CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

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

Final Report of Findings

June 2025

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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About Myers and Stauffer

Myers and Stauffer works exclusively with local, state, and federal government health and human services agencies in all 50 states and the District of Columbia, providing consulting and accounting services. Myers and Stauffer intentionally restricts our practice to government-sponsored health care and human service programs. We do not accept health care providers, Programs of All-Inclusive Care for the Elderly (PACE) organizations, health plans, or individuals as clients. We are required to meet the rigorous professional and ethical standards required of certified public accounting firms, including all standards of independence.

About this Study

The objective of this study is to assist the State in making the decision of whether to implement PACE as an optional State plan service for the Medicaid program. This information is not intended to imply Myers and Stauffer's promotion of PACE.

Executive Summary

The Executive Summary presents background on the purpose and scope of the feasibility study performed by Myers and Stauffer LC regarding the Program of All-Inclusive Care for the Elderly in Connecticut. It provides a high-level overview of the program, considerations for implementing the program in Connecticut, and a brief discussion of the feasibility study results.

On behalf of the Connecticut Department of Social Services (DSS), Myers and Staffer LC (Myers and Stauffer) conducted a feasibility study to evaluate the potential implementation of the Program of All-Inclusive Care for the Elderly (PACE). If adopted, PACE would represent a new optional State plan service for the Connecticut Medicaid program.

The purpose of PACE is to delay or prevent institutional care admissions through intensive care coordination and services that allow participants to remain safely in their homes or communities. An interdisciplinary team (IDT) of professionals at the PACE center plan and oversee all services required for participants, who typically have complex medical needs. PACE organizations act as both a payor and a health care provider, receiving a capitated payment for coordinating and providing the care of enrolled participants. To be eligible, a participant must be aged 55 or older, meet the State's nursing facility (NF) level of care (LOC) criteria, reside in a PACE service area, and be able to safely live at home with supports. It is a model of care in which the PACE organization is fully at risk for all costs of service. Any service that is approved by the IDT is provided without regard to the amount, scope, or duration of services. Typical benefit limitations for Medicare and Medicaid-funded services do not apply.

PACE Considerations

PACE has expanded and evolved from its beginning in the 1970s to 185 PACE organizations operating in 33 states and the District of Columbia and serving over 83,500 participants.[1] On average, states who offer PACE have between 2,000 and 2,500 participants enrolled. Data from the National PACE Association (NPA) as of April 2025 indicates that 10 PACE states account for more than 83% of participants. The average number of participants in the remaining state programs, including District of Columbia, is approximately 550[2].

Relative to the number of participants it serves, PACE programs may require a larger share of resources from both the State and PACE organizations. PACE centers often have high start-up costs and can take years to financially break even, typically requiring significant upfront capital investment. PACE is also challenging to implement in rural areas due to low population density and limited health care infrastructure. However, the benefit to individual participants and their caregivers can be life changing. The individually tailored nature of all-inclusive, 24-hour access to locally based medical care not subject to Medicaid and/or Medicare benefit limits, coupled with access to an IDT and a network of 26

[1] National PACE Association (NPA). NPA reported PACE Enrollment as of January 2025.
[2] Ibid.

specialists creates greater opportunity for positive outcomes for PACE participants compared to their non-PACE counterparts including: [3]

- A lower probability of hospitalization and NF admission for participants.
- A higher probability of participants receiving ambulatory care.
- Participants are more likely to be in good health, find life satisfying, and attend social programs at least once per week.
- Despite high care needs, over 90% of PACE participants continue to live in their community with a good quality of life for up to 4 years. [4]
- There is a lower probability of having an unaddressed visual or hearing disability, bowel/bladder incontinence, or other limits on activities of daily living (ADL) for participants.[5]
- Higher rates of consumer, caregiver, and family satisfaction.[6]

Once a participant is enrolled in PACE, they can no longer access services through traditional Medicaid and Medicare. Instead, the PACE organization becomes the participant's sole provider responsible for planning, providing and paying for all necessary care. The participant is guaranteed access to PACE services, but not to a specific provider. Participants are guaranteed the right to emergency health care services whenever the need arises without prior authorization by the PACE IDT. Outside of emergency services, participants have the right to choose their health care providers within the PACE organization's network and to receive necessary care in all settings, up to and including placement in a long-term care facility when the PACE organization can no longer provide services necessary to maintain living safely in the community. Participants, their caregivers, or their authorized representatives are encouraged to participate in treatment decisions.

A PACE participant may voluntarily disenroll at any time for any reason. PACE organizations may disenroll participants only under a very narrow set of circumstances. Per Federal regulation, a PACE organization must ensure that its employees and contractors do not engage in any practice that would steer or encourage a participant to disenroll due to a change in health status.[7]

Connecticut PACE Feasibility Results

Myers and Stauffer completed the feasibility study and identified the following findings for DSS to consider regarding the potential adoption of PACE.

[3] Arku D, Felix M, Warholak T, Axon DR. Program of All-Inclusive Care for the Elderly (PACE) versus Other Programs: A Scoping Review of Health Outcomes. Geriatrics (Basel). 2022 Mar 12;7(2):31. doi: 10.3390/geriatrics7020031. PMID: 35314603; PMCID: PMC8938794.

[4] C Eng, J Pedulla, G P Eleazer, R McCann, N Fox. Program of All-inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing. J Am Ger Soc, 1997 Feb; 45(2):223-32.

[5] Ibid.

[6] NPA and Vital Research. PACE Reduces Burden of Family Caregivers. August 31, 2018.

[7] National Archives. Code of Federal Regulations 42 CFR 460.162(c)v. June 3, 2019.

- Potential PACE service areas could include Bridgeport, Hartford, New Haven, Stamford, and Waterbury areas, which include approximately 9,000 potential PACE eligibles.
- Several Connecticut service areas exhibit substantial income disparities, where affluent residents and those experiencing poverty reside in proximity. This socio-economic divide could pose significant challenges for the implementation of a PACE program in these regions, particularly due to social segregation and prevailing attitudes regarding the locations of PACE centers.
- The PACE start-up and ongoing program costs are significant for both providers and the state administering agency. Initial investment in capital, personnel, and systems may not be recovered for many years due to the lengthy ramp up period for PACE enrollment. From a state agency standpoint, additional staff may be required to closely monitor the provision of care, quality of services, and financial sustainability of PACE organizations operating in Connecticut.
- Stakeholder opinions and perspectives on PACE feasibility for Connecticut were mixed. Some asserted that Connecticut may not have the financial or programmatic resources to support the program. Others expressed support for PACE as an option that could align with existing home and community-based service waivers and support the needs of the growing population of older adults over the next decade.
- Stakeholder feedback and analysis of Health Resources and Services Administration data identified health care workforce shortages and competition as a significant challenge impacting the provision of care for older adults. There are multiple factors that drive the workforce shortage including wages, Medicaid reimbursement, and more attractive employment options in other states.
- Responses to the feasibility study survey showed high interest in PACE from providers currently operating in Connecticut as well as those with operations outside the state.
- If Connecticut decides to implement PACE, a key first step will be the gathering of existing Medicaid claims data for the nursing facility level of care population to set the PACE capitated rate
- Social determinants of health, predominantly housing, are concerns for older adults in Connecticut. In some states, PACE organizations have established innovative solutions to housing challenges by partnering with community organizations, developing housing supply, and facilitating networks dedicated to finding housing solutions for participants.
- Several stakeholders cited behavioral health issues in older adults as an area of concern. Stakeholders indicated that an all-inclusive reimbursement model such as PACE, if implemented, should be designed to attempt to address the behavioral health needs of these individuals.

Introduction

The Introduction outlines the context of the feasibility study, detailing Myers and Stauffer's methodology for market analysis, readiness assessment, and overall study execution.

Purpose

Myers and Stauffer LC (Myers and Stauffer) conducted a feasibility study to evaluate the potential implementation of PACE. If adopted, PACE would represent a new optional State plan service for the Medicaid program. This study presents an analysis of potential market demand, program costs, implementation requirements, and program sustainability requirements to help inform State leadership regarding the potential adoption of PACE.

Background

Connecticut Public Act No. 23-30, "AN ACT CONCERNING ADULT DAY CENTERS" includes provisions that require the Commissioner of Social Services in Connecticut to develop plans related to adult day services that include studying the establishment of PACE. DSS engaged Myers and Stauffer to conduct the study.

The goal of the study was to prepare information that assists DSS in making a recommendation on whether PACE is an appropriate service for Connecticut. The study was conducted in two phases. In June 2024, DSS provided the phase one report, "A Feasibility Study for the Program of All-Inclusive Care for the Elderly PACE): Interim Report of Findings" to the General Assembly.

The report herein represents phase two, presents the results of the feasibility study.

PACE Feasibility Study Approach

In-Depth Market Analysis

Myers and Stauffer performed the following market analysis activities:

- Compiled stakeholder feedback to identify concerns and interest regarding the Connecticut long-term care (LTC) continuum and the potential implementation of PACE.
- Identified underserved and/or health shortage areas or target areas suggested by DSS.
- Identified areas of the state that appear to be viable PACE markets based on estimated eligible residents.
- Assessed criteria for consideration when constructing potential PACE service areas in Connecticut, such as areas where provider networks may be insufficient.

- Designed potential PACE service areas throughout Connecticut in consideration of potential cultural and geographic boundaries.
- Analyzed waiver enrollment to identify areas of the state PACE could be an alternative service.
- Evaluated potential health care workforce availability in the state.
- Created heat maps to illustrate potential PACE eligibility and potential service areas, where appropriate.

State Readiness Assessment

The second component of analysis involved assessing the existing health care and state agency capacity infrastructure to determine the ability to support a PACE program with the current level of resources. The following activities were conducted:

- Performed a high-level assessment of the existing Medicaid Management Information System and its capabilities to support the needs of PACE.
- Evaluated DSS's other internal resources and systems necessary that may be necessary for implementation and support of PACE.
- Engaged Connecticut stakeholders to inform the study with respect to an understanding PACE, attitudes and perspectives about PACE, how it could align with the health care environment in Connecticut, areas of the state where PACE might be successful, and barriers and/or keys to success.
- Requested information from entities who might be interested in becoming a PACE provider in Connecticut if the State were to adopt PACE. Provider interest was gauged using a survey designed to identify interested providers and assess whether they have the financial resources for the necessary investment, as well as whether they have the experience necessary to start a PACE organization.
- Performed an assessment of current licensing, Medicaid service rates, State plan, waivers, policies, and procedures.
- Performed preliminary assessment of potential rate setting issues involving the computation of the PACE rates in service regions considered potentially viable, given the administrative services organization model used in Connecticut.

Methodology

At the core of PACE are several key functional areas. This feasibility study explored these functional areas to determine if a PACE program is right for Connecticut. While conducting the study, we explored the following questions:

Table 1. PACE Key Functional Areas.

Functional Areas	Questions
Participation and Enrollment Levels	• Is there a large enough pool of potential PACE participants? • What other programs may compete with PACE for enrollment/participants? • What is the incentive for an individual to enroll in PACE in Connecticut (i.e., the reward differential)?
Health Outcomes	• Are there opportunities for improvement in outcomes, and does PACE offer the potential for hospitalizations and other costly services to be mitigated by reductions in utilization? • Can behavioral health and substance use disorder be emphasized within a PACE model to address Connecticut specific health care needs? • Are there geographic, cultural, or socioeconomic factors that could impact PACE implementation?
Potential PACE Organization History and Viability	• Can the PACE model be financially sustainable in Connecticut? • What are the histories of those organizations interested in providing PACE services in the state? • How will each organization leverage existing community partnerships and develop other relationships needed to provide comprehensive participant care? • What type of innovative deployment strategies could be used to address the unique care needs and social determinants health for elderly individuals in Connecticut? • Would the Connecticut Medicaid and health care environment be attractive to enlist providers to offer PACE services?

Functional Areas	Questions
Community Awareness and Integration	• How does PACE fit within the local health care ecosystem and market conditions? • What is the level of community acceptance and understanding of PACE? • How would providers at the local level leverage PACE as another community-based care option for older adults in Connecticut?
State Resources Required to Support PACE	• What is the opportunity cost of implementing a PACE program in Connecticut? • What staffing resources are required? • What information systems are required? • How will quality and service delivery be monitored? • How will financial sustainability be monitored? • How will the state collect the data necessary to make informed decisions about the direction of the program?

PACE Model Overview

The PACE Model Overview section explains the comprehensive care delivery model of PACE, its historical background, and eligibility criteria. It defines a PACE organization and describes the interdisciplinary team approach. The section details the wide range of services provided, the program's community focus, the enrollment process, and the mechanisms for rate setting and funding. Additionally, it discusses the nationwide adoption of PACE, current enrollment figures, and the growth of the program.

PACE is a health care delivery model that provides comprehensive medical and social services to individuals aged 55 and older who need NF LOC but can live safely in their communities with appropriate supports. PACE provides seamless, coordinated services using a contracted, fully at-risk organization that receives a monthly capitation payment for each enrolled participant.

The PACE organization includes an IDT of professionals who assess and monitor participant needs and authorize services. Services include all Medicaid and Medicare covered services and any other services determined necessary by the IDT.

PACE services are primarily delivered in an adult day-like setting within the PACE center and supplemented by in-home and specialist visits. Services may also be provided at inpatient facilities when necessary. Participants are provided with transportation to and from the PACE center, specialists, and other appointments.

PACE Model of Care

Participant care is coordinated by an 11-member IDT responsible for assessments, plans of care, and coordination of 24-hour care delivery.

The PACE organization provides comprehensive medical, health, and social services that integrate primary care, acute care, and LTC.

The place of service may be the PACE center, the home, inpatient facilities, and specialist office locations.

Participants are provided transportation to and from home, the PACE center, specialists, and other appointments.

PACE is unique in that it integrates Medicaid and Medicare funding under a collaborative three-way agreement between the federal and state governments and the PACE organization. This fully integrated model of care with pooled funding resources is intended to allow for greater service flexibility, coordination, and continuity of care because care approved by the IDT is not subject to the same limitations in amount, scope, or duration as traditional Medicaid and Medicare benefits.

Brief History of PACE

PACE has a 50-year history. The first PACE program was launched by On Lok Senior Health Services, a not-for-profit community-based organization in San Francisco, in the early 1970s to address the long-term care needs of elderly immigrants. In 1974, Medicaid began reimbursing On Lok for adult day

services and later broadened reimbursable services to include comprehensive medical care for older adults certified to be nursing home eligible. In 1979, the United States Department of Health and Human Services provided a four-year grant to On Lok to develop a model of care delivery for individuals with long-term care needs. With a one-year grant from The Robert Wood Johnson Foundation (RWJF), On Lok initiated a project to determine the feasibility of replicating the model in other parts of the country. Following the 1986 authorization of 10 replication site waivers by Congress, RWJF provided grant funding for replication sites. By 1994, there were ten operational replication sites. The demonstration continued until PACE was established as a permanent Medicare program by the Balanced Budget Act of 1997 (BBA). Not only did the BBA establish PACE permanently within the Medicare program, but it also enabled states to provide services to Medicaid participants as a state plan option. California was the first state to offer PACE. There are 17 states not currently offering PACE services. We are aware of several states, including Connecticut, that are actively assessing the feasibility of PACE. Several other states are analyzing the potential of expanding PACE.

Eligibility

PACE-eligible individuals must be at least 55 years of age, meet state-defined nursing facility level of care, reside in a PACE organization service area, and be able to live safely in the community upon program enrollment. The average PACE participant has multiple complex medical conditions, cognitive and/or functional impairments, and significant health and LTC needs. Most PACE enrollees qualify as dually eligible Medicare and Medicaid participants, meaning they have benefit coverage under both programs. PACE participants can also qualify as Medicaid only, Medicare only, or private pay.

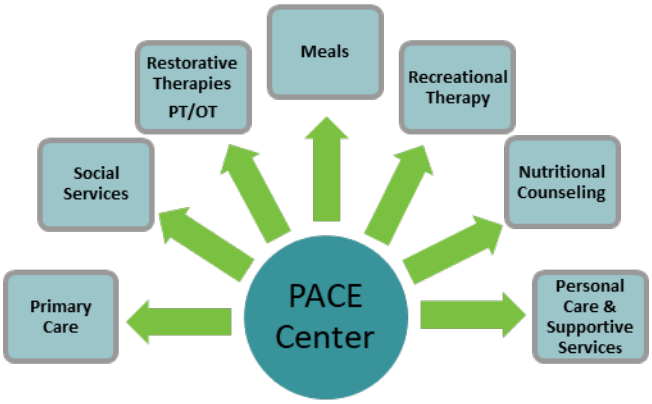
What is a PACE Organization?

A PACE organization is a private or public entity often considered both a provider and a payor of health care services. There are no federal licensing requirements for a PACE organization. Most states do not have a separate licensing category for a “PACE facility”. Rather, they may require a PACE facility to meet licensing requirements for a home health agency or an adult day center, or both, plus any other applicable local and state ordinances and regulations. PACE organizations may be standalone PACE providers or affiliated with hospital systems, nursing facilities, adult day service providers, federally qualified health centers (FQHCs), community-based services non-profits, health insurance plans, or a partnership between multiple organizations.

The PACE organization must operate at least one PACE center for its defined service area. PACE services are primarily delivered in an adult day-like setting within the PACE center and supplemented by in-home and specialist visits but may also be provided at inpatient facilities when necessary. Participants are provided with transportation to and from the PACE center, specialists, and other appointments. The PACE center serves as an adult day center that also includes a primary care clinic, restorative therapies,

and areas for dining, socialization, and therapeutic recreation. The frequency of a participant's PACE center attendance is determined by the IDT based on each participant's needs and preferences.

Figure 1. PACE Center & Services



A PACE organization is an entity that has a current PACE program agreement, approved by both the Centers for Medicare & Medicaid Services (CMS) and the State (commonly known as a three-way agreement), to operate a PACE program. The three-way agreement is structured to contain the terms and conditions that describe how the PACE organization will provide comprehensive, coordinated, community-based, and capitated health care services to PACE participants.

PACE is unique in that it integrates Medicaid and Medicare funding. The fully integrated model of care, with pooled funding resources, is intended to allow the PACE organization greater service flexibility, coordination, and continuity of care. PACE participants receive services covered by Medicaid and Medicare, as well as any other services determined necessary by the PACE organization's IDT. Benefit limitations or conditions relating to amount, scope, or duration of services, deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under Medicare or Medicaid do not apply in PACE. The PACE organization is financially responsible for all services required for participants.

The IDT

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

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

PACE Services

The PACE organization provides comprehensive medical, health, and social services that integrate primary care, acute care, and LTC. It is responsible for providing care that meets the needs of participants across all care settings, no matter the frequency, day, or time.

Service determination is based solely on an assessment of the participant's current medical, physical, emotional, and social needs consistent with the clinical practice guidelines and professional standards of care. PACE services include any service necessary to meet the needs of a participant when authorized by the IDT, some of which include the following:

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

As previously noted, services provided to PACE participants are not limited to those covered only by Medicare and/or Medicaid. The IDT determines what services are necessary to ensure the participant is healthy and safe in the community. An example of PACE services that may not normally be covered is the installation of an air conditioning unit for a patient with asthma or congestive heart failure. If the IDT determines that an air conditioning unit is needed to improve and maintain the participant's overall health status, then the cost is covered by the PACE organization.

