jeopardizing his/her health or safety based on criteria set forth in the program agreement; and
- Meet any additional program-specific eligibility conditions imposed under its respective PACE Program Agreement.[1]

If for some reason, an enrollment is denied because of his or her health or safety would be jeopardized by living in a community setting, the PO is required to complete the following steps:

- Notify the individual in writing of the reason for enrollment denial and their appeal rights;
- Refer the individual to alternative services as appropriate;
- Maintain supporting documentation of the reasons for denial; and
- Notify the Centers for Medicare and Medicaid Services (CMS) and the State Administering Agency and make the documentation available for review. [2]

Therefore, suggesting that a PO is "cherry picking" is misleading and stands in contrast to state and federal requirements. If for some reason, a PO improperly denies enrollment, there are steps an individual can take to appeal that decision. If an individual does appeal the decision, CMS and the state can review the decision and information and either uphold or reverse the enrollment decision.

The report defines "dumping" as "where organizations try to off-load high-cost clients on other organizations. The classic example here is a nursing home discharging a patient to a hospital and refusing to take them back." Like enrollment of a PACE participant, there are strict requirements about when a PO can involuntarily disenroll someone, which include:

- Failure to pay – A participant who fails to pay, or make satisfactory arrangements to pay any premiums due, to the PO after a 30-day grace period;
- Disruptive or threatening behavior;
- Relocation outside of the PACE service area;
- Non-renewal or termination of the Program Agreement – The PO's program agreement with CMS and the State Administering Agency is not renewed or terminated;
- Inability to provide services – The PO is unable to offer health care services due to the loss of state licenses or contracts with outside providers;
- Ineligibility – It is determined that the participant no longer meets the state Medicaid nursing facility level of care requirements and is not deemed eligible, the participant may be disenrolled.[3]

Before an involuntary disenrollment is effective, the State Administering Agency must review it and determine in a timely manner that the PO has adequately documented acceptable grounds for disenrollment.

Given these federal requirements, we urge the report to either remove any mention of cherry picking and dumping and/or include these requirements; or, as an alternative offer facts and data to support such an allegation. It seems significantly important that the report clarify this erroneous discussion so readers understand the process a PO must go through if they deny enrollment or proceed with an involuntary disenrollment.

Section 2.6.4 – PACE premiums provide predictable revenue – NPA does not object to this language, but we think it is worth noting that predictable rates are also helpful to the state.
Knowing how much money will be spent on each participant allows the state to properly budget for costs associated with care for these individuals.

Section 2.7.1 – Members have less choice in providers – It is true that POs have an established "network" of providers that most participants interact with. However, if a participant has a long-standing relationship with a provider and they want to keep that continuity of care, POs have the option of working and contracting with that provider.

This section also notes that home visits and transportation can operate on a reduced schedule or limit services, particularly during inclement weather. NPA believes it would be helpful to clarify that each participant has a specific and detailed care plan. In that care plan, the interdisciplinary team – a crucial component of the PACE model – assesses the various needs of each participant. If for some reason that care plan does not meet the participant's needs, the participant or his/her designated representative may make a service delivery request, which could initiate, eliminate, or continue a particular service.[4]

Section 3.6.1 – PACE administrative overhead was disproportionately high for the state – The report notes Wyoming Medicaid had to employ two full-time equivalent (FTE) employees to manage the PACE program. This seems to imply that these two individuals only worked on PACE. However, the report also notes that those individuals also worked for the larger Community Choice waiver program. It would be helpful for the report to clarify how much of their time was spent on PACE. Administering and overseeing PACE does require time and effort. However, when NPA checked with various states, it was reported that the number of staff ranged from less than one FTE (in smaller PACE states) to 5 FTEs (in larger PACE states). Having two FTEs working solely on PACE in a state with one PO seems disproportionate.

Section 3.6.2 – Administration was also heavy for the PACE provider – NPA agrees that operating a PO requires significant work and commitment. However, NPA takes issue with referring to this work as a "burden" as noted in the fourth paragraph. NPA has not heard any PO call this level of commitment a "burden." Given the lack of background, data or facts to substantiate this claim we would recommend it be removed from the report.

Section 3.6.4 – The state did investigate and substantiate some complaints – Generally speaking, PACE is effective and efficient in treating individuals with multiple and complex health care needs. However, there are times when issues and deficiencies in care occur. NPA believes it is important for strong oversight of the state and CMS to ensure that these instances are rare and when they occur a corrective action plan is put in place.