PACE organizations must also ensure access to a provider network that, at a minimum, contracts for the following 26 specialties:[8]

- 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.

[8] National Archives. Code of Federal Regulations. 42 CFR 460.7. Contracted Services. November 27, 2024.

- Pulmonology.
- Radiology.
- Rheumatology.
- General surgery.
- Thoracic and vascular surgery.
- Urology.

The PACE organization may use telemedicine appointments to connect participants with medical specialists for consultations and ongoing care.

Community Emphasis

PACE emphasizes community — it seeks to underscore the values, beliefs, and other community customs and standards that influence health care. States should consider these factors in the identification of PACE service areas, and PACE organizations should develop their structures, service mechanisms, and staff based on the community they serve. Language barriers, cultural perceptions, stereotypes, family models, religions, and traditions all play a part in a person's access to and decisions regarding health care services. PACE organizations build community trust by tailoring their centers and services to fit the culture, beliefs, and values of potential and enrolled participants. In particular, the beliefs of enrollees may influence how they access services, participate in center activities, express their happiness with services, communicate with their health team, and comply with medical plans.

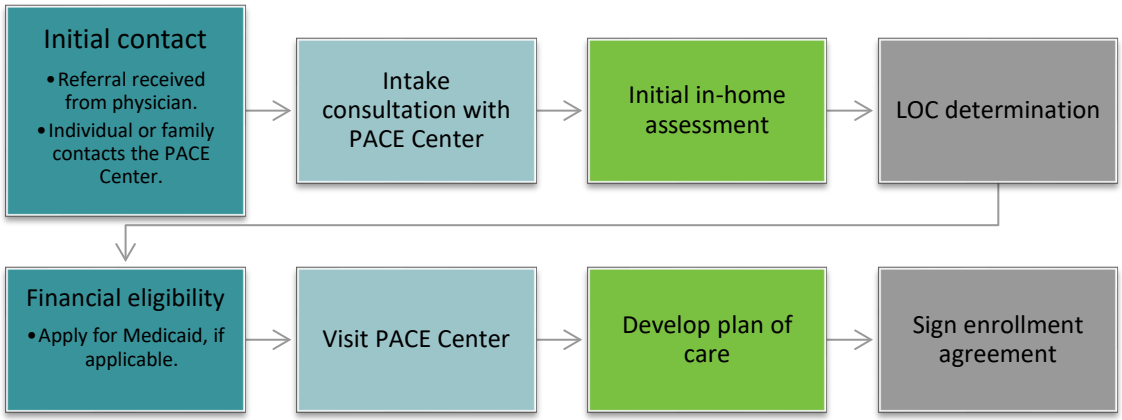
PACE Enrollment Process

PACE is an optional benefit under the Medicaid State plan and participant enrollment is voluntary. The enrollment process begins with an intake consultation at the PACE center or participant's home, when necessary, followed by an in-home assessment, and the NF LOC and Medicaid eligibility determination.[9] If the individual meets eligibility requirements, a care plan is then developed, and an enrollment agreement with the PACE organization is signed. Some aspects of the process may happen simultaneously. From start to finish, the enrollment process generally takes 30-45 days. Once the agreement is signed, the PACE organization becomes the sole provider of Medicaid and Medicare benefits for the participant (i.e., the participant must forego care from all other sources and historical relationships).

Figure 2 presents a generalized PACE enrollment process from initial contact to the signed enrollment agreement. The process may vary by state.

[9] If the individual is already Medicaid eligible this step would be to confirm eligibility.

Figure 2. PACE Enrollment Process



Note: The process described is generalized. The State has the final authority to establish the enrollment process.

PACE participants may voluntarily disenroll from the program without cause at any time. PACE organizations may not involuntarily disenroll participants without cause. CMS maintains strict parameters around involuntary disenrollment. Both CMS and the State coordinate monitoring quality of services delivered by the PACE organization, including surveilling disenrollment trends. Participants cannot be disenrolled because of a change in their acuity or health status. Additionally, the PACE organization must ensure its employees or contractors do not engage in 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.[10] If it is determined that a participant would be best serviced by transitioning to nursing facility care, the PACE organization continues to oversee and coordinate their care through the IDT while the participant is a resident at the nursing facility. All costs of service, including nursing facility services, are borne by the PACE organization. In this example, the nursing facility would bill the PACE center directly for these services.

Participant Disenrollment

Participants in PACE can voluntarily disenroll at any time. However, they cannot be disenrolled by the PACE organization due to changes in health status.

Even if transitioning to a nursing facility is needed, a participant remains enrolled, and costs are covered by PACE.

PACE Rate Setting and Program Funding

PACE is a full-risk health care model, meaning that the PACE organization is financially responsible for the total cost of all participant services. PACE organizations receive payment on a per-member, per-

[10] National Archives. Code of Federal Regulations. 42 CFR 460.50 Participant Enrollment and Disenrollment. November 2024.

month basis. Under the full-risk model concept, the capitated payment is intended to incentivize the PACE organization to manage costs through ongoing intensive care management and the provision of preventive quality health care and social services.

Table 2. PACE Payor Source

PACE Payor Types	Typical PACE Census Mix
Medicaid and Medicare for Dually Eligible Participants	87%
Medicaid Only	12%
Medicare Only and Private Pay	1%

Source: American Association of Retired Persons Public Policy Institute. How PACE Integrates Medical Care with Long-term Services and Supports. October 2023.

Approximately 75%-90% of participants are dually eligible (i.e., those eligible for both Medicaid and Medicare). For these participants, a payment is paid for their Medicaid eligibility portion as well as their Medicare eligibility portion. Approximately 10% to 15% of participants are covered by Medicaid only. For these participants, a payment is paid for their Medicaid eligibility portion. For the remaining smaller percentage of participants that are either Medicare only or private pay, a single payment is made to the PACE organization from the Medicare Administrative Contractor or through a private insurance premium, as applicable. PACE organizations combine revenue into a common pool from which health care expenses are paid.

State Medicaid Funding

Under a PACE program agreement, the state administering agency (SAA) makes a prospective monthly payment to the PACE organization for each participant. The SAA sets the amount of the PACE monthly capitation rate based on CMS regulations that require:[11]

- The capitated payment must be less than the amount that would otherwise have been paid (AWOP) under the Medicaid State plan if the participants were not enrolled in PACE.
- The rate accounts for the comparative frailty of PACE participants.
- The rate is a fixed amount regardless of changes in the participant's health status or living situation.
- The rate is updated annually.

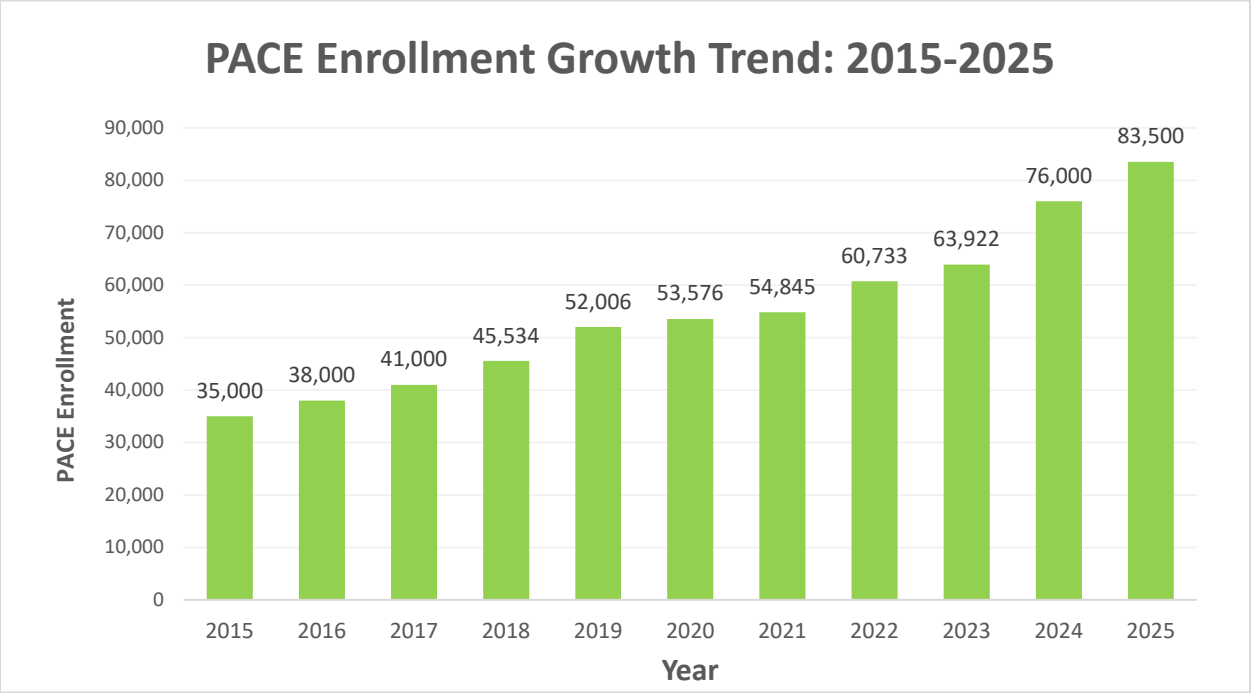
The PACE organization must accept the capitation payment amount as payment in full whether it is paid by Medicaid, Medicare, or a private pay participant. The PACE organization may not bill, charge, collect, or receive any other form of payment from the SAA or from, or on behalf of, the participant, except payment with respect to any applicable spenddown liability, any amounts due under the post-eligibility treatment of income (PETI) process, or Medicare payment received from CMS or from other payors.

[11] National Archives. Code of Federal Regulations. 42 CFR 460.182 Medicaid Payment. April 2025.

PACE Adoption by States

Although the origins of PACE date back to the early 1970s, the program continues to expand and evolve. Since 2015, national PACE enrollment has more than doubled, increasing from approximately 35,000 in 2015 to 83,500 in 2025. One contributing factor to the growth of PACE was the availability of American Rescue Plan Act (ARPA) funding. Some states elected to use this funding to explore implementing or studying the potential to implement a PACE program.[12]

Figure 3. PACE Enrollment Growth Trend: 2015-2025



According to the NPA,[13] there are 185 PACE Programs operating in 33 states and the District of Columbia.

[12] NPA. NPA reported PACE Enrollment as of January 2025.
[13] Ibid.

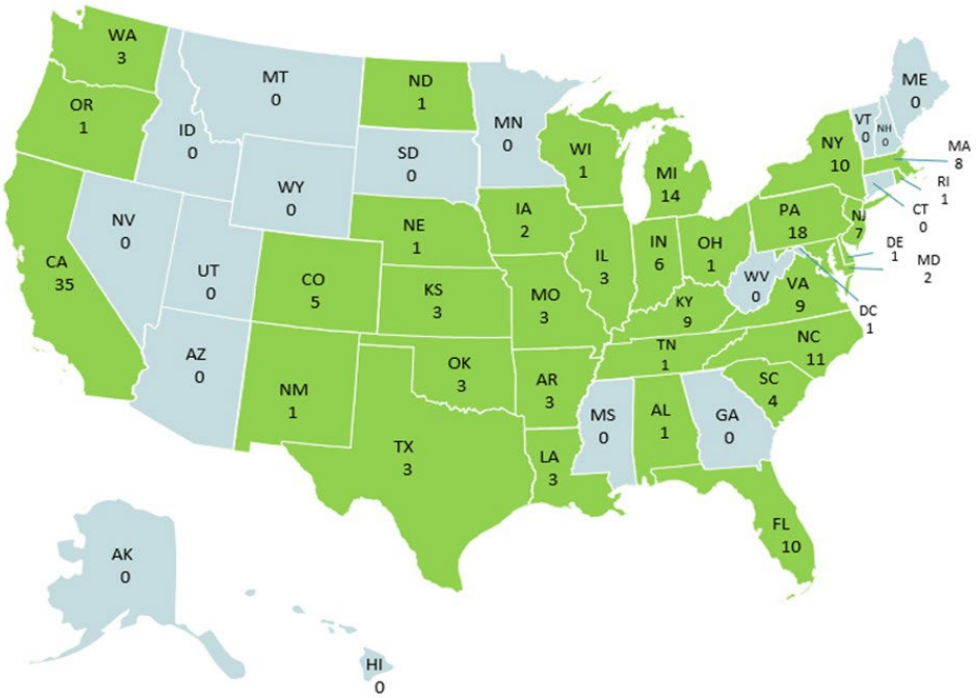
PACE Enrollment by State

PACE is a relatively small program. *Figure 4* displays the number of PACE organizations by state, and *Table 3* shows enrollment across the 34 current PACE programs as of April 2025. There are currently 17 states without a PACE program, including Alaska, Arizona, Connecticut, Georgia, Hawaii, Idaho, Maine, Minnesota, Mississippi, Montana, Nevada, New Hampshire, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

In April 2025, Georgia issued a request for proposals to establish PACE in 13 service areas across the state. Wyoming participated in PACE from 2013-2021 with a center located in Cheyenne. The State discontinued PACE in 2021 due to budget restrictions.

On average, states who offer PACE have between 2,000 and 2,500 participants enrolled. Enrollment reported by the National PACE Association as of April 2025 indicates that 10 states with PACE account for more than 84% of participants. The average number of participants in the remaining state programs, including District of Columbia, is approximately 550[14].

Figure 4. Number of PACE Organizations by State



[14] Ibid.

Table 3. PACE Enrollment by State

State	Census	State	Census
Alabama	183	North Carolina	2,115
Arkansas	585	North Dakota	207
California	25,549	Nebraska	212
Colorado	4,897	New Jersey	1,367
District of Columbia	58	New Mexico	440
Delaware	380	New York	10,010
Florida	3,351	Ohio	686
Iowa	748	Oklahoma	815
Illinois	64	Oregon	1,996
Indiana	871	Pennsylvania	8,226
Kansas	1,087	Rhode Island	460
Kentucky	510	South Carolina	564
Louisiana	471	Tennessee	271
Massachusetts	5,822	Texas	1,126
Maryland	162	Virginia	2,188
Michigan	5,739	Washington	1,718
Missouri	153	Wisconsin	491

Growth of PACE

Many states are continuing to expand current PACE markets and consider expansion applications, leading to growth across the country. Other states elected to use ARPA funding to explore implementing or are studying the potential to implement a PACE program. As states contemplate the aging baby boomer generation, they are considering various options to offer long-term services and supports to this population. As a result, providing services within the community through a PACE program, while allowing aging adults to remain in their home, may be an attractive option.

Table 4. Top PACE State Programs by Census

State	Census	Percent of Nationwide Enrollment
California	25,549	30.59%
New York	10,010	11.98%
Pennsylvania	8,226	9.85%
Massachusetts	5,822	6.97%
Michigan	5,739	6.87%
Colorado	4,897	5.86%
Florida	3,351	4.01%
Virginia	2,188	2.62%
North Carolina	2,115	2.53%
Oregon	1,996	2.39%
All Others (n=24)	13,629	16.33%
Total	**83,522**	**100%**

The Impacts of PACE

The section on PACE program impacts summarizes research findings on its effectiveness and benefits. It includes data and experiences from other states, highlighting the program's positive outcomes and challenges faced during implementation.

Research

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

Overall, studies have come to the following conclusions:

- PACE provides quality and cost-effective community-based care to older adults who could otherwise require a nursing home or other model of care.[15]
- There has been steady census growth, good consumer satisfaction, reduction in use of institutional care, and controlled utilization of medical services.[16]
- PACE has been associated with the following statistically significant impacts:
  - **Formal support services** — a higher probability of attending a day health center and more day health center days; a lower probability of receiving nurse visits to the home.
  - **Utilization of medical services** — a lower probability of having a hospital admission and fewer inpatient hospital nights; a lower probability of having a nursing home admission and fewer nursing home nights; a higher probability of receiving ambulatory care and more ambulatory visits.
  - **Health status, quality of life, and satisfaction** — a higher probability of being in good or excellent health, finding life to be satisfying, attending social programs at least once per week.
  - **Functional status** — a lower probability of having a visual or hearing disability or weekly bowel/bladder incontinence; a lower level of ADL limitations.[17]

[15] Arku, D.; Felix, M.; Warlock, T.; Axon, D.R. Program of All-Inclusive Care for the Elderly (PACE) versus Other Programs: A Scoping Review of Health Outcomes. Geriatrics 2022, 7, 31. https://doi.org/10.3390/geriatrics 7020031

[16] C Eng, J Pedulla, G P Eleazer, R McCann, N Fox Program of All-inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing. J Am Ger Soc, 1997 Feb; 45(2):223-32

[17] The Impact of PACE on Participant Outcomes, Pinka Chatterji, PhD Nancy R. Longbottom, PhD David Kidder, PhD Alan White, PhD, July 1998.

- PACE reduced family caregiver burden and provided support to improve family caregiving: [18, 19]
  - More than 96% of family members report being satisfied with the support they receive through PACE and 97.5% of family caregivers would recommend PACE to someone in a similar situation.
  - While nearly half of family members reported a high caregiver burden at the time their loved one enrolled in PACE, more than 58% experienced less burden after enrollment.[20]
  - 27% of new PACE enrollees scored as depressed on an assessment administered before enrollment. Nine months later, 80% of those individuals no longer rated as depressed.[21]

What Other States Say

New York

According to the New York Department of Health, PACE has led to reduced hospital admissions, better preventive care, high rates of community residence, and high caregiver satisfaction.[22] In summary, results in New York indicate the following:

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

Rhode Island

Rhode Island reports[23] the following results:

- 93% of participants rate their care very favorably (good, very good, and excellent).
- 72% of participants enrolled for at least a year have not had an inpatient stay in 12 months.

[18] Ibid.

[19] NPA and Vital Research. PACE Reduces Burden of Family Caregivers. August 31, 2018.

[20] National PACE. (2018). PACE Reduces Burden of Family Caregivers, Aug. 30.

[21] Vouri, S.M., Crist, S.M., Butterman, S., Austin, S. (2015). Changes in Blood in New Enrollees at a Program of All-Inclusive Care for the Elderly. The Consultant Pharmacist®, 30 (8): 463-71.

[22] New York State Department of Health. Discussion of Structural Alternatives for PACE Expansion in New York. June 2022. https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2022-06-02/docs/pace.pdf

[23] PACE Rhode Island.

- PACE participants enter a nursing facility four years later, on average, than a similar population not enrolled in PACE.
- PACE participants make 11% fewer visits to the emergency department than other participants with similar health conditions.

California

California reports the following results:

- The PACE program has a low rate of voluntary disenrollment.
- The rate of satisfaction with the care of PACE participants is greater than 90%.
- PACE participants would refer PACE to a close friend 94% of the time.[24] [25]

[24] California Health and Human Services. PACE Expansion.
[25] CalPACE. PACE Cost-Effectiveness. February 14, 2019.

PACE Implementation

The PACE Implementation section outlines the state-level processes for developing the program, procuring providers, handling application procedures, and amending the Medicaid state plan. It also covers the PACE organization's perspective, detailing the application submission, PACE center construction, state readiness review, and the culmination in a signed three-way PACE program agreement.

State-Level Implementation

For the SAA, PACE implementation may be a complex and lengthy process requiring investment in administrative resources to plan and establish program parameters, financing, procurement, operational procedures, and system updates.

State resources in the form of funding, staff, and information technology (IT) systems must be identified to perform the following tasks:

- A feasibility study to determine whether PACE is a viable option for State implementation. This includes service area determination to identify the PACE locations (e.g., by county, zip code) that optimize the provision of program benefits. Once the service areas are confirmed they would be included in the state's PACE procurement process.
- Development of CMS-compliant State Medicaid PACE rates.
- Procurement or application initiatives to identify and select entities best qualified to provide PACE services.
- Policy, legal, and regulatory development, including but not limited to:
  - Development and submission of a PACE State plan amendment (SPA), reflecting that the State has elected PACE as part of its Medicaid State plan and authorizes PACE organizations to operate in the state.
  - Potential development of PACE regulations that allow the State to establish requirements, such as provider network access (e.g., time and distance standards), fiscal soundness, licensure, and/or certification, reporting, and other state-specific standards. It may be that PACE falls under existing state regulations and that new regulations are not necessary.
  - Development and dissemination of a PACE Provider Manual defining operational policy and procedures (e.g., eligibility, enrollment, disenrollment, quality, encounter data submission, oversight and reporting) for the PACE program.
- Configuration of the MMIS to manage the State's processes for PACE organization provider enrollment, level of care determinations, participant enrollment, and PACE capitation payments.

Additional MMIS modifications would likely be necessary so the MMIS can accept, process, and store PACE encounter data. Edits and audits must be configured to confirm compliance for incorrect enrollments, rosters, and claim submissions. The system will also need to be programmed to deny FFS claims, or any other type of service, submitted when a participant is enrolled in PACE.

- Monitoring and oversight of any providers who may be undergoing the CMS application process and establishing their PACE center.
- Completion of a state readiness review (SRR) to confirm the PACE organization has the necessary policies and procedures, personnel, licensure, and will meet Life Safety Code requirements and other protocols necessary to begin enrolling participants.
- Confirmation that a PACE organization receives a signed program agreement from CMS and the SAA before enrolling participants.
- Development and performance of PACE operational monitoring and oversight. The State's ongoing monitoring and oversight, in cooperation with CMS, includes, but is not limited to:
  - Oversight of PACE participant care.
  - Observation of program operations.
  - Detailed analysis of the entity's substantial compliance with marketing, participant services, enrollment and disenrollment, and grievances and appeals requirements.
  - Comprehensive assessment of fiscal soundness and the organization's provision of PACE services to all participants.
  - Any other elements that the SAA finds necessary.

Once the PACE center is operational, particularly as the program ramps up enrollment, the SAA must regularly meet with and assist the PACE organization with policy and procedural issues.

Flow charts showing a generalized SAA implementation process are presented in *Appendix B: Implementation Charts*. States will vary in their implementation approach. The flow charts identify two phases of PACE implementation:

- **Phase 1 Program Development and Procurement**. PACE implementation typically involves a feasibility study, development of service areas, stakeholder engagement, capitation rate development, Medicaid SPA submission, State policy and procedures development, MMIS configuration, and procurement. This phase can span 12-24 months, but many take longer especially if the MMIS requires significant configuration.

- **Phase 2 PACE Center and Application Procedures.** Once the State has identified an organization to enter into a PACE program agreement. This phase involves a PACE organization application to CMS, provider construction of a PACE center, the SRR, finalization of State policy and procedures, and systems configuration. The duration of this phase is typically 18-36 months or longer.[26]

PACE Organization-Level Implementation

The process of becoming a PACE organization entails significant investment of time, capital, and resources, as well as assistance from the State. It begins with the awarding of a service area from the State, construction or renovation of a PACE center, hiring and training PACE center personnel, developing provider networks, and undergoing an SRR before enrolling participants and delivering services. The capital requirements can be significant, depending on the existing capital infrastructure of the PACE organization and the need for renovation or new construction of a PACE center. Project management and coordination is a significant investment of time for both the PACE organization and the SAA during the implementation process.

Figure 5 details the different steps involved for an organization to become a PACE organization once a service area has been awarded.

Figure 5. Steps Involved in Becoming a PACE Organization

[26] The duration of this phase is largely dependent on the PACE organization.

The first step for the provider entity is applying to CMS. Applications must include an assurance from the SAA that the State considers the entity qualified to be a PACE organization and is willing to enter into a PACE program agreement with the entity.

Next, the PACE center is designed, constructed, and equipped. This process must ensure the physical safety of participants, personnel, and visitors. The PACE center must be a sanitary, functional, accessible, and comfortable environment for the delivery of services that protects the dignity and privacy of the participant. The PACE center must include sufficient space and equipment to provide primary medical care and suitable space for team meetings, treatment, therapeutic recreation, restorative therapies, socialization, personal care, and dining.

The PACE organization must have policies and procedures for providing services while ensuring safety and emergency preparedness. At a minimum, PACE organizations must have contracts in place with 26 medical specialists unless they directly employ personnel who are legally authorized to provide those specialty services. These contracts must be fully executed prior to enrollment of participants and must be maintained on an ongoing basis. PACE organizations are required to have all members of the IDT and all other necessary staff hired, onboarded, and ready to provide services prior to enrollment of any participants. All services must be readily available on the first day of operation, regardless of participant census.

The SAA will assess the provider's readiness to open the PACE center in terms of CMS and any State-specific criteria for program design, service delivery, policies, and procedures. This occurs during the SRR stage.

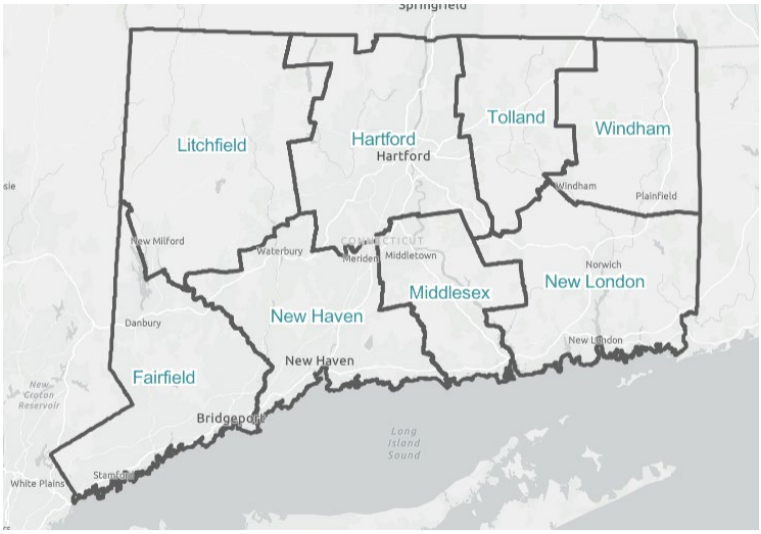
Once the provider successfully passes the SRR, CMS will continue reviewing the provider application, which can involve requests for additional information (RAIs). If CMS approves the provider to operate as a PACE organization, then the three-way agreement between CMS, the State, and the provider is executed. The PACE organization can then begin marketing to their service area, enrolling participants, and providing services.

Upon enrollment, PACE organizations will begin receiving monthly capitation rate payments from Medicaid, Medicare, and private payors, depending on the enrollment status of their participants. On average, a PACE organization enrolls 2-6 new participants per month. In other states, PACE organizations have forecasted their break-even point to be approximately 36 to 60 months from the date services begin.

Connecticut and Connecticut Medicaid

This section provides an overview of Connecticut's Medicaid program, detailing the state's LTSS and Home and Community-Based Services (HCBS). It examines how PACE could integrate within this environment, highlighting its role in enhancing services for older adults.

Figure 6. Connecticut County Map



Connecticut is a state in New England bordered by New York, Rhode Island, and Massachusetts. The Atlantic Ocean is immediately south of the state. Regions in the state can be identified by traditions, income, history, industries, educational institutions, and other factors. We believe that any PACE implementation may wish to consider the regional values and uniqueness of Connecticut in addition to where potential participants are saturated and clustered in the various communities. Connecticut is unique in its use of towns rather than counties for administrative purposes, which influences the implementation of state programs. We use the broader county designations to discuss regional distinctions.

Figure 7. County Designations

Fairfield County

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

Hartford County

The Hartford region includes state capital. The University of Connecticut, Trinity College, University of Hartford, and the University of St. Joseph's are also located in the region.

Litchfield Region

The Litchfield Region contains a group of 21 towns in northwest Connecticut.

Middlesex Region

Along the Connecticut River, the Middlesex Region Middlesex has one of the highest median household incomes in the United States.

New Haven Region

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

New London Region

Along the Atlantic shore lies the New London Region of Connecticut. The region is home to the Coast Guard Academy.

Tolland Region

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

Windham Region

The Windham Region is mostly small communities.

Rural Connecticut

Rural Connecticut faces challenges in health care access and utilization, including longer travel times, fewer providers per capita, and disparities in health outcomes. However, efforts appear to be underway to improve access through programs like mobile health units and by leveraging telecommunications. Rural areas in Connecticut face a shortage of primary care physicians, dentists, and mental health professionals, as designated by the Health Resources and Services Administration (HRSA). Residents in rural areas often face longer travel times to health care facilities compared to urban areas, which can limit access. Income disparities, food insecurity, and other social determinants of health can disproportionately affect health outcomes, particularly among Black, Latino, and Native American populations. Some rural towns have lower rates of health care utilization, including dental and annual check-ups, than the state average.

Certain organizations are using mobile health units to bring health care services to communities where traditional facilities are inaccessible, both physically and financially. The Rural Health Care Program supports health care facilities in rural areas by funding telecommunications and broadband services to facilitate telehealth services. The State Office of Rural Health (CT-ORH) provides resources, technical assistance, and grants to support rural health initiatives in Connecticut, according to the CT-ORH. The Federal Office of Rural Health Policy (FORHP) supports rural health initiatives in Connecticut through grants that aim to improve health care delivery systems, advance maternal health, and reduce substance use disorder. Efforts are underway to build collaborative networks between community members, health care providers, and other organizations to leverage resources and improve rural health.

Connecticut Medicaid

In State fiscal year 2023, roughly 1,179,500 individuals in Connecticut were enrolled in Medicaid for at least one month. This included 94,500 residents aged 65 or older, or who are aged 18 through 64 and who are blind or have another disability under HUSKY C. Of this group, 18,400 received care in nursing homes.[27] According to CMS filings, Connecticut's Medicaid program cost $10.4 billion dollars in federal fiscal year 2023. This amount did not include administrative costs or accounting adjustments.[28] The state's share of those costs was $4.55 billion or approximately 43.8%.

Connecticut Medicaid is structured as a self-insured, managed fee-for-service model, much like the model used by many employers (including the State of Connecticut) for their employees. This contrasts with most other state Medicaid programs, many of which use managed care arrangements under which companies receive capitated payments for serving beneficiaries. Connecticut Medicaid contracts with three statewide Administrative Service Organizations (ASOs), respectively, for medical, behavioral, and dental health services. Each ASO provides member and provider services, utilization review, quality

[27] Connecticut Department of Social Services. Agency Annual Report SFY 2023.
[28] Kaiser Family Foundation. Total Medicaid Spending. April 2025.

management and improvement services to the members of the Medicaid program. However, claims are paid on a fee-for-service basis. The ASO is not at-risk to fund services for enrolled members.

Current Connecticut Long-Term Care Services and Supports

Structural Overview

Connecticut older adults receive long-term care through a mix of programs and organizations, including nursing facilities, intermediate care facilities (ICFs), and assisted living facilities. These facilities are state-licensed and certified to participate in Medicaid and/or Medicare. Medicaid coverage for assisted living services is limited to those in the assisted living demonstration project. Connecticut has approximately 200 nursing facilities.

However, the state has a long history of working to enhance and prioritize home and community-based services (HCBS). Since the 2013 announcement of the first Strategic Rebalancing Plan, Connecticut has actively worked to rebalance its Long-Term Services and Supports (LTSS) system, moving from a reliance on institutional care to a greater focus on HCBS. This strategic initiative is designed to enhance individual choice, autonomy, and dignity for care recipients, while simultaneously ensuring cost-effectiveness within the Medicaid program.[29] In state fiscal year 2022, 69% of Medicaid members who required LTSS received services in the community.[30] The state Medicaid program, HUSKY Health, funds HCBS through State plan options and Medicaid waiver programs.

HCBS Waiver Programs

Sections of the Social Security Act grants the U.S. Secretary of Health and Human Services the authority to approve experimental, pilot, or demonstration projects that further the objectives of state Medicaid and Children's Health Insurance Programs (CHIP). These demonstrations are designed to provide states with additional flexibility to design and enhance their programs while testing and evaluating various policy approaches. The primary goals include expanding eligibility to individuals who are not otherwise eligible for Medicaid or CHIP, providing services not typically covered by Medicaid, and implementing innovative service delivery systems that improve care, increase efficiency, and reduce costs. There are many CMS approved Medicaid waivers in Connecticut that have specific eligibility, service delivery, and programmatic requirements.

Waivers and PACE work together providing options for eligible populations. The waiver system is currently the main continuum available to individuals who qualify for PACE. While PACE would offer another option for these individuals, enrolling in PACE would require disenrolling from their current waiver coverage. It is important to consider HCBS waiver services, their structure, the populations they

[29] Connecticut Department of Social Services. Strategic Rebalancing Plan: A Plan to Rebalance Long Term Services and Supports. January 29, 2020.
[30] Connecticut Department of Social Services; Agency Annual Report SFY 2023

serve, and their level of saturation when evaluating the feasibility of PACE. Understanding the alignment and potential implications of these waivers with the PACE-eligible population helps to determine the best alternative options available to individuals. In considering PACE feasibility, it is important to view PACE in relation to the next best alternative for which an individual qualifies.

Most notably, potential PACE participants may currently qualify or be enrolled in the Section 1915(c) CT Home and Community Based Services Waiver for Elders (CHCPE). This waiver is structured for those individuals over 65 who meet a nursing facility level of care. The waiver aims to help older adults remain in their homes and avert placement in institutional settings, such as nursing facilities. Older adults must be enrolled in a HUSKY program to participate in HCBS. Access Agencies are the primary point of contact for individuals seeking HCBS. They provide information, support, case management services, and assist individuals in navigating the HCBS application and service process.

Potential PACE participants aged 55 to 64 may currently qualify for or be enrolled in other waiver programs in Connecticut. Waiver programs for this age group typically require the individual to meet one or more criteria to be eligible:

- **Nursing Facility Level of Care**
  Some waiver programs require that eligible older adults meet a nursing facility level of care; this means that the older adult requires assistance with critical needs such as bathing, dressing, eating, toileting, or taking medications.

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

- **Condition-Specific**
  Waiver programs exist that require older adults have specific conditions and diagnoses.

Below, we have HCBS waivers that may apply to those individuals who may also qualify for PACE in Connecticut. [31]

- **Personal Care Assistance (PCA) Waiver**
  The Personal Care Assistance Waiver program serves those who meet a nursing facility level of care. The program provides adult day services, agency-based personal care assistant, care management, meals on wheels, adult family living, mental health counseling, and personal

[31] CMS. Section 1115 Waiver Fact Sheet.

emergency response system. This waiver operates with a concurrent 1915(c) and 1915(b)(4) authority. This waiver currently has a waiting list of approximately three years.

- **Connecticut Home Care Program for Elders**
  The CHCPE serves those who may require long-term facility services or have health conditions that meet nursing facility level of care criteria. They must also meet financial criteria. The program provides adult day services, homemaker services, companion services, emergency response system, home delivered meals, chores, mental health counseling, assisted living, personal care attendants, assistive technology, adult family living, care management, environmental accessibility adaptations, transportation, chronic disease self-management, and respite. This financial assistance program helps low income, elderly residents afford the high cost of assisted living (non-skilled nursing, residential care). Presently, all of Connecticut's Medicaid funding for assisted living is administered through the CHCPE. This program operates with 1915(b)(4) authority. There is currently no waiting list for enrollment in this program.

- **Mental Health Waiver**
  The Mental Health Waiver provides adult day services, community support program, supported employment, assisted living, assistive technology, brief episode stabilization, chore services, home accessibility adaptations, home delivered meals, interpreter, mental health counseling, non-medical transportation, overnight recovery assistant, peer supports, personal emergency response systems, recovery assistant, specialized medical equipment, and transitional case management services to individuals with mental illness ages 22 or older who meet a nursing facility level of care. This program operates under Section 1915(c) authority. Currently, this waiver has an estimated two month waiting list for enrollment.

- **Acquired Brain Injury (ABI) Waivers**
  There are two Section 1115 waivers available in Connecticut to individuals with brain injury who meet a hospital, nursing facility, or intermediate care facilities for individuals with intellectual disabilities (ICF/IID) level of care. The programs differ in specific services. The waivers provide group day, adult day services, homemaker, personal care, prevocational services, respite, supported employment, ABI recovery assistants, assistive technology, chore services, cognitive behavioral programs, community living support services, companion, consultation services, environmental accessibility modifications, home delivered meals, independent living skills training, personal emergency response systems, substance abuse programs, transportation, and vehicle modification services. ABI waiver number one is closed for new enrollees. The ABI II waiver currently has an estimated five-year waiting list. These waivers are authorized under Section 1915(c).

- **Comprehensive Supports Waiver**
  The Comprehensive Supports Waiver is available to individuals with developmental and/or intellectual disabilities who meet an ICF/IID level of care. Services available include adult day services, blended supports, group day supports, group supported employment, live-in caregiver, prevocational services, respite, independent support broker, assisted living, assistive technology, behavioral support services, community companion homes, community living arrangements, companion supports, continuous residential supports, customized employment supports, employment transitional services, environmental modifications, health care coordination, home delivered meals, individual directed goods and services, individual supported employment, individualized day supports, individualized home supports, interpreter, nutrition, parenting support, peer support, personal emergency response system, personal support, remote supports service, older adult supports, shared living, specialized medical equipment and supplies, training/counseling/support services for unpaid caregivers, transportation, and vehicle modification services. This waiver is authorized under Section 1915(c). There is no waiting list for coverage under the Comprehensive Supports waiver.

- **Individual and Family Support Waiver**
  The Individual and Family Support Waiver program serves older adults with developmental disabilities ages 55 or older, and older adults with intellectual disabilities aged 55 or older who meet an ICF/IID level of care. Services offered by the program include adult day services, blended supports, community companion homes, group day supports, individual supported employment, live-in companion, prevocational services, respite, independent support broker, assistive technology, behavioral support services, adult companion, continuous residential supports, customized employment supports, employment transitional services, environmental modifications, group supported employment, health care coordination, home delivered meals, individualized day supports, individualized home supports, individually directed goods and services, interpreter, nutrition, parenting support, peer support, personal emergency response system, personal support, remote supports services, older adult supports, shared living, specialized medical equipment and supplies, training/counseling/support services for unpaid caregivers, transportation, and vehicle modification services. This waiver operates under Section 1915(c) authority. There is no waiting list for coverage under the Individual and Family Support waiver.