Section 4.1 – A cost-effective PACE rate depends on where PACE members would have been served without PACE – As noted in the report, PACE rates must be less than the state would have to pay for those individuals if they were not enrolled in PACE. That estimate – as well as the PACE rate – is determined by the state and the state's actuarial firm. As states develop these rates there are often assumptions that need to be made. In

addition, states and actuarial firms should take a longitudinal view of costs as the care a participant will evolve and change over time.

Knowing that states are often curious about the cost and value of PACE, NPA often conducts research to better understand these comparisons. Most recently, NPA worked with IBM Consulting to compare calendar year (CY) PACE 2019 PACE Medicaid capitation rates to the CY 2019 Medicaid per-member per-month (PMPM) costs of a nursing facility (NF) level of care (LOC) population defined as those (1) enrolled in other (non-PACE) state Medicaid programs requiring NF LOC; or (2) who had at least 90 Medicaid-covered days in a NF during the year. The study was broken down into three groups: (1) Mostly HCBS – more than 50% of beneficiaries in the NF LOC population were enrolled in Medicaid HCBS programs; (2) Mostly NF – more than 50% of beneficiaries in the NF LOC population had at least 90 Medicaid- covered days in a NF; and (3) All NF – more than 95% of beneficiaries in the NF LOC population had at least 90 Medicaid-covered days in a NF. Wyoming was included in the study since it had an operating PO in 2019 and Wyoming was in Group 1 (mostly HCBS). The analysis found that for the full benefit dual eligibles, Wyoming PMPM for HCBS beneficiaries exceeded the PACE capitation rates by about 30%. Were additional costs for beneficiaries residing in Medicaid funded NFs included the costs savings to the state from PACE would increase. Further, the PMPM exceeded the PACE capitation rate by more than 50% for the
Medicaid-only PMPM costs.[5] The IBM analysis supports the concept that PACE capitation rate is less than what the state would otherwise pay.

4.3 Remaining problem: is PACE for life – or not? – The report accurately states that an individual can voluntarily disenroll from PACE at any time. However, NPA objects to implication that POs are "persuading" people to drop out of PACE. There are instances of individuals who voluntarily disenroll from PACE when they are permanently moved to a nursing facility. However, NPA is unaware that it is occurring because of some sort of persuasion effort. Instead disenrollments often occur due to a preference in the nursing home that they'll need to reside in or to be closer to certain family members. Recognizing that the inferences in this section are not linked to facts, data or research we would recommend this section be removed.

5.1 Very few providers in Wyoming would be capable of bringing PACE back, regardless of the rate paid – NPA acknowledges that opening and operating a PACE organization takes substantial effort and commitment. The authors of this report know the current provider landscape in Wyoming better than NPA. Therefore, we trust that the providers listed in the report are the most viable options currently in the state. However, there are other potential providers across this country that are very interested and invested in operating PACE. If none of the current providers have the bandwidth to operate PACE, the state should be willing to look beyond Wyoming. Like other areas of the report including inferences not supported by facts, research or data will likely only service to mislead the reader if the report. We suggest this section be removed from the report.

5.1.3 Post-COVID staffing shortages make things more difficult now and 5.1.4 "All- inclusive" services require a robust provider network – The points raised in 5.1.3 and 5.1.4 are valid and real concerns. The report tacitly acknowledges this, but it would be helpful if the report is very clear that these are valid and real concerns for all different types of health care providers and not just limited to the PACE model of care.

5.2 No capable providers have expressed interest – As previously noted there are several providers that are very interested in exploring PACE in unserved areas and unserved states. However, it is not surprising that these providers have not reached out to Wyoming, since the state closed its one PO just a couple of years ago. As the report highlights, operating PACE is a commitment and requires significant upfront costs. A potential provider is not going to invest those types of resources without a clear commitment from the state, which currently does

not exist in Wyoming. If the state of Wyoming becomes serious about bringing PACE back to the state, NPA suspects there would be potential providers that would express interest and would be willing to work with the state to make it happen. Should the state be interested in engaging with interested providers NPA could identify and facilitate such engagement.

6.2 The State should not attempt to restart PACE – NPA is very disappointed in this decision and strongly urges the state to reconsider this recommendation.

6.3 Instead, it should consider three alternative options – Below are our specific concerns and questions about these options. However, in general, the report seems to go to great lengths to not recommend PACE – a proven model of care that provides high quality care – and instead pursue untested options and models of care that may or may not save the state money or provide better care to this vulnerable population.

6.3.1 Mild: Increase select home-and community-based service rates – The report clearly states that the PACE rate should be lower. However, this recommendation urges a higher home and community-based rate to help ensure that adult day care and non-emergency medical transportation (two important components of the PACE model) are properly utilized. When discussing the adult day care option, the report specifically notes that staffing, capital requirements, and rates are primary barriers to this option and that higher rates could help offset those concerns. However, throughout the report, those are some of the same concerns, barriers, and reason not to bring back PACE. It is unclear to NPA why this would be a better alternative to PACE.