- **Employment and Day Supports Waiver**
  The Employment and Day Supports Waiver is available to those with developmental or intellectual disabilities who meet an ICF/IID level of care. The program provides adult day services, blended supports, group day supports, individual supported employment, prevocational services, respite, independent support broker, peer support, assistive technology, behavioral support services, customized employment supports, employment transitional

services, environmental modifications, group supported employment, home delivered meals, individual direct goods and services, individualized day support, interpreter, personal emergency response system, remote supports, specialized medical equipment and supplies, training/counseling/support services for unpaid caregivers, transportation, and vehicle modification services. This waiver operates under Section 1915(c) authority. There is no waiting list for coverage under the Employment and Day Supports waiver.

- **Home and Community Supports Waiver for Persons with Autism**
  The Home and Community Supports Waiver for Persons with Autism is available to those who meet ICF/IID level of care. This program provides live-in companions, respite, assistive technology, clinical behavioral support services, community mentor, individual goods and services, interpreter, job coaching, life skills coach, non-medical transportation, personal emergency response system, social skills group, and specialized driving assessment services. This waiver operates under Section 1915(c) authority. This waiver currently has an estimated waiting list for enrollment of eight years.

Other programs and waivers in Connecticut may apply to those potentially PACE-eligibly individuals, as well.

- **Connecticut Home Care Program for Disabled Adults (CHCPDA)**[32]
  The CHCPDA serves those who have been diagnosed with degenerative, neurological conditions such as Multiple Sclerosis, Alzheimer's Disease, Parkinson's, Huntington's, and Amyotrophic Lateral Sclerosis but are not able to qualify for other services because they do not meet the financial eligibility criteria for Medicaid. Services include homemakers, visiting nurses, home health, occupational and physical therapy, chore services, meals on wheels, care management, companion, adult day services, emergency response system, mental health counseling, adult family living, minor home modifications, assisted living services in approved managed residential communities, personal care attendant services, highly skilled chore services, and transportation. This program is limited to a maximum of 100 individuals.

- **Connecticut Housing Engagement and Support Services (CHESS)**[33]
  The CHESS initiative is for Medicaid individuals who are experiencing homelessness and higher rates of hospitalization than would otherwise be expected based on diagnoses and other risk factors. The program provides key services to assist these individuals and operates with a blended State plan option with a Medicaid waiver (through section 1915[i] and the 1915[b] options).

[32] My Place CT. CT Home Care Program for Disabled Adults.
[33] CT DSS. Connecticut Housing Engagement and Support Services (CHESS) Initiative. January 2023.

- **Community First Choice**
  The Community First Choice program offers personal care attendants and other services through self-direction that help eligible individuals remain in their communities and not become institutionalized. Eligible persons must meet functional or medical criteria that reflects a nursing home level of care. This is an optional State Plan service and does not have a waiting list for enrollment.

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

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

Older Adults and Changing Needs

Connecticut offers robust HCBS waiver programs managed by multiple agencies, alongside community options not administered by the state. PACE could enhance the existing long-term care services and supports environment, helping older adults remain healthy at home and alleviating the burden on programs with waitlists. It may also address gaps in health care coverage for older adults as their needs change. Instead of moving between waiver programs or becoming ineligible for existing programs, PACE provides comprehensive health care coverage across the continuum of care for those eligible for enrollment, ensuring continuous care and mitigating periods without support.

Older Adults with Disabilities

Connecticut has been working to transition older adults with developmental disabilities out of institutions and into community-based settings, which includes expanding services such as group homes and closing state-run institutions like Southbury Training School. In 2016, the state closed four centers for individuals with intellectual disabilities, allowing residents to relocate to other state centers or community settings. The Connecticut General Assembly passed legislation to address transfers from DDS-operated or -funded residential facilities. Additionally, the state has invested in expanding community-based residential and day services, using Medicaid waivers to provide services in community settings like assisted living. Despite the progress made in integrating individuals with developmental disabilities into the community through legislative changes, funding adjustments, and systemic shifts in service delivery, challenges remain in meeting the needs of those on waiting lists and ensuring access to necessary services for all residents. Legislative acts, including Public Act 23-137, aim to improve services

and resources, emphasizing individualized support to enable individuals to live in the most integrated settings appropriate for them.

The Olmstead Decision of 1999 prohibits states from discriminating against individuals with disabilities by restricting their long-term care services to institutional settings when they can be served in the community. In Connecticut, this decision ensures that individuals with disabilities have the right to live in community settings rather than institutions, provided that such placements are appropriate and can be reasonably accommodated given the state's resources and the needs of other individuals with disabilities. The Connecticut Legal Rights Project emphasizes the state's obligation to provide access to community-based services and support, allowing individuals to live in the least restrictive environment possible. This approach aims to integrate individuals with disabilities into the broader community, enhancing their interaction with non-disabled individuals and fostering a sense of belonging. To comply with the Olmstead decision, Connecticut has developed a comprehensive plan named "Choices are for Everyone: Continuing the Movement Toward Community-based Supports," which details strategies for expanding community options and promoting integrated living arrangements.

PACE's capitated and integrated care delivery model aligns well with Connecticut's efforts to rebalance LTSS from institutions to community-based settings. Legislative acts like Public Act 23-17 emphasize individualized support, which PACE programs provide through tailored care plans that enable participants to live at home. By offering comprehensive medical and social services funded through Medicaid and Medicare, PACE could support Connecticut's goals of promoting integrated living arrangements and enhancing community inclusion for individuals with disabilities.

Dual Eligible Special Needs Plans (D-SNPs) and PACE

Multiple insurers in Connecticut offer D-SNPs for individuals who are eligible for both Medicare and Medicaid. Dual-eligible individuals have the option to choose between standard Medicare and a D-SNP. These plans are akin to Medicare Advantage Plans as they integrate various coverages and manage healthcare benefits.

While D-SNP and the PACE program are similar in many respects, they also differ in numerous ways. The following illustrates the key differences between the two programs.

D-SNP plans are governed by the Medicare Advantage Program regulations at 42 CFR § 422.101(f) and § 422.107; SNPs are subject to approval by the National Committee for Quality Assurance based on evaluation of the Medicare Advantage Organization's (MAO) Model of Care and subject to sub-regulatory guidance, reflected within the Medicare Managed Care Manual Chapters 2 and 16-B. PACE programs are governed by regulations at 42 CFR §460 and sub-regulatory guidance as cited in the PACE Manual.

The most significant difference between the programs is that D-SNP sponsors function as an insurance company, while PACE organizations serve *as both insurer and provider*. D-SNPs function as an insurer by providing care coordination in adherence with an approved model of care. In general, the model of care must detail the D-SNP's processes for needs assessment, care coordination, management of care transitions, and certain educational requirements.

In contrast to insurer functions, the care and services provided to participants through the PACE organization is directed by an 11-member Interdisciplinary team (IDT), unconstrained by Medicare and Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing. As a provider, PACE organizations include a facility (PACE center) to furnish primary care, nursing services, social services, restorative therapies (including physical and occupational), personal care and supportive services, nutritional counseling, recreational therapy, and meals. Adequate space for these services and team meetings is required.

The implications of this difference include greater responsibility for participant care, services, and outcomes on the part of the PACE organization. A summary of select differences includes the following:

Table 5. Summary of Differences

Eligibility	
D-SNP	**PACE**
To be eligible to elect a D-SNP, an individual must: ■ Meet the definition of a special needs individual, as defined at § 422.2. ■ Be entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). ■ Be eligible to elect an MA plan under § 422.50.	To be eligible to enroll in PACE, an individual must meet the following requirements: ■ Be 55 years of age or older. ■ Be determined by the State administering agency to need nursing facility level of care required. ■ Reside in the service area of the PACE organization. ■ At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety.
Care and Services	
D-SNP	**PACE**
The MAO must: ■ Provide coverage of — by furnishing, arranging for, or making payment for — all services covered by Medicare Part A and Part B (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the plan's service area. Services may be provided	The PACE organization must: ■ Provide care that meets the medical, physical, emotional, and social needs of each participant across all care settings, 24 hours a day, every day of the year. Medicare and Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles,

outside the service area of the plan if the services are accessible and available to enrollees. ■ Establish panels of primary care providers (PCPs) and specialists from which the enrollee may select.	copayments, coinsurance, or other cost-sharing do not apply. ■ Employ or contract with a medical director who is responsible for the delivery of participant care, clinical outcomes, and implementation of the quality improvement program, as well as oversight. ■ Integrate acute and long-term care and furnish comprehensive medical, health, and social services in at least the PACE center, the home, and inpatient facilities. ■ Provide primary care by a primary care physician, community-based physician, physician assistant, and/or nurse practitioner, usually in the PACE center. ■ Contract with the 26 medical specialties reflected in § 460.70. ■ Assessment, care planning, and care team
The D-SNP must:	The PACE organization must:
■ Conduct comprehensive initial and annual health risk assessments using an approved tool/survey; face-to-face encounters for this purpose is required but conditions do apply. ■ Develop and implement a comprehensive individualized plan of care through an interdisciplinary care team in consultation with the beneficiary (as feasible), identifying goals and objectives including measurable outcomes, as well as specific services and benefits to be provided. ■ Use an Interdisciplinary Care Team (ICT) to manage care; the composition of the ICT is not prescribed but rather determined by the SNP sponsor and described in the NCQA-approved D-SNP Model of Care.	■ Conduct the initial in-person comprehensive assessment including, at a minimum, evaluation of 11 prescribed elements; it must be performed by the eight clinical disciplines of the 11 member IDT. ■ Perform semi-annual reassessments; the PCP, registered nurse (RN), master's-level social worker (MSW), and other team members that the PCP, RN, MSW determine are actively involved in the development or implementation of the participant's plan of care. ■ Conduct unscheduled assessments in response to change(s) in participant status and/or service determination requests.

Pros and Cons of D-SNPs compared to PACE

Considering the general differences between D-SNPs and PACE and the specific requirements for each, there are several pros and cons of D-SNPs compared to the PACE program:

Pros:

- A D-SNP program may be easier for a state to implement since the state could leverage an established managed care organization MCO).

- A D-SNP program may be more financially stable from the onset if the state is able to leverage a large, established MCO.
- D-SNPs provide similar benefits to members.
- D-SNPs generally provide a much larger provider network to members.

Cons:

- D-SNPs are not focused on long-term care and do not provide early intervention to the 55-64 population to refer members to less-restrictive, long-term care services like PACE does.
- D-SNPs are not generally local, provider-based organizations like PACE organizations.
- D-SNPs do not provide day centers for care provision and coordination like PACE organizations.

Potential PACE Eligibility in Connecticut

The Potential PACE Eligibility in Connecticut section examines the attributes of a viable PACE service area and presents a market analysis to estimate the number of potentially PACE-eligible residents. It includes benchmarks for PACE organization enrollment, identifies the top 10 towns with the highest number of potentially eligible residents, and provides eligibility maps, market density, and enrollment estimates. The section also details potentially viable PACE service areas and offers in-depth explorations of each area.

Typically, a PACE service area is considered a viable market if it has three primary attributes:

- Sufficient potential PACE enrollment that yields PACE organization financial sustainability.
- Reasonable travel time and distance standards. These geographic considerations are important due to the heavy transportation requirements necessary to provide access to PACE center services.
- Sufficient availability of the health care workforce and specialty care to support PACE center services and ensure timely access to medical care.

The market analysis identifies potential PACE service areas using U.S. Census data to estimate the number of PACE-eligible participants residing in each Connecticut ZIP code. An “eligible” is an individual who meets the PACE eligibility criteria. The estimate of potential eligibles is mapped to illustrate how their concentration varies by location across the state and to identify potential PACE service areas.

Next, using benchmarks associated with PACE organization enrollment, the market analysis estimates the number of PACE participants residing in potential PACE service areas. The term “participant” refers to individuals that meet PACE eligibility criteria and enroll with a PACE organization. Geographic criteria associated with drive time and distance are then applied to identify potentially sustainable PACE service areas. The analysis then drills down further to assess the sustainability of the prospective service areas by examining the health care workforce availability and specialty care network adequacy.

Estimate of PACE-Eligibles

To estimate the number of PACE-eligibles, the analysis applies three PACE qualifying factors related to eligibility:

- Individuals must be aged 55 and older.
- Individuals must meet the Connecticut Medicaid clinical eligibility requirements for NF LOC.
- Since such a large percentage of PACE participants are dually eligible for Medicaid and Medicare services, we analyzed the number of individuals who meet the Connecticut Medicaid financial eligibility thresholds to best calculate the number of potential participants.

These factors were applied to U.S. Census American Community Survey (ACS) data related to age, income, and disability. According to the 2022 U.S. ACS Data:[34]

- Connecticut has a total population of 3,611,317. Of those, 32%, or 1,151,163 individuals, are over the age of 55.
- Within that subset, the ACS estimates that approximately 95,742 individuals, or 8.3%, have an independent living difficulty.
- When combined with economic data and Medicaid eligibility data, an estimated 15,500 individuals state-wide may be eligible and likely to enroll in PACE.
- These PACE-eligibles are distributed across the state but are most heavily concentrated in urban areas. From a visual perspective, we noted they are more concentrated centrally in the state and south and west primarily. *Table 6* shows the towns with the 10 highest number of estimated PACE-eligibles.

Table 6. Top 10 Towns for Estimated PACE-Eligibles

Top Ten Towns by Population	Estimated PACE Eligible
1. Bridgeport	1,539
2. Waterbury	1,408
3. Hartford	1,288
4. New Haven	1,034
5. Stamford	600
6. New Britain	586
7. East Hartford	398
8. Danbury	365
9. Meriden	329
10. Norwalk	279
Total	**7,826**

The choropleth map in *Figure* 6 presents the PACE-eligible individuals and ZIP codes in which they reside. The dark blue shading is used to identify ZIP codes with the highest concentration of potential PACE eligibility. The lighter green shading indicates areas with low concentrations of eligible individuals. *Table 7* presents the potential PACE eligibles by top 10 ZIP codes. The map and tables suggest that there are five areas to assess as potential PACE service areas: Bridgeport, Stamford, Hartford, Waterbury, and New Haven.

[34] U.S. Census Bureau. American Community Survey.

Figure 6. PACE-Eligible Individuals by Zip Code

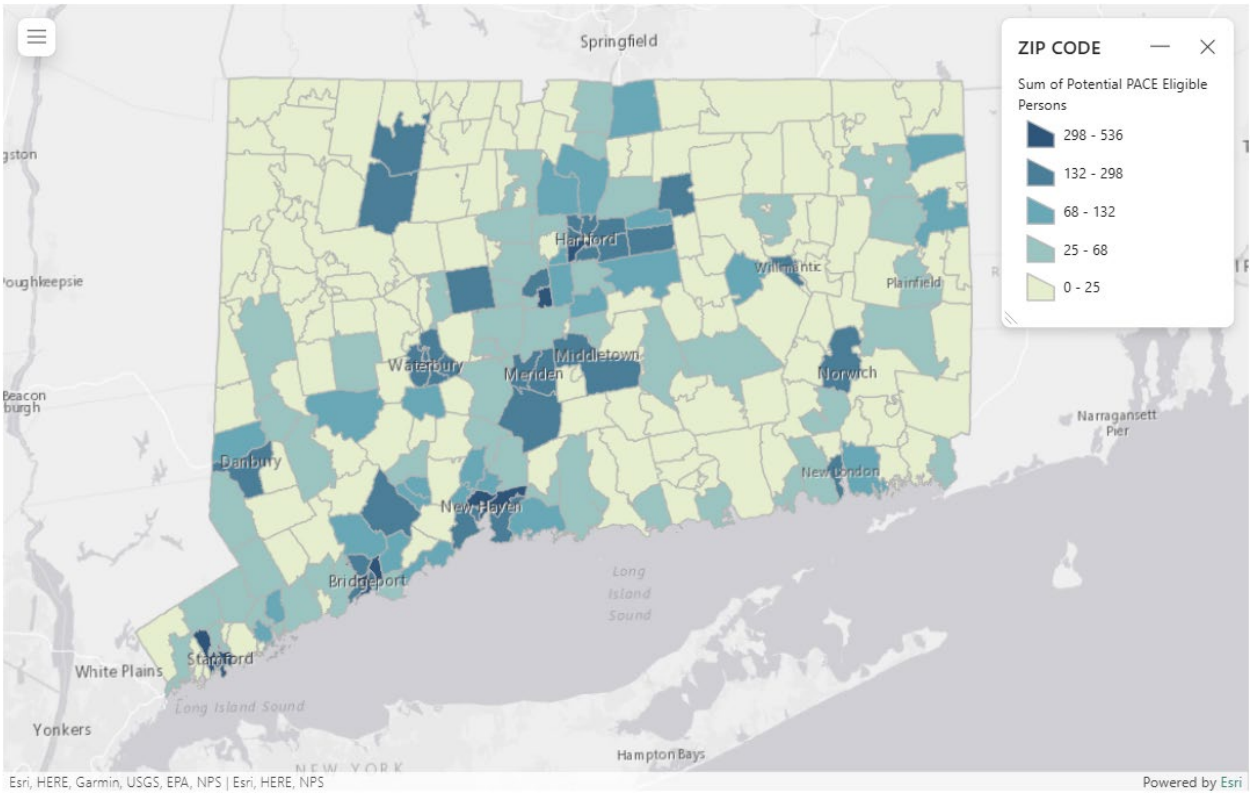


Table 7. Top 10 ZIP Codes for PACE-Eligibles

Top 10 ZIP Codes for Estimated PACE-Eligibles (Comprises 34% of Total PACE-Eligibles)		
ZIP Codes	**City**	**Estimated PACE-Eligible**
06106	Hartford	512
06702	Waterbury	433
06604	Bridgeport	416
06902	Stamford	374
06513	New Haven	341
06511	New Haven	335
06051	New Britain	329
06610	Bridgeport	324
06810	Danbury	285
06606	Bridgeport	265
		3,614

Determining Feasible Service Areas – Market Density

PACE organizations must provide transportation and other services to participants throughout their designated service area, which makes market density a critical factor in determining service area viability. To address market density, the next step in the analysis is to divide the PACE-eligibles by the land area for each ZIP code to determine the estimated number of eligible residents per square mile. This analysis found that:

Market Density

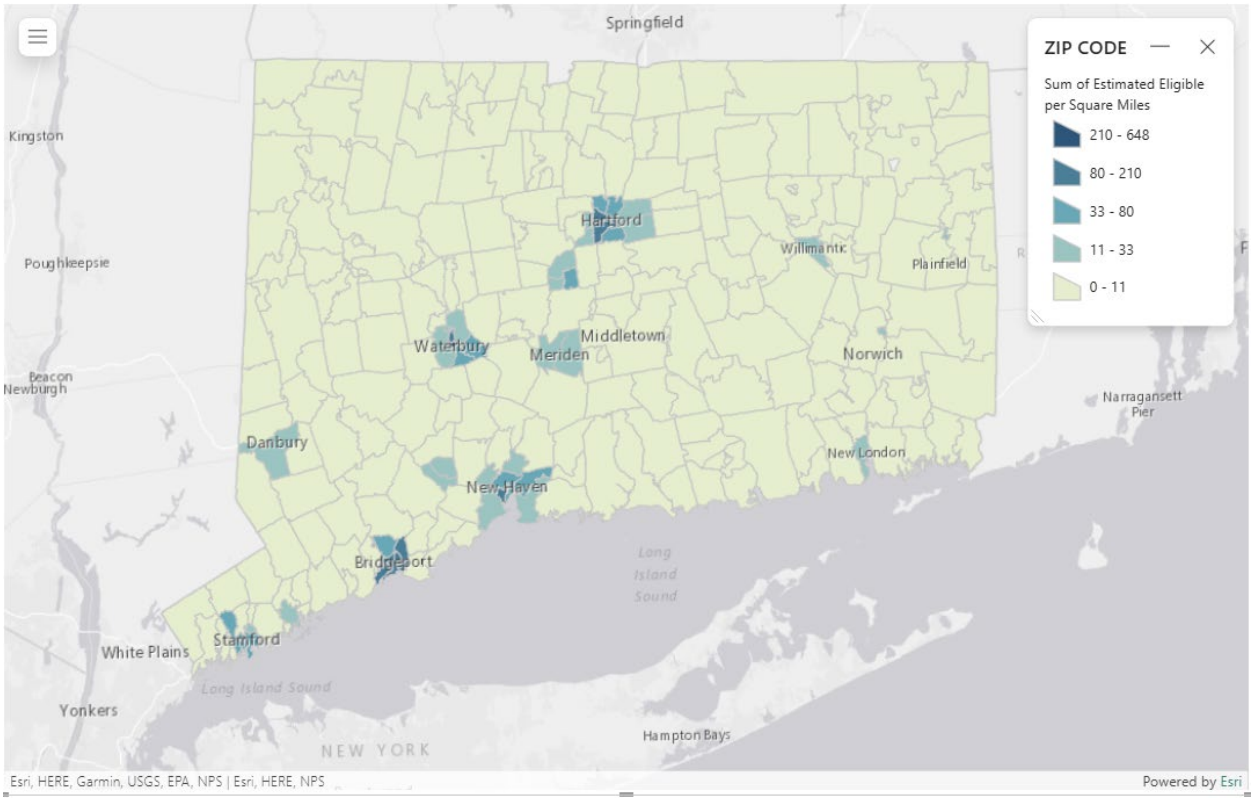
PACE organizations must provide transportation and other services to their participants throughout their designated service area.

This makes market density, meaning the number of eligible residents per square mile, a critical factor in determining PACE market viability.

- The Stamford area includes ZIP codes that average 18 estimated eligible residents per square mile.
- The Bridgeport area includes ZIP codes that average 58 estimated eligible residents per square mile.
- The New Haven area includes ZIP codes that average 25 estimated eligible residents per square mile.
- The Waterbury area includes ZIP codes that average 56 estimated eligible residents per square mile.
- The Hartford area includes ZIP codes that average 37 estimate eligible residents per square mile.
- In contrast, the remaining ZIP codes in Connecticut average only 3 estimated eligible residents per square mile.

Each ZIP code in *Figure 7* is shaded based on the calculated market densities. Dark blue shading represents ZIP codes with the highest density, whereas light green shading represents the lowest density.

Figure 7. Population Density - Statewide



Estimating Enrollment

To be financially sustainable, a PACE organization typically requires a minimum of 100-150 participants. Using a benchmark market penetration rate of 10%-15%, a reasonable expectation for a prospective PACE organization would be to have a minimum of 1,000-1,500 potentially eligible individuals in each service area.

Geographic Considerations

Because Connecticut uses a local government system with primary units of towns, we approached the geographic considerations portion of the study with that in mind. The analysis uses the central town ZIP code as the focus ZIP code of the proposed service areas. This focus ZIP code could be a likely location for a PACE center. We screened for reasonable access to hospitals and health care providers. We analyzed distance measurements in miles but primarily focused on grouping nearby smaller town units with their nearest urban town neighbors.

Results

The towns of Stamford, Bridgeport, New Haven, Waterbury, and Hartford could potentially support PACE organizations and serve the towns surrounding them. The study considered other areas of the

state but determined they were not feasible due to low PACE-eligible population density and extended travel times required to amass the required number of PACE participants to sustain services.

Table 8 presents estimates of the potential PACE-eligibles and participants in each of the identified towns. Because there are numerous influences on enrollment decisions, we present stair-stepped participant penetration rates based on the PACE eligibility estimates. The table includes data for market penetration rates of 10%, 15%, and 20%. For service area development purposes, we have used the 10% benchmark for market penetration to analyze service area feasibility.

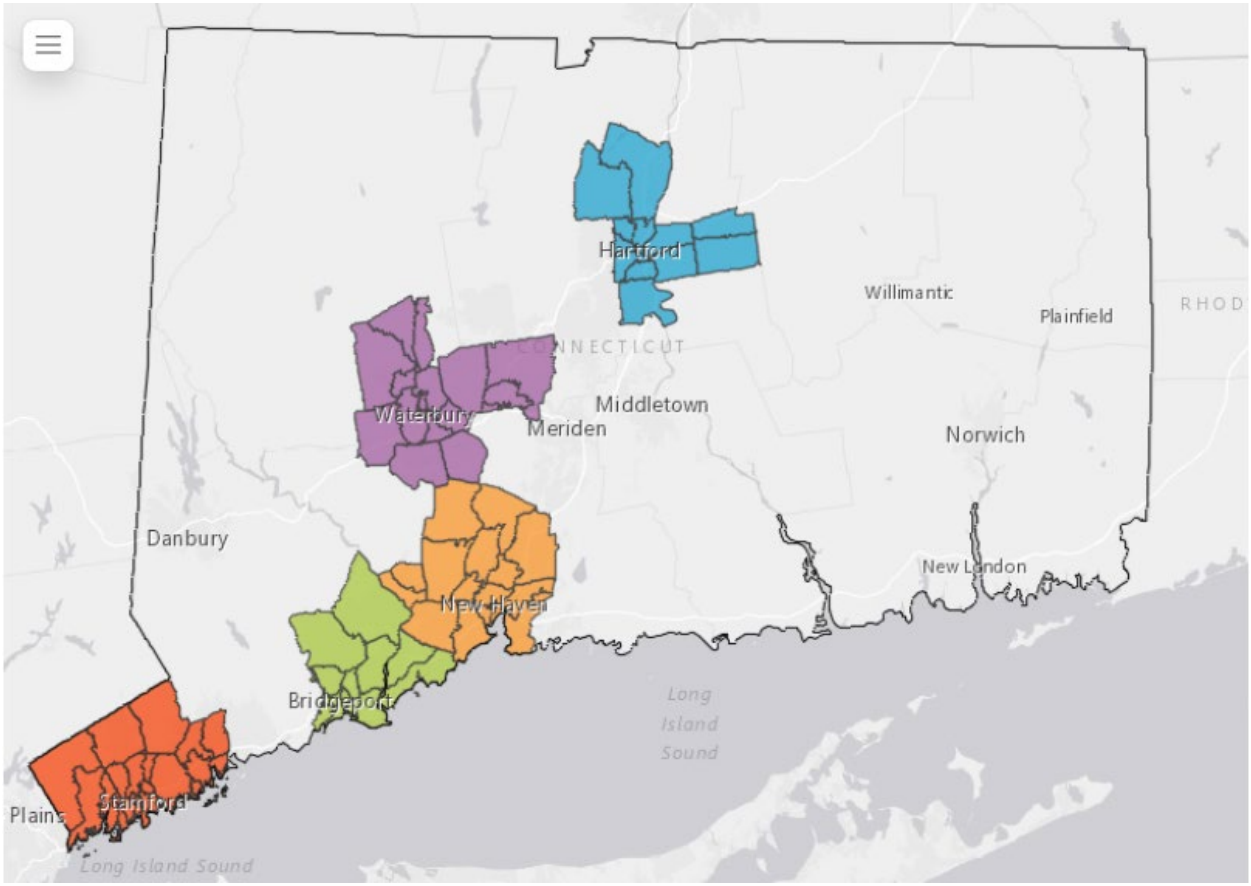
Table 8. Summary of Potentially Viable PACE Service Areas

Summary of Potentially Viable PACE Service Areas: Estimated Eligibles and Program Enrollment								
General			Population Data		Eligibility Estimates	Market Potential – Participants		
Potential Service Area	Average Travel Distance from PACE Center	Central ZIP Code	Total Population (2022)	Age 55+ Population (2022)	Based on Clinical and Financial Analysis	Projected Enrollment @ 10%	Projected Enrollment @ 15%	Projected Enrollment @ 20%
Stamford	20 miles	06902	332,167	97,215	1,034	103	155	207
Bridgeport	20 miles	06604	331,317	105,447	2,067	206	310	413
New Haven	20 miles	06513	364,094	101,486	1,897	190	285	379
Waterbury	20 miles	06702	254,902	77,857	1,670	167	251	334
Hartford	20 miles	06106	310,014	85,281	2,134	213	320	427

Based on the market analysis that considers potential eligibility, access to care, and geographic considerations, the State may wish to consider Hartford, Bridgeport, and New Haven as the most viable options for establishing PACE in Connecticut. Waterbury and Stamford are also viable options for PACE. The combined five options would cover approximately 57% of the estimated PACE eligibles statewide. *Figure 8* displays the ZIP code coverage of each proposed service area.

It is important to note that any PACE organization selected to operate in these service areas will have to strategically assess the market to determine the most appropriate PACE center location and must exercise targeted outreach plans to generate sufficient enrollment to be financially sustainable. In addition, the PACE organization will need to carefully consider and manage their transportation strategy. PACE participant transportation must consider the time it takes for this frail population to access and disembark from vehicles.

Figure 8. Potentially Viable PACE Service Areas by ZIP Code



Potential Service Areas Town Highlights

*Table 9 p*rovides highlights for major towns in the potential service areas where available.

Table 9. Demographic Information

Service Area	City	Population (CY 2024)	Number of Households	Median Age	Median Household Income	Poverty Rate	Top Industry	Unemployment Rate
Stamford	Darien	21,571	7,116	40	$ 250,001	5%	Retail Trade	4%
Stamford	Greenwich	63,498	22,662	43	$ 185,850	5%	Government	3%
Stamford	New Canaan	20,639	7,025	44	$ 250,001	2%	Health Care and Social Assistance	4%
Stamford	Norwalk	91,050	35,272	40	$ 97,879	11%	Health Care and Social Assistance	4%
Stamford	Stamford	135,413	53,520	38	$ 100,718	10%	Professional, Scientific, &Tech Svc	4%
Bridgeport	Bridgeport	148,470	55,550	38	$ 54,440	23%	Health Care and Social Assistance	4%
Bridgeport	Milford	52,283	21,951	47	$ 104,441	4%	Retail Trade	4%
Bridgeport	Shelton	41,206	15,774	45	$ 112,366	6%	Health Care and Social Assistance	4%
Bridgeport	Stratford	52,436	20,821	47	$ 91,025	6%	Manufacturing	4%
Bridgeport	Trumbull	36,922	11,820	43	$ 153,846	5%	Health Care and Social Assistance	4%
New Haven	Ansonia	18,954	7,922	41	$ 67,474	11%	Retail Trade	4%
New Haven	Bethany	5,295	1,742	43	$ 141,000	1%	Government	3%
New Haven	Derby	12,373	5,713	46	$ 69,835	13%	Health Care and Social Assistance	4%
New Haven	East Haven	27,871	11,028	45	$ 83,489	7%	Retail Trade	4%
New Haven	Hamden	61,069	22,891	38	$ 90,484	9%	Health Care and Social Assistance	3%
New Haven	New Haven	135,736	52,977	31	$ 54,305	25%	Educational Services	4%
New Haven	North Haven	24,179	9,559	46	$ 121,250	6%	Transportation and Warehousing	3%
New Haven	Orange	14,231	5,192	46	$ 138,514	3%	Retail Trade	3%
New Haven	West Haven	55,336	20,405	36	$ 72,827	11%	Educational Services	4%
Waterbury	Cheshire	28,791	9,810	43	$ 147,969	4%	Health Care and Social Assistance	3%
Waterbury	Middlebury	7,665	2,812	42	$ 135,114	5%	Health Care and Social Assistance	3%
Waterbury	Naugatuck	31,653	12,257	39	$ 91,145	5%	Retail Trade	4%
Waterbury	Plymouth	11,712	4,496	43	$ 94,600	8%	Manufacturing	4%
Waterbury	Prospect	9,411	3,208	46	$ 124,382	3%	Construction	3%
Waterbury	Southington	43,569	17,020	44	$ 118,790	4%	Accommodation and Food Services	3%
Waterbury	Watertown	22,177	8,796	44	$ 84,536	7%	Manufacturing	4%
Hartford	East Hartford	50,942	20,086	38	$ 64,244	14%	Manufacturing	4%
Hartford	Hartford	121,057	48,277	33	$ 41,841	27%	Health Care and Social Assistance	4%
Hartford	Manchester	59,510	24,900	37	$ 85,048	12%	Government	4%
Hartford	Wethersfield	27,192	11,362	44	$ 108,656	6%	Government	3%

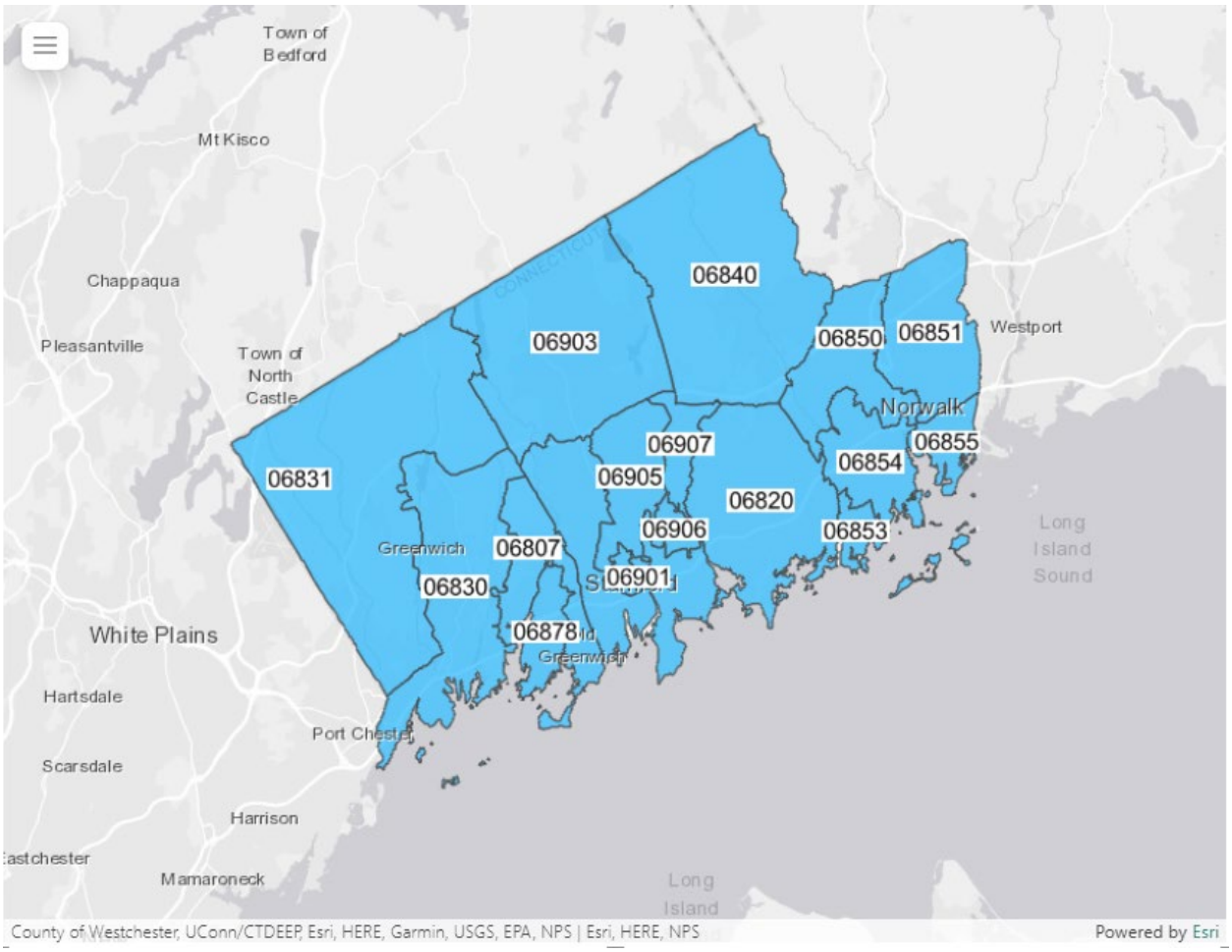
Source: CTData, Town Profiles, https://www.ctdata.org/data-resources

** Data for some towns not available.*

Stamford PACE Service Area

The Stamford PACE service area in southwest Connecticut covers the towns of Cos Cob, Darien, Greenwich, New Canaan, Norwalk, Old Greenwich, Riverside, and Stamford. There are 18 ZIP codes included and an estimated 1,034 PACE eligibles. As a part of the Greater New York metropolitan area, it is the second largest population center in Connecticut. It is generally an affluent area, but it is a diverse area with varying income levels and neighborhoods. Due to the relative affluence of Stamford, many older adults may not be eligible for government health care programs. However, these individuals may have the means to pay for PACE services privately. The service area would need a high penetration rate to be viable. Strong community partnership and an innovative deployment strategy would be necessary.