6.3.1 Medium: Implement bundled "PACE light" services – The report notes that this option would allow for bundling core PACE services, but "avoid the 'all-inclusive' PACE risk of open-ended long-term care, pharmacy, specialist, inpatient, and other costs." There could be some type of benefit to bundling these services, but the costly services that would not be included do not go away. Individuals in Wyoming will still need long-term care, hospitalization, etc… and the state will have to pay for those services for individual who rely on Medicaid. Instead of pursuing PACE, which leads to a predictable all-inclusive capitation rate, the state will have unpredictable costs.

6.3.2 Spicy: Study establishment of state-operated Medicare Advantage plan – NPA feels that this is a complicated and risky option. It is also unclear if this arrangement would be viable, cost-effective, or provide better care than PACE. As the state considers this option, they should be aware that the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning found that PACE participants, when compared to Medicare Advantage enrollees were "significantly less likely to be hospitalized, to visit the ED, or be institutionalized[.]"[6] It is unclear why the state would want to embark on this endeavor just to avoid restarting PACE in the state.

Final Comments – NPA recognizes that this comment letter primarily focuses on questions and concerns regarding this report. We are disappointed with some of the findings in the report and the overall recommendation to not restart PACE. However, NPA does want to acknowledge that the report does try to present the advantages as well as the disadvantages of the PACE model of care. We hope that the state will reconsider the decision not to move forward with PACE either now or sometime in the future. If and when the state does reconsider its decision, NPA hopes that the state will see the association as a trusted resource to ensure that the next PO is truly successful in ensuring the state saves money while providing the best care possible to this vulnerable population.

NPA welcomes the opportunity to continue dialogue with the state of Wyoming and offers any additional resources that could be useful if the state reconsiders its decision to restart PACE. Please feel free to reach out to me at ShawnB@npaonline.org or Liz Parry, Senior Director, State Policy at LizP@npaonline.org.

Sincerely,

Shawn Bloom President and CEO
National PACE Association

---

[1] 42 CFR 460.150
[2] 42 CFR 460.122
[3] 42 CFR 460.164
[4] 42 CFR 460.104(d)(2)
[5] "PACE Medicaid Cost Comparison Study: Methodology and Findings – Wyoming"
[6] U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Office of Behavioral Health, Disability, and Aging Policy. "Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care: Final Report." September 2021.

Appendix H: PACE Membership Rates

PACE Membership Current and Potential Membership Rates

Membership for December 2023

County	County Name	Total beneficiaries w/ NFLOC	Current PACE Membership PACE Members	Penetration Rate = 11.25% Potential PACE Beneficiaries (PPB)	Remaining Capacity at Current Provider		True Potential PACE beneficiaries (TPBB)	Unmet/Met	
01	ALCONA	41				4.61	-	4.61	Unmet Need
02	ALGER	59				6.64	-	6.64	Unmet Need
03	ALLEGAN	367			40	41.29	12	(10.71)	Met
04	ALPENA	148				16.65	-	16.65	Unmet Need
05	ANTRIM	87			6	9.79	2	1.79	Unmet Need
06	ARENAC	64				7.20	-	7.20	Unmet Need
07	BARAGA	52				5.85	-	5.85	Unmet Need
08	BARRY	209			5	23.51	2	16.51	Unmet Need
09	BAY	636			19	71.55	7	45.55	Unmet Need
10	BENZIE	107			10	12.04	4	(1.96)	Met
11	BERRIEN	1,043			182	117.34	5	(69.66)	Met
12	BRANCH	197				22.16	-	22.16	Unmet Need
13	CALHOUN	904			278	101.70	65	(241.30)	Met
14	CASS	189			15	21.26	-	6.26	Unmet Need
15	CHARLEVOIX	113				12.71	-	12.71	Unmet Need
16	CHEBOYGAN	74				8.33	-	8.33	Unmet Need
17	CHIPPEWA	133				14.96	-	14.96	Unmet Need
18	CLARE	262			41	29.48	1	(12.53)	Met
19	CLINTON	191			15	21.49	7	(0.51)	Met
20	CRAWFORD	71				7.99	-	7.99	Unmet Need
21	DELTA	182				20.48	-	20.48	Unmet Need
22	DICKINSON	130				14.63	-	14.63	Unmet Need
23	EATON	415			32	46.69	16	(1.31)	Met
24	EMMET	133				14.96	-	14.96	Unmet Need
25	GENESEE	1,199			226	134.89	23	(114.11)	Met
26	GLADWIN	142			12	15.98	-	3.98	Unmet Need
27	GOGEBIC	137				15.41	-	15.41	Unmet Need
28	GRAND TRAVERSE	462			123	51.98	49	(120.03)	Met
29	GRATIOT	288			44	32.40	1	(12.60)	Met
30	HILLSDALE	231			9	25.99	3	13.99	Unmet Need
31	HOUGHTON	278				31.28	-	31.28	Unmet Need
32	HURON	211				23.74	-	23.74	Unmet Need
33	INGHAM	1,126			154	126.68	76	(103.33)	Met
34	IONIA	150			3	16.88	2	11.88	Unmet Need
35	IOSCO	126				14.18	-	14.18	Unmet Need
36	IRON	147				16.54	-	16.54	Unmet Need
37	ISABELLA	303			102	34.09	2	(69.91)	Met
38	JACKSON	828			206	93.15	71	(183.85)	Met