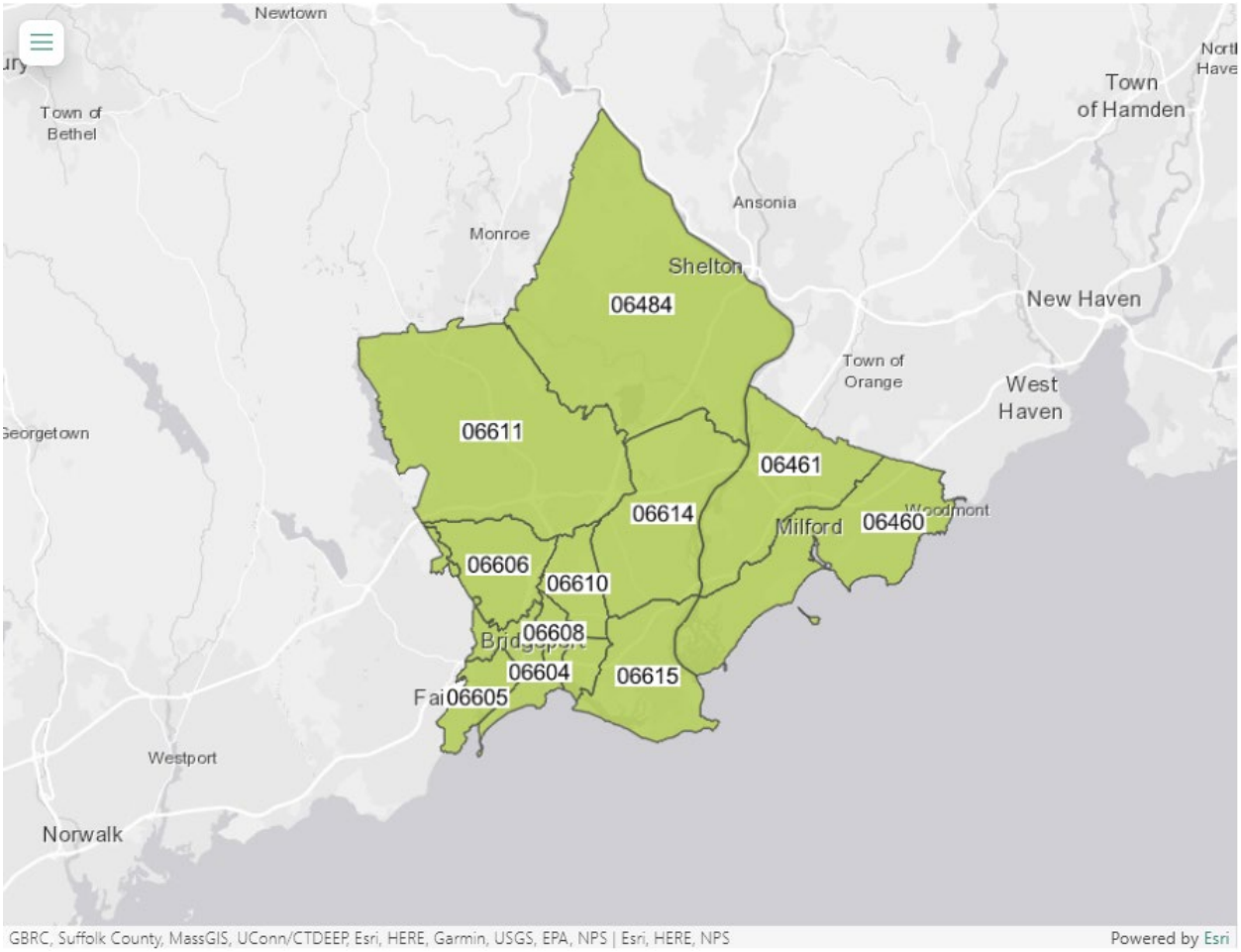
Figure 9. Detail of Stamford PACE Service Area



Bridgeport PACE Service Area

The Bridgeport PACE service area includes the towns of Bridgeport, Milford, Shelton, Stratford, and Trumbull. This is the largest area by population in Connecticut. The proposed service area covers 12 ZIP codes and approximately 2,100 PACE-eligible residents. Bridgeport, like many urban areas, experiences economic and social stratification with notable disparities across its neighborhoods. The city has a wide range of income levels, with affluent areas as well as neighborhoods facing economic challenges. These disparities are reflected in housing quality, access to education, employment opportunities, and public services. Efforts at the local and state levels aim to address disparities by improving economic opportunities, housing, and education for all residents.

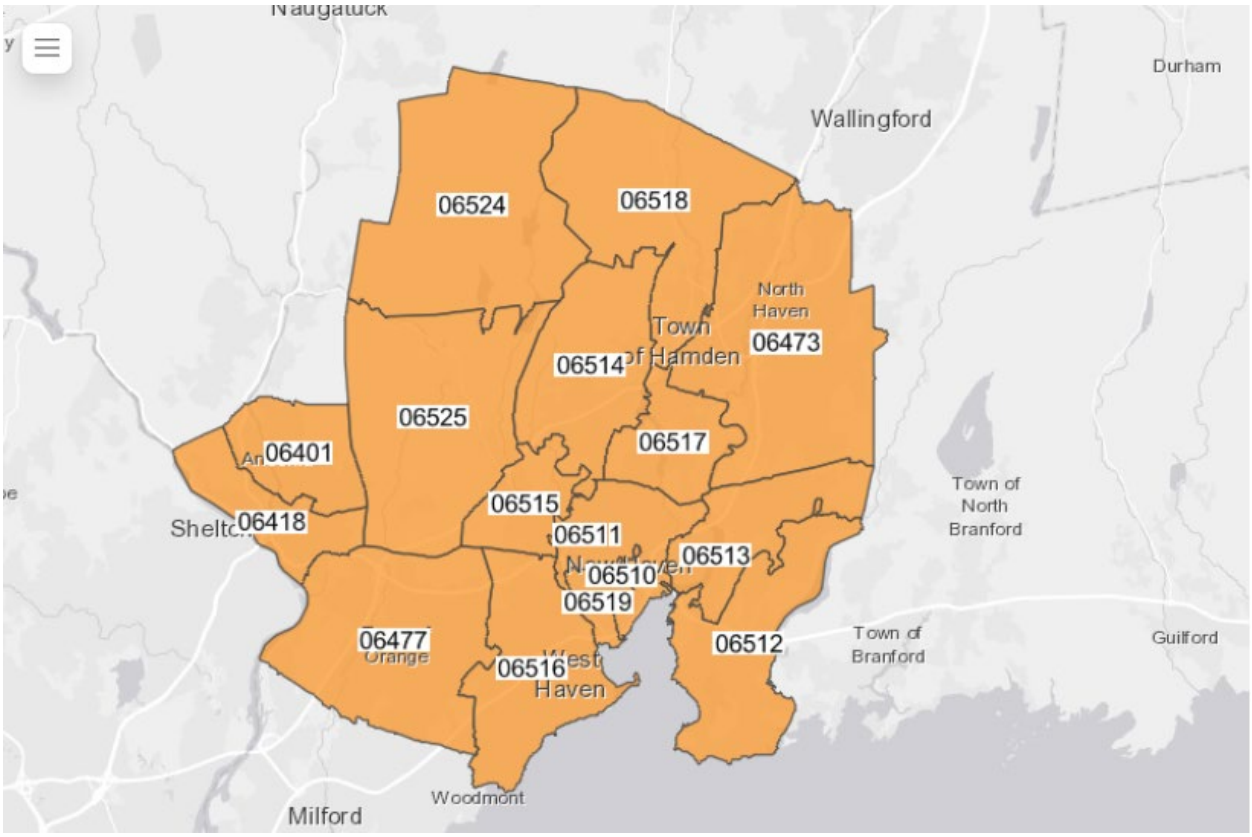
Figure 10. Details of Bridgeport PACE Service Area



New Haven PACE Area

The New Haven PACE service area includes the town Ansonia, Bethany, Derby, East Haven, Hamden, New Haven, North Haven, Orange, West Haven, and Woodbridge. The proposed service area covers 16 ZIP codes and approximately 1,900 PACE-eligible residents. The Greater New Haven area offers a mix of urban, suburban, and rural settings with varied access to health care, economic disparities, and opportunities for older adults. It is well served by several prominent health care facilities offering comprehensive medical services and specialized care. While New Haven hosts affluent areas and a prestigious university, the Greater New Haven area experiences significant economic disparities. Cities like Ansonia and Derby have mixed economic profiles, with some areas struggling economically. Organizations such as the Agency on Aging of South-Central Connecticut provide support services, including meal programs, transportation, and health education, ensuring that older adults have access to necessary resources and opportunities to maintain their quality of life.

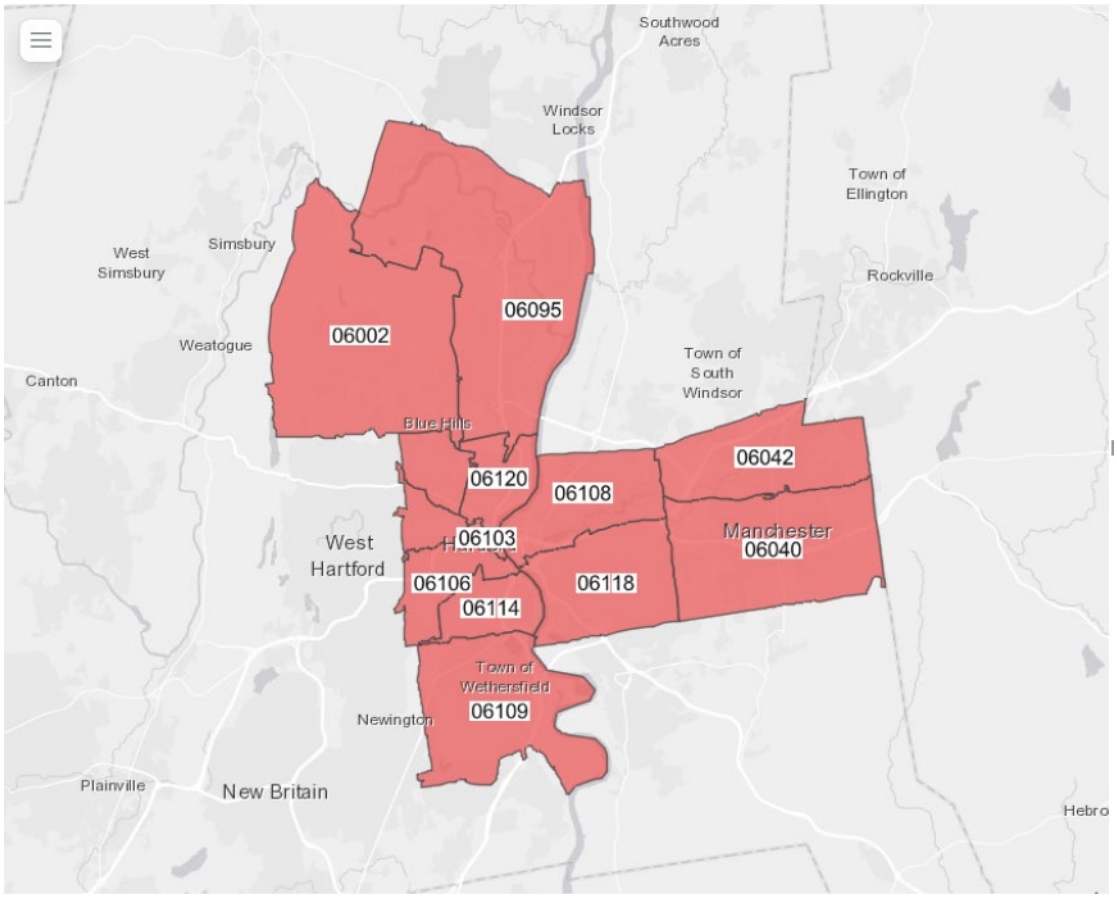
Figure 11. Details of New Haven PACE Service Area



Hartford PACE Service Area

The Hartford PACE service area includes the towns of Bloomfield, East Hartford, Hartford, Manchester, Wethersfield, and Windsor. The proposed service area covers 13 ZIP codes and approximately 2,100 PACE-eligible residents. The area is home to several top-tier health care facilities. These institutions, along with various community health centers and clinics, provide comprehensive medical care and specialized services to residents. The availability of such facilities ensures that health care is accessible to many, although there may still be barriers for lower-income populations. The Greater Hartford area experiences significant economic disparities. Hartford, the state capital, has areas of considerable wealth juxtaposed with neighborhoods facing high poverty and unemployment rates. Surrounding towns like Bloomfield and Wethersfield typically have more stable economic conditions with higher median incomes. East Hartford and Manchester have more mixed economic profiles, with some areas experiencing economic hardship. Windsor, like Bloomfield, has a diverse economic base, but overall better economic stability.

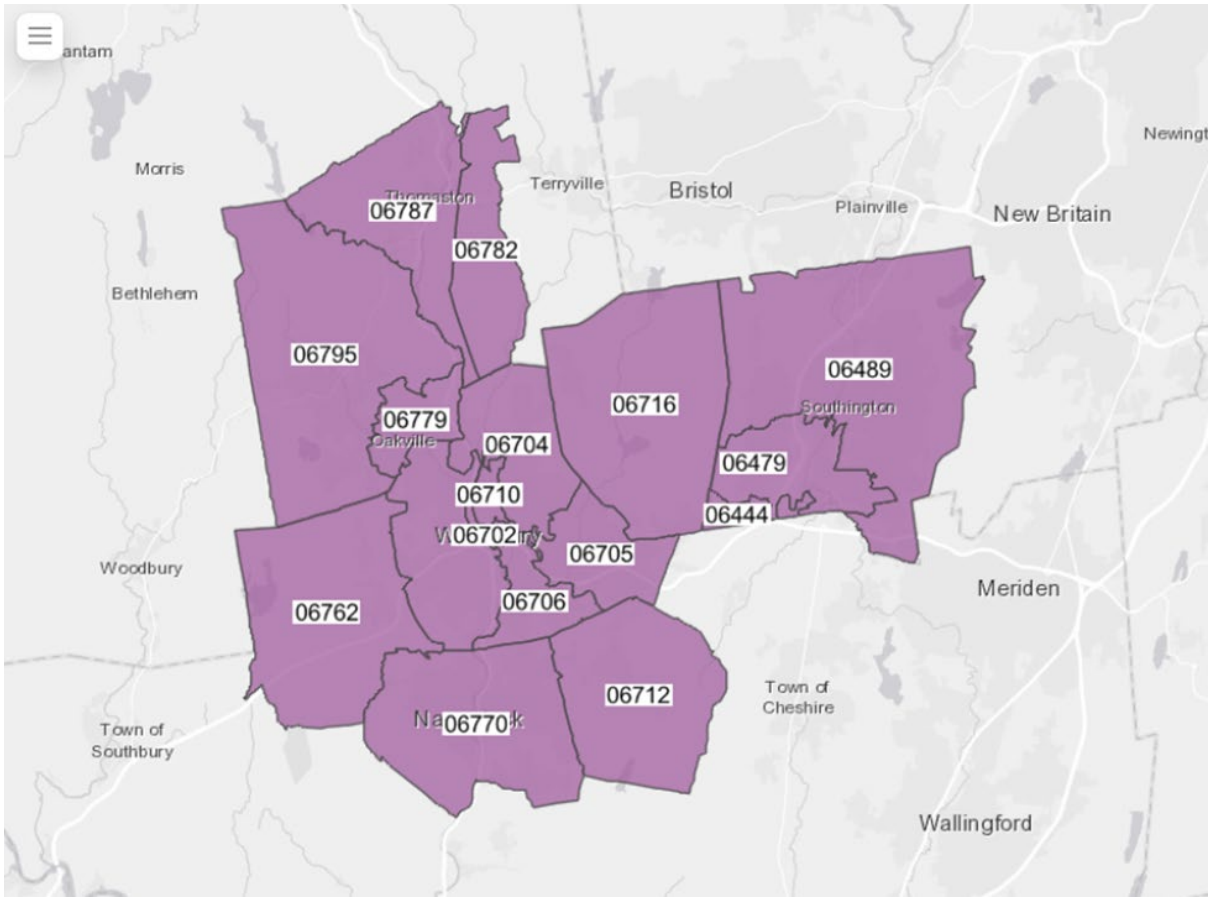
Figure 12. Details of Hartford PACE Service Area



Waterbury PACE Service Area

The Waterbury PACE service area includes the towns of Marion, Middlebury, Milldale, Naugatuck, Oakville, Plantsville, Plymouth, Prospect, Southington, Thomaston, Waterbury, Watertown, and Wolcott. The proposed service area covers 18 ZIP codes and approximately 1,700 PACE-eligible residents. The region is served by several key health care facilities, including Waterbury Hospital and Saint Mary's Hospital, both located in Waterbury. These hospitals provide a wide range of medical services, including specialized care and emergency services. Additionally, there are various clinics and health centers spread throughout the towns, which help cater to the health care needs of the local populations. However, access to health care can vary depending on the town, with more rural areas potentially facing greater challenges in accessing comprehensive medical services. Economic disparities are evident within the Greater Waterbury region. Waterbury, the central city of the region, has areas experiencing significant economic challenges, including high poverty and unemployment rates. Overall, the region reflects a spectrum of economic conditions, from affluent suburbs to struggling urban areas.

Figure 13. Details of Waterbury PACE Service Area



Potential PACE Service Areas Health Workforce Analysis

PACE organizations are responsible for arranging or directly providing all services to participants that advance their health and allow them to live in their homes. PACE organizations must recruit or contract with personnel and entities that can provide care for their participants.

To comply with the required employment or contracting of specialties, it is essential that PACE organizations build relationships with medical provider networks accessible to their service area. It is also necessary to understand how income, workforce availability, health facility infrastructure, and other related factors can impact PACE development and operations. Health professional shortages and medically underserved data can provide valuable insights. Failure to address these factors can severely hinder the ability of PACE organizations to meet their federal obligations and effectively serve their participants.

Health Professional Adequacy in Areas for Potential PACE Implementation

In Connecticut, Health Professional Shortage Areas (HPSA)s reflect areas of the state where there may be too few primary care physicians, dentists, or behavioral health providers. The HRSA maps medically underserved areas and populations. A medically underserved area (MUA) is a geographic region or population group designated by HRSA as having a shortage of personal health services. A medically underserved population (MUP) is a specific group of individuals within a defined geographic area who face difficulties accessing primary care services, often due to economic, cultural, or language barriers. These populations may also experience a shortage of primary care providers, high infant mortality, or high poverty rates.

Myers and Stauffer analyzed the potential PACE service areas for HPSAs and MUAs.

Bridgeport

The data reflects that Bridgeport is designated a low-income population HPSA related to primary care and dental health. Much of the area also lies within a designated Mental Health low-income population HPSA. There are likely opportunities to enhance the availability of health professionals and services available to care for its population. The area is not designated as an MUA.

Hartford

Data reflects that the Greater Hartford area is designated as a low-income population HPSA related to primary care, dental health and mental health. The area also is designated as an MUA for primary care

and contains a low-income MUP. There are likely opportunities to enhance the availability of health professionals and services available to care for its population.

New Haven

Data reflects that New Haven and West Haven are designated as low-income population HPSAs for primary care. Greater New Haven is also designated as a dental health HPSA. Ansonia, Bethany, Derby, Hamden, However, New Haven, North Haven, Orange, West Haven, and Woodbridge are all considered Mental Health low-income population HPSAs. The area is also designated as a primary care MUA. West Haven has a designated low-income MUP. There are likely opportunities to enhance the availability of health professionals and services available to care for its population.

Stamford

Data reflects that Stamford is not designated as a primary care HPSA but does have a low-income population designated as both dental health and mental health HPSAs. South-End Stamford is designated as a primary care MUA. The South Norwalk area contains a low-income MUP.

Waterbury

Data reflects that Waterbury is designated as a low-income population HPSA for primary care and dental health. Middlebury, Naugatuck, Thomaston, Waterbury, Watertown, and Wolcott lie within a designated Mental Health low-income population HPSA. Central Waterbury is designated as a primary care MUA. There are likely opportunities to enhance the availability of health professionals and services available to care for its population.

It is notable that several hospitals in Connecticut appear to be facing financial difficulties and uncertainties, including potential closures.

Trends in the Direct Care Workforce

The direct care workforce (DCW) plays an essential role in preserving the quality of life for older adults by promoting their independence and aiding them to live safely in their homes and communities. DCW includes certified nursing assistants, home health aides, and personal care aides. They provide services in private homes, group homes, residential care facilities, assisted living facilities, continuing care retirement communities, as well as nursing homes and hospitals.[35]

Connecticut is facing a significant shortage of direct health care workers, including nurses, certified nursing assistants, and other long-term care staff, leading to challenges in staffing and patient care, with some nursing homes limiting admissions or temporarily closing wings. As Connecticut's population ages, there will be an increase in the demand for DCW to assist with daily activities like bathing, dressing,

[35] PHI. Understanding the Direct Care Workforce. (n.d.). March 17, 2022.

cooking, and medication management. According to the Paraprofessional Healthcare Institute (PHI), there were nearly 62,000 direct care workers in Connecticut in 2023. That number is forecast to grow by over 11,000 through 2032. Total DCW job openings in Connecticut over the next decade will be over 118,000.[36] This is an important consideration for PACE as DCWs play a crucial role in helping participants remain safely at home, especially when their care needs surpass the capacity of the participant or their family caregivers.[37] If the State decides to add PACE as an option, a potential PACE organization's plans to recruit and maintain DCW should be closely examined.

Stakeholder Impressions

Stakeholders report that other important considerations for the DCW are (1) proximity to Connecticut border-states, (2) employment by an agency versus self-directed employment, (3) unionization status, and (4) worker safety.

[36] PHI. Connecticut – Key State Characteristics. Accessed May 2025.
[37] Garibay, Jane. Community-Based Integrated Care for Older Adults – The Role of Direct Care Providers in PACE. August 17, 2023. In: Keitt, Sarah (eds).

Stakeholder Engagement

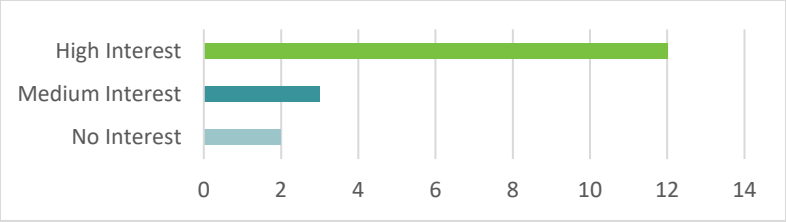
Interested Parties Survey

Myers and Stauffer conducted a survey to gauge the potential interest of entities to operate a PACE program in Connecticut, should the State adopt PACE as an optional Medicaid State plan service in the future. Additionally, the survey sought to gather insights into various questions regarding the suitability of PACE in Connecticut. We collected the following data fields via the survey:

- Organization Name
- Organization Street Address
- Town
- State
- Organizational Structure
- Interest
- Interest Level
- Interest Driver
- Financial Capacity
- Financial Viability
- Provider Network
- Existing Provider Network
- Potential Provider Network
- Organizational Experience
- Connecticut Experience
- Connecticut Business Explanation
- Experience Elsewhere
- Business Explanation - Non-Connecticut
- Required Specialties
- Experience Providing Care
- Other Comments or Questions
- Name of Respondent
- Respondent Email Address
- Barriers to Providing Services in Connecticut
- Can PACE work in Connecticut?
- Is PACE needed in Connecticut?

Over 25 entities responded to the survey, ten of whom reported Connecticut-based operations. In addition to those from Connecticut, entities based in California, Massachusetts, Michigan, New Jersey, Pennsylvania, and New York responded. Organizations that responded included home care providers, PACE organizations in other states, long term care facilities operators, FQHCs, a public benefit corporation, and a low-income housing entity.

Figure 14. PACE Survey Results - Organization Interest Level



Respondents expressed a strong interest in PACE being implemented in Connecticut, driven by several key motivations. Their primary goals include improving care quality for the population, reducing poor health outcomes and institutionalization, providing better-integrated services for older adults, addressing on-going housing issues facing older adults, leverage existing community relationships and care management systems, and mitigating adverse circumstances related to social determinants of health.

Many respondents were confident in their financial viability within any PACE market opened in Connecticut. They acknowledged start-up costs, the need to build or refurbish facilities, and other pre-enrollment expenses. Despite these challenges, they believed they could leverage their existing contractual and resources both within Connecticut and nationally, even if profit margins were narrow. Most respondents already had existing contractual or other relationships with health services providers and organizations in the state. Additionally, they highlighted the importance of adequate reimbursement rates for PACE as a consideration for the viability of PACE organizations in Connecticut.

Respondents generally believed that PACE could be successful in Connecticut. They felt that PACE would offer a more comprehensive set of services than existing care models in the state. Many emphasized the cost-effectiveness of PACE and stressed the importance of collaboration between DSS, CMS, and PACE organizations. While one respondent doubted PACE's success due to the issues faced by SNFs in Connecticut, others suggested that the rollout of additional information during implementation would influence their views towards PACE's potential success in the state.

"PACE 101" Stakeholder Webinar

Myers and Stauffer worked with DSS to convene a webinar-style stakeholder meeting for those who wished to learn more about PACE and the feasibility study. It was also designed to serve as an orientation to support individuals that would be participating in the subsequent stakeholder survey and focus meetings. The presentation:

- Provided an opportunity to inform and educate the audience about PACE.
- Provided an opportunity for stakeholders to submit questions and engage DSS and Myers and Stauffer.
- Further informed DSS and Myers and Stauffer regarding community perspectives and specific health care challenges that older adults and their families may face.
- Further informed DSS and Myers and Stauffer regarding other stakeholder perspectives on how PACE could impact them.
- Helped further assess the existing health care infrastructure in Connecticut.

Internal Stakeholder Meetings

Myers and Stauffer convened several virtual meetings with key internal stakeholders to inform the feasibility study.

During internal stakeholder sessions, the goals were to:

- Learn about each attendee's role within DSS or a partnering state agency.
- Identify key systems and their design.
- Identify the current infrastructure in place to serve the elderly population.
- Discuss any challenges or known gaps in administering care for the elderly.
- Determine whether the agency would have the resources to implement and/or administer PACE.
- Gauge interest, attitudes, and perspectives towards the potential of offering the PACE service.
- Discuss trends observed in serving the aging population, including emerging issues and shifting demographics.

Over the course of the focus group sessions, several common themes and trends emerged. These are presented below.

- **Staffing.** Stakeholders informed us that licensing agencies have difficulties hiring and maintaining adequate staffing levels, especially RNs, for surveys and inspections. Implementing a new program like PACE could require significant resources and could strain the agency's existing resources due to multiple competing initiatives.
- **Existing Projects.** The agency has several high priority goals and initiatives, including projects focused on reimbursement, LTSS services, program management, care models, and others.
- **Systems.** DSS is working to centralize intake and eligibility and to reprocure the MMIS. Eligibility intake to meet federal timelines in the current structure and with systems were reported to be challenging. Beneficiary access to services has recently been problematic due to system issues.
- **PACE Payment Methodology.** PACE uses a capitated payment method to reimburse PACE organizations. Concerns were expressed that capitated payment arrangements must be monitored and may not incentivize quality. Further, unlike risk-based managed care organizations, PACE program providers are not required to spend a certain level of capitation payments on direct services.

- **Housing**. Connecticut faces a housing shortage. The shortage could further exacerbate the challenges of an aging population, as it can make it difficult for older adults to find affordable housing.

External Stakeholder Focus Groups

Myers and Stauffer convened several meetings with key external focus groups to gain input from stakeholders to inform the feasibility study. These focus groups included trade associations, older adult advocates, and academic organizations.

During stakeholder focus group sessions, the goal was to:

- Gauge interest, attitudes, and perspectives towards the potential of PACE in Connecticut.
- Learn about services provided to the 55+ population in Connecticut.
- Identify challenges in providing services.
- Discuss trends observed in serving the aging population, including emerging issues and shifting demographics.

Over the course of the focus group sessions, several common themes and trends emerged. These are presented below.

- **Reimbursement Rates.** Concerns were raised over the level of reimbursement.
- **Healthcare Worker Shortages.** Connecticut has shortages in key service provider categories that are necessary to support PACE, including nurses, nurse assistants, personal care assistants and other direct service workers. Additional shortages are anticipated to occur over the next several years.

PACE Cost Analysis

PACE implementation and operation has both programmatic and administrative cost impacts. The full program cost impact may be realized once the PACE organizations have fully ramped up enrollment and is able to break even financially. Administrative cost will be incurred during the implementation process and will continue once the program is operational. The extent of the administrative costs, and ultimately net fiscal impact, depends upon the State's approach to managing the program.

Program Costs

For program costs, federal regulation requires that states establish an AWOP.[38] This AWOP represents what the cost of providing services under the State plan would be if participants were not enrolled in the PACE program. PACE rates must be held below the AWOP. This requirement means that the monthly per member per month (PMPM) rates paid by Medicaid could result in cost savings.

There are numerous factors that influence the extent and timing of program savings. These factors include the length of time the PACE program has been active, the availability of PACE data to inform rate setting, the number of participants enrolled in PACE, and the participants' resource needs, among others.

We have modeled PACE adoption and enrollment projections based on the following assumptions:

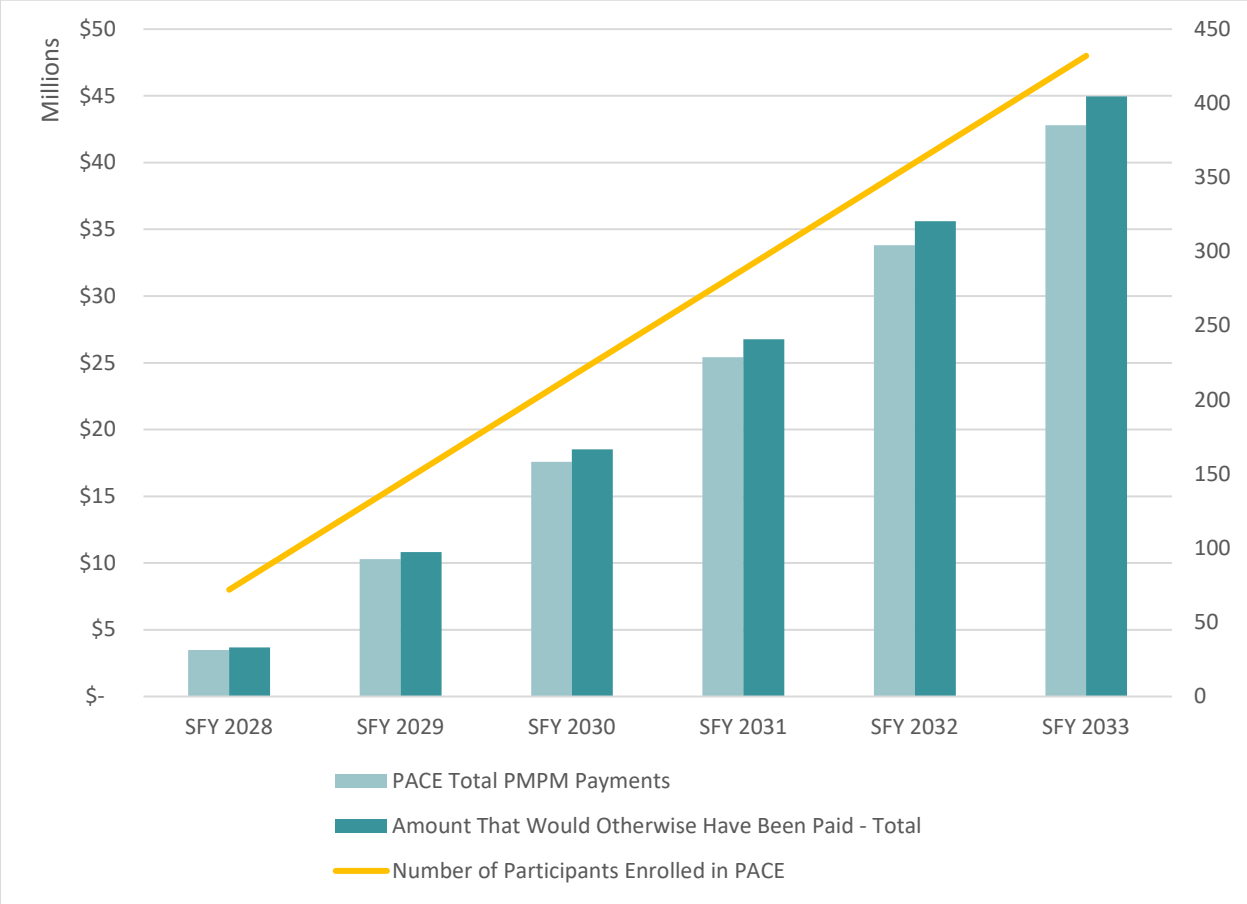
- Connecticut begins implementing PACE in state fiscal year (SFY) 2026 and begins incurring administrative costs for staff, contractors, and updates to the MMIS.
- Two PACE service areas are awarded in Bridgeport and Hartford and PACE services begin early in SFY 2028.
- Enrollment is steady for each PACE center at three participants per center per month. Centers reach optimal market penetration of 10% in the second half of SFY 2033. *Figure 15* charts an example assuming steady enrollment of three participants per center, per month. It shows the initial PACE organization enrollment over 6 years.
- Using an estimated capitation rate of $7,447 in SFY 2028 and average growth of rates at 4.3% each year, *Figure 15* displays the federal and state fund expenses during the three-year ramp-up period.[39] Federal and State shares are configured at 50% FMAP. This chart indicates that

[38] Code of Federal Regulations. 42 CFR 460.182.

[39] The estimated capitation rate is based on the publicly available FFY AWOP for Virginia PACE and is 95% of the AWOP. Source: Mercer Government Human Services Consulting. FY2024 PACE AWOPs. August 14, 2023.

because of the small program size and the 6-year ramp-up period, state fund impacts are likely to be minimal during the first few years of program operations.

Figure 15. Comparison of PMPM Payments, AWOPs, and Enrollment - Years 1 through 6



There are potential savings identified by other states with PACE that are not as easily quantified but should be considered, including:

- A higher probability of the PACE participant being in good health and delaying nursing facility placement.[40]
- A higher probability of fewer emergency department visits, hospital admissions, and shorter inpatient hospital stays.[41]

[40] C Eng, J Pedulla, G P Eleazer, R McCann, N Fox. Program of All-inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing. J Am Ger Soc, 1997 Feb; 45(2):223-32.
[41] Ibid.

- A higher probability of fewer nursing facility admissions and shorter nursing facility stays.[42]
- A higher probability of fewer health care costs during the last three months of life compared to non-PACE participants.[43]

The State can realize these potential savings by applying a greater percentage discount off the AWOP when setting the PMPM rate. This means that access to timely, accurate, and complete encounter and financial data is essential for the State to measure potential savings when establishing the appropriate PACE capitation rate.[44]

State Administering Agency Costs

The designated PACE SAA will have initial implementation and ongoing administrative costs. These costs will vary depending on the size of the State's program. In general, administrative costs include:

- Project management during implementation.
- Development and ongoing maintenance of PACE policy and procedures.
- Stakeholder engagement and procurement.
- PACE organization technical assistance.
- MMIS and other system modifications
- Actuarial assistance with AWOP development.
- Quality assurance and a state-defined assessment (auditing) to ensure compliance with state and federal PACE requirements.
- Guidance and support to ensure compliance with federal reporting requirements.

For DSS, implementing PACE will likely have significant impacts including potential upfront costs associated with staffing needs, additional contracting, and MMIS configuration.

Some states conduct administrative and oversight activities internally using SAA staff. Other states outsource certain oversight responsibilities to sister state agencies or to third-party contractors that lead or support ongoing monitoring on behalf of, and in cooperation with, the SAA. Our analysis factors

[42] The Impact of PACE on Participant Outcomes, Pinka Chatterji, PhD Nancy R. Burstein, PhD David Kidder, PhD Alan White, PhD, July 1998.
[43] University of Kansas, School of Social Welfare. Program of All-inclusive Care for the Elderly Medicaid Cost-Benefit Study. Chapin, Rosemary K.; Wendel, Carrie; Lee, Robert; Landry, Sarah; Zimmerman, Mary K.; Oslund, Pat; Bruns, Kim; Leedahl, Skye; Hill, Jacqueline; Rachlin, Roxanne; Sergeant, Julie. June 2013.
[44] Encounter data consists of data collected when a provider submits a claim to a managed care entity This data includes detail on patient, diagnosis, procedures and billing.

in an assumption that the State will conduct all oversight responsibilities using existing or planned information technology.

For staffing support, the study estimates that up to three positions may be required. Additional personnel with clinical or financial backgrounds may be required during periods of State-defined assessments or reviews.

States that implement PACE programs typically use dedicated staff and/or certain levels of full-time equivalents (FTEs) among existing staff to support PACE. Common areas that are staffed include those who are involved in policy and regulatory support, contract management/PACE organization oversight, program analytics, quality monitoring, and advocacy and public awareness.

- **Policy and Regulatory Support** – PACE requires a strong regulatory and administrative structure to clearly delineate roles, responsibilities, processes, reporting, and other items. Programs should be supported by guidelines to be followed by PACE organizations, internal staff, and agencies, and others. There are usually policy considerations for rate-setting, enrollment, marketing, participant welfare, quality program, and other areas in addition to applicable CMS rules, regulations, and policies. There must be reconciliation between federal instructions, state guidance, and PACE organization policies and procedures. CMS provides higher levels of guidance and standards. States execute those mandates, monitor, report, and ensure compliance. These efforts require an ability to coordinate between multiple entities, interpret and prepare policies and rules and guidance manuals and communications and ensure that all stakeholders are informed, understand, and comply.
- **Contract/PACE Organization Oversight** – PACE requires a three-way agreement between the PACE organization, CMS, and the SAA. There may also be separate agreements between the PACE organizations and the SAA. It is essential that the various provisions, requirements, and standards in each agreement are honored, monitored, and reported, where applicable or required. In addition, states typically have internal agency and interagency items to monitor. Relationships with other entities within the state require coordination to ensure the best use of state resources, honor the various roles and activities of multiple older adults' stakeholders, and create and maintain an overall environment where PACE, Waiver Services, external advocates for older adults, and referral resources all work together as best possible for the betterment of older adults and their health.
- **Program Analytics** – Data to support a PACE program is used for AWOP rate-setting and calibration, quality monitoring, contract monitoring for compliance, quality of care analysis, internal and external reporting, decision-making, and other items. Encounter data, enrollee information, network information, and other information are often used and needed.

- **Quality Monitoring** – The central purpose of PACE programs is to help eligible-older adults to live the best quality of life in their homes and communities. To support that goal, it is necessary to assess and monitor the quality of PACE organizations examine outcomes, and make decisions regarding potential improvement, while correcting undesirable outcomes as best possible. Quality monitoring and oversight is needed to develop and maintain quality standards, communicate the standards to stakeholders and PACE organizations, implement quality programs, interpret and act on reports and other information related to the program and PACE organization performance, monitor compliance with quality standards, and continuously seek improvement opportunities.
- **Advocacy and Public Awareness** – Anecdotal evidence suggests that PACE programs thrive better in environments where PACE is understood, marketed, well-known in the community, and advocated. It is important that efforts be made by the SAA and the PACE organizations to garner public support for and understanding of PACE. Referrals to PACE organizations from community resources and partners are typically higher than they would be without advocacy or public awareness. Enrollment is impacted. Service delivery may be smoother. Other aspects of PACE may benefit.

To support the key areas of SAA staff activities for PACE, Myers and Stauffer recommends that SAA's have a basic framework of staff to administer their PACE program. Such staff typically include one manager, one policy analyst, and one clinical person. Below, we summarize the types of activities that we would anticipate each would pursue and what credentials such staff may need to properly support SAA activities.