39	KALAMAZOO	1001	306	112.61	71	(264.39)	Met
40	KALKASKA	82	11	9.23	4	(5.78)	Met
41	KENT	2,276	336	256.05	197	(276.95)	Met
42	KEWEENAW	5		0.56	-	0.56	Unmet Need
43	LAKE	75	6	8.44	1	1.44	Unmet Need
44	LAPEER	188	3	21.15	-	18.15	Unmet Need
45	LEELANAU	61	11	6.86	4	(8.14)	Met
46	LENAWEE	320	8	36.00	3	25.00	Unmet Need
47	LIVINGSTON	273	18	30.71	5	7.71	Unmet Need
48	LUCE	22		2.48	-	2.48	Unmet Need
49	MACKINAC	47		5.29	-	5.29	Unmet Need
50	MACOMB	2,966	535	333.68	287	(488.33)	Met
51	MANISTEE	85	2	9.56	1	6.56	Unmet Need
52	MARQUETTE	334		37.58	-	37.58	Unmet Need
53	MASON	125	3	14.06	1	10.06	Unmet Need
54	MECOSTA	138	5	15.53	1	9.53	Unmet Need
55	MENOMINEE	121		13.61	-	13.61	Unmet Need
56	MIDLAND	292	9	32.85	3	20.85	Unmet Need
57	MISSAUKEE	97		10.91	-	10.91	Unmet Need
58	MONROE	322	13	36.23	4	19.23	Unmet Need
59	MONTCALM	224	23	25.20	4	(1.80)	Met
60	MONTMORENCY	35		3.94	-	3.94	Unmet Need
61	MUSKEGON	893	195	100.46	62	(156.54)	Met
62	NEWAYGO	192	69	21.60	16	(63.40)	Met
63	OAKLAND	2,806	393	315.68	208	(285.33)	Met
64	OCEANA	106	9	11.93	2	0.93	Unmet Need
65	OGEMAW	87		9.79	-	9.79	Unmet Need
66	ONTONAGON	17		1.91	-	1.91	Unmet Need
67	OSCEOLA	80	3	9.00	1	5.00	Unmet Need
68	OSCODA	36		4.05	-	4.05	Unmet Need
69	OTSEGO	86		9.68	-	9.68	Unmet Need
70	OTTAWA	815	182	91.69	59	(149.31)	Met
71	PRESQUE ISLE	49		5.51	-	5.51	Unmet Need
72	ROSCOMMON	89	2	10.01	-	8.01	Unmet Need
73	SAGINAW	1,137	146	127.91	52	(70.09)	Met
74	SAINT CLAIR	461	46	51.86	98	(92.14)	Met
75	SAINT JOSEPH	228		25.65	-	25.65	Unmet Need
76	SANILAC	182	1	20.48	2	17.48	Unmet Need
77	SCHOOLCRAFT	48		5.40	-	5.40	Unmet Need
78	SHIAWASSEE	229	10	25.76	3	12.76	Unmet Need
79	TUSCOLA	255	4	28.69	1	23.69	Unmet Need
80	VAN BUREN	380	75	42.75	8	(40.25)	Met
81	WASHTENAW	636	200	71.55	56	(184.45)	Met
82	WAYNE	8,843	839	994.84	438	(282.16)	Met
83	WEXFORD	183	19	20.59	8	(6.41)	Met
	Totals	38,362	5,004		1,948		

Appendix I: Actuarial Analysis

The actuarial analysis portion of this legislative requirement can be found in the Program of All-Inclusive Care for the Elderly (PACE) Actuarial Analysis published on March 1, 2024.

VIII. Appendix

Add appendices to a report to show interesting material that reinforce the report, such as a list of committee members and their affiliations, detailed survey instruments, supporting information and data.