- **Manager** – Serves as the agency central leader and resource for internal and external efforts to advance and support PACE in the state at the SAA level. Primary duties involve activities to facilitate PACE organization procurement, monitor PACE Organizations' contract compliance, ensure appropriate reporting to CMS, and direct compliance with all regulatory standards, guidelines, and mandates related to PACE. This person oversees internal staff assigned to PACE, serves as advocate in resolving any service problems that may occur at the PACE organizational level and assists with oversight of the operational capabilities of the PACE Organization as a Medicaid Provider. They perform duties to maintain the integrity of the Medicaid Program, contractual agreements and the provision of health care to PACE enrollees. For this position, we would anticipate that the ideal staff person would have a master's degree in nursing, healthcare administration, or a related field and have extensive experience in geriatrics and knowledge of managing complex chronic conditions, possess strong leadership and team management skills, and have extensive knowledge of Medicare and Medicaid regulations, particularly related to PACE programs.
- **Clinician** – Assists the Manager in understanding, interpreting, and acting on clinical aspects of the PACE program. This person would work closely with the Analyst and Manager to define

policies, data needs, quality monitoring activities and other relevant tasks. As needed, they would coordinate services for and on behalf of enrollees, in special cases where it may be optimal that the SAA get involved, including making referrals to outside agencies, participating in grievance processes, and being a final arbiter on behalf of the SAA in clinical matters and policy with the PACE organization where applicable. They would serve as a key state resource for PACE organizations on clinical matters and work directly with PACE organization IDT teams. They would assist state clinical oversight and quality monitoring programs and lead agency efforts to develop, implement, and monitor PACE organizations' quality. For this position, we would anticipate that the ideal staff person would have an associate's degree in Gerontology, Geriatrics, Social Work, Community Services, Business/Public Administration, or a related field and have three years of gerontology case management experience in a health or home healthcare environment.

- **Policy Analyst** – Assists the Manager and Clinician with support activities to allow the Manger and Clinician to optimally oversee the state PACE program in a variety of ways. This staff person would typically be mostly engaged in generating reports on participant demographics, utilization patterns, quality metrics, and program performance for internal and external stakeholders; researching programs and services that would benefit the PACE program; drafting communications and materials related to PACE for internal purposes and marketing, maintaining program documentation, owning program policies, designing and performing economic and other financial analyses, preparing and presenting PACE-related comprehensive written reports and recommendations to other internal state staff and leadership; and assisting with analytics by either producing reports and working with data directly or by communicating and coordinating analytical needs with other state agencies or departments that perform analytical and/or data services. For this position, we would anticipate that the ideal staff person would have knowledge, skills, and experiences with health planning, health administration, public health policy, or health economics, a bachelor's degree, and three years of professional policy research and analysis experience and project management skills.

For staffing or contractual support, we estimate that two to three positions may be required. The number of positions is based on our understanding that if Connecticut elects to implement PACE, it would do so in a select area or a few areas of the state rather than statewide. Our estimates regarding staffing would change if statewide implementation were selected. We recommend one additional State staff for every two to three new PACE centers. Additional personnel with clinical or financial backgrounds may be required during periods of State-defined assessments or reviews.

During the implementation phase, information technology staff will be required to perform MMIS and eligibility system modifications. DSS would also have to modify functional processes such as LOC determinations, provider enrollment, member enrollment, and home safety assessments. We have included an estimate of costs for time and change orders to modify these systems and functions. During

focus group sessions, none of the stakeholders indicated that significant changes would be required to systems or processes, and all indicated that changes were doable. The most noteworthy issue that influenced the cost estimate is that all staffing resources are extremely busy with existing projects.

PACE Rate Risk Analysis

If DSS adopts PACE, one of the required state administrative functions would be to establish PMPM rates. It would be necessary for PACE rates to be sufficient to enlist providers to offer PACE as a service. Typically, providers most interested in offering PACE in a new state have a well-established history in another service category, such as adult day services, a hospital or health system, a nursing facility, a hospice provider, or a health clinic. A new PACE organization may also be an out-of-state entity interested in entering the market.

To receive federal funding, CMS requires states to set monthly PACE capitation rates that are less than the AWOP in the absence of PACE.[45] The AWOP represents the costs associated with the following PACE eligibility requirements:

- Reflect the State's criteria for NF LOC.
- Include individuals at least 55 years of age.
- Accounts for the comparative frailty of those likely to enroll in PACE.
- Reflect participants that can live safely in the community and live in a location designated as a PACE service area.

In January 2025, CMS published a PACE Medicaid Rate Setting Guide[46] to provide additional guidance to states. To calculate PACE capitation rates, states must first establish the UPL or AWOP. Rate calculations should also:

- Use the most recent year of data available, but not greater than three years old.
- Demonstrate that cost and utilization data is reflective of the population consistent with frailty and age of PACE participants.
- Include fee for service experience, managed care plan encounter data, and managed care plan financial data and reports.
- Document how the base data was reviewed and validated, along with any concerns related to the quality of the data and steps being taken to enhance data quality.

[45] National Archives. Code of Federal Regulations. 42 CFR § 460.182. October 1, 2002.
[46] Centers for Medicare and Medicaid Services. PACE Medicaid Capitation Rate Setting Guide. January 2025.

States can use different approaches to compute AWOP, depending on their unique circumstances, so long as the final capitation payments paid to PACE organizations are less than the AWOP.

Methods for computing AWOPs typically include the following:

- Claim and encounter payment data.
- Using utilization and cost data.
- Using managed LTSS payment data.

PACE AWOP calculations are a function of numerous data, calculations, and adjustments. Certain factors tend to have a greater influence on the outcome. These include the type of health care delivery system of a state, the payment rates for services, and the state's institutional mix. We completed a high-level risk assessment of these factors to consider the likelihood that if the State were to adopt PACE as a new optional Medicaid State plan service that PACE rates would be sufficiently attractive to prospective providers.

Table 10. PACE Capitation Risks to DSS

PACE Capitation Rate Influencers	Risk Not Identified	Risk Identified	Risk Undetermined
Health care delivery system. Managed care and/or HCBS payments will typically have a downward influence on PACE AWOP calculations relative to FFS payments.	✓		
Payment rates for services. Payment rates for services used by the PACE comparable population. Encounter payment data would be used to establish AWOPs.		✓	
State's institutional mix. A higher level of community care will typically have a downward influence on AWOP calculations relative to institutional care.	✓		
	Potentially Not At Risk	**Potentially At Risk**	
Risk that PACE AWOPs could be "low" or "lower" in Connecticut.		✓	

Approximately 43% of Connecticut's Medicaid-enrolled older adults meeting NFLOC are in nursing facilities. Connecticut uses a managed fee-for-service approach for reimbursing most services. Based on the analysis of the PACE rate influencers established in 42 CFR 460.182 and applied to the current health care ecosystem within Connecticut, we believe there is a risk that PACE rates could be "low" or "lower" than desired by prospective PACE providers. Despite these conditions, there may be tools or adjustments available to the State or a contracted actuary that could prove helpful such as a frailty adjustment in achieving an adequate level of AWOP should DSS decide to adopt PACE.

Estimated Cumulative Net Cost Impact

Table 11 displays the hypothetical scenario with assumptions as outlined for *Figure 15* in which Connecticut implements PACE centers in Bridgeport and in Hartford. The table projects cost beginning in SFY 2026 through SFY 2033 and assumes that the PACE organizations are paid a capitated rate that is 95% of the AWOP. When compared to the AWOP, this results in program savings accumulating as enrollment ramps up.

Next, the table estimates the state agency costs to administer the program. When factoring in state agency costs, the net program savings from PACE will not immediately be realized and could result in increased costs. This is dependent on the State's approach to program administration and rate setting. The study assumes that three full-time staff are needed to implement and oversee the program. The SAA will also need to contract for actuarial services to calculate the AWOP amounts on an annual basis. We used an estimated $100,000 per year for these costs.

The MMIS update is estimated at $500,000 over the 2-year program implementation term, but this amount will require additional DSS analysis. The hypothetical scenario assumes that the federal matching percentage for the MMIS update is available at 75%.

In this hypothetical scenario, costs are shown during a 2-year implementation period and a 6-year PACE organization enrollment ramp-up period. The net impact over this 6-year period is an approximate $1.4 million decrease in cost to provide services to participants in PACE rather than in HCBS. Of this, approximately $825,000 are state funds. It should be noted that one dated study from 2000 suggests that program savings could be negative (i.e., PACE could cost more) in the first few years of operations for Medicaid participants.[47]

DSS identified per-enrollee spend on individuals with disabilities and older adults as an area of opportunity in December 2024. Based on state and federal Medicaid data, industry research, and enrollee/provider feedback, Connecticut Medicaid's per-enrollee spend for these individuals is much higher than its peers. Performance on related quality and access measures is average.[48] Financial data collection and analysis post-implementation of PACE would be necessary to assess the impact of PACE on per-enrollee spend.

[47] White, Alan J; Abel, Yvonne; Kidder, David. 2000. Evaluation of the Program of All-Inclusive Care for the Elderly: A Comparison of the PACE Capitation Rates to Projected Costs in the First Year of Enrollment. Contract No. 500-01-0027. Abt Associates for the Centers for Medicare and Medicaid Services.
[48] Department of Social Services. Medicaid Landscape Analysis. December 2024.

Table 11. Hypothetical PACE Implementation Scenario

PACE Implementation Hypothetical Scenario for 10% at Bridgeport and Hartford Service Areas Net Impact to State Revenues SFY 2026 - SFY2033								
Program Detail	SFY 2026 Cost	SFY 2027 Cost	SFY 2028 Cost	SFY 2029 Cost	SFY 2030 Cost	SFY 2031 Cost	SFY 2032 Cost	SFY 2033 Cost
No PACE - 100% AWOP								
Total	**$0**	**$0**	**$3,668,652**	**$10,830,492**	**$18,518,868**	**$26,765,820**	**$35,598,528**	**$44,965,611**
State Share	**$0**	**$0**	**$1,834,326**	**$5,415,246**	**$9,259,434**	**$13,382,910**	**$17,799,264**	**$22,482,806**
PACE Program Costs - Capitated Rate (95% AWOP)*								
Total	**$0**	**$0**	**$3,485,196**	**$10,288,368**	**$17,592,156**	**$25,428,600**	**$33,817,032**	**$42,799,932**
State Share	**$0**	**$0**	**$1,742,598**	**$5,144,184**	**$8,796,078**	**$12,714,300**	**$16,908,516**	**$21,399,966**
Program Savings: AWOP minus Capitated Rate								
Difference Total	**$0**	**$0**	**($183,456)**	**($542,124)**	**($926,712)**	**($1,337,220)**	**($1,781,496)**	**($2,165,679)**
State Share	**$0**	**$0**	**($91,728)**	**($271,062)**	**($463,356)**	**($668,610)**	**($890,748)**	**($1,082,840)**
State Administrative Costs**								
PACE Staff	$473,360	$488,308	$503,934	$520,060	$536,702	$553,876	$571,600	$589,891
MMIS Update	$250,000	$250,000	$0	$0	$0	$0	$0	$0
Vendor Support	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000
Total	**$823,360**	**$838,308**	**$603,934**	**$620,060**	**$636,702**	**$653,876**	**$671,600**	**$689,891**
State Share	**$349,180**	**$356,654**	**$301,967**	**$310,030**	**$318,351**	**$326,938**	**$335,800**	**$344,946**
Total Program and Administrative Cost Impact of PACE								
Total Funds Impact	**$823,360**	**$838,308**	**$420,478**	**$77,936**	**($290,010)**	**($683,344)**	**($1,109,896)**	**($1,475,788)**
Net State Funds Impact	**$349,180**	**$356,654**	**$210,239**	**$38,968**	**($145,005)**	**($341,672)**	**($554,948)**	**($737,894)**

**Assumes the PACE rate is 95% of AWOP for SFY 2028 through SFY 2033. State fund savings will increase if the rate is reduced to a lower percent of AWOP or if there are more PACE Participants.*

***Assumes state match for MMIS configuration is 25%.*

Findings

Table 12 summarizes the general benefits, challenges and drawbacks of PACE identified in this study.

Table 12. PACE Benefits, Challenges, and Drawbacks

PACE Benefits, Challenges and Drawbacks	
Benefits[49,50]	
1.	Delays or prevents expensive institutional care placements through intensive care coordination and services that allow participants to remain in their home or community.
2.	Comprehensive health and social services tailored to each participant's needs and coordinated by the IDT.
3.	Access to 24-hour, locally based medical care.
4.	Provision of services beyond the usual Medicaid and Medicare limits on benefits. Any service deemed necessary by the IDT to maintain the participant's overall health status.
5.	Rates of hospitalization, readmission, and potentially avoidable hospitalizations were lower for PACE enrollees than for comparable populations.
6.	Participants survived longer (4.2 years) than the 5-year median survival for those in a nursing home (2.3 years) and in a waiver program (3.5 years).
7.	Despite high care needs, over 90% of PACE participants continue to live in their community with a good quality of life for up to 4 years.
8.	PACE programs report high rates of consumer, caregiver, and family satisfaction, generally greater than 90%.
9.	PACE emphasizes community — PACE organizations build trust by tailoring their centers and services to fit the culture, beliefs, and values of potential and enrolled participants.
Challenges and Drawbacks	
1.	PACE participants must live in the service area and will usually have one PACE center option for services.
2.	Participants must be able to live in a community setting at the time of enrollment, without jeopardizing their health or safety. A potential PACE participant must be assessed before enrollment to ensure they can be cared for appropriately in a community setting.
3.	PACE is a capitated program, which requires careful oversight of care delivery to ensure that all participants receive the necessary level of care. It is essential to monitor care provision closely to prevent any instances where providers might be tempted to deliver less care than required.
4.	Participants in PACE are not allowed to receive regular Medicaid services or services from home and community-based waivers or even Medicare Advantage plans.
5.	Participants may not be allowed to use their primary care physician unless that physician is part of PACE network.
6.	PACE start up is costly for the PACE organization and takes considerable time to break even financially.
7.	State agencies may have start-up costs and will need to identify resources to manage the PACE implementation process.
8.	It is likely that state savings under PACE will be marginal, initially, especially for smaller programs and depending upon how the state manages the program and sets the capitation rate. One dated study from 2000 suggests that PACE program costs for Medicaid participants could be higher.[51]

[49] Arku, Daniel et al. "Program of All-Inclusive Care for the Elderly (PACE) versus Other Programs: A Scoping Review of Health [2]Outcomes." Geriatrics (Basel, Switzerland) vol. 7,2 31. 12 Mar. 2022, doi:10.3390/geriatrics7020031

[50] Wieland D, Boland R, Baskins J, Kinosian B. Five-year survival in a Program of All-inclusive Care for Elderly compared with alternative institutional and home- and community-based care. Journal Gerontology A Biol Sci Med Sci.2010 Jul;65(7):721-6.

[51] White, Alan J; Abel, Yvonne; Kidder, David. 2000. Evaluation of the Program of All-Inclusive Care for the Elderly: A Comparison of the PACE Capitation Rates to Projected Costs in the First Year of Enrollment. Contract No. 500-01-0027. Abt Associates for the Centers for Medicare and Medicaid Services.

PACE Implementation in Connecticut

PACE addresses several of the key needs identified in the Connecticut 2024 – 2027 State plan on Aging including: encouraging older adults to age in the way they want and in the community setting of their choosing, providing a range of long-term care services and supports, addressing gaps, increasing access, and creating connections.[52] PACE provides options to older adults to be involved in their care plan and to request services from their PACE organization.

PACE could fit into the Connecticut LTSS as a non-institutional service option. It offers a community-based approach that could support individuals with higher LOC and further delay expensive institutional placements.

Connecticut Market Analysis Results

- Using U.S. Census Data and benchmarks for PACE sustainability, the feasibility study identified five potentially viable PACE service areas in terms of population density and accessible healthcare infrastructure. They are:
  - Hartford
  - Bridgeport
  - New Haven
  - Waterbury
  - Stamford
- Each of the identified potential service areas could likely sustain one PACE center. PACE organizations in Waterbury and Stamford will need to maximize outreach to eligible populations and achieve high penetration rates for participant enrollment to ensure long-term financial sustainability.

PACE Capitation Rates

- States pay a prospective monthly capitated rate on behalf of each PACE enrolled Medicaid participant. The capitation rates, per federal requirements, are determined on an annual basis as a percentage of the AWOP in the absence of PACE.[53] AWOPs are typically set by dual and non-dual populations.
- Ahead of implementing PACE, Connecticut would need to perform actuarial analysis to calculate preliminary AWOPs for each of the selected service areas. This analysis can determine whether

[52] Connecticut Aging and Disability Services, Bureau of Aging. Connecticut's State Plan on Aging: October 1, 2024 – September 30, 2027.
[53] National Archives. Code of Federal Regulations. 42 CFR 460.70 Contracted Services. November 27, 2024.

potential PACE rates would be sufficient to interest qualified providers and support a PACE program.

State Agency Concerns and Impacts

- PACE is a type of managed health care program. Connecticut has employed this type of program in the past and, ultimately, changed to an Administrative Services Organization program. The appetite for return to a managed care-like program offering may not be strong.
- One additional state full-time position is recommended for every 2-3 new PACE centers after the initial start-up. Additional staff and contract resources may be necessary for DSS to implement, administer, and oversee PACE. Adjustments may be necessary depending on the uptake rates and utilization of the program.
- Connecticut has a wide array of program offerings, however, many of these programs appear to have waitlists and stringent criteria for access. PACE could serve as an expansion of service offerings for those unable to access services, currently. Education of potential participants and of typical referral sources would need to be robust to ensure that those enrolling in PACE fully understand that they must be removed from all other government health care programs.

PACE Financial Impact

- PACE has both programmatic and administrative cost impacts.
    - A full picture of the program cost impact will be realized once the PACE organizations have fully ramped up enrollment and is able to break even financially.
    - Administrative cost will be incurred during the implementation process and will continue once the program is operational. The extent of the administrative costs, and ultimately net fiscal impact, depends upon the State's approach in managing the program.
- Once the AWOPs are calculated, the State sets the capitation rate as a percentage of AWOP. Typically, many states establish an initial capitation rate that is close to AWOP. This means that PACE cost savings may be marginal in the first few years of program operations. One study suggests there may be no savings or perhaps additional costs related to participants with Medicaid eligibility.
- When the program is finally operating at full enrollment, there may be additional program savings because of greater levels of preventive care and the delay of institutional placement. The State can realize savings by taking a higher discount off AWOP when setting the capitation

rate. This means that access to timely, accurate, and complete encounter and financial data is critical to the process of establishing appropriate capitation rates.[54]

- Depending upon the state administrative approach, any program savings may be offset by the cost of new staff, MMIS updates, and contracting for actuarial and other support services. The bulk of these costs will occur during implementation.
- Overall, the PACE financial impact in Connecticut may be marginal given the relatively small size of the program but will require upfront state funding to support administrative requirements.

Other PACE Challenges and Concerns

- **PACE Organization Financial Burden**. PACE organizations carry the entire financial burden of operations until the PACE center opens and has reached break even enrollment. The PACE organization's financial burden includes a significant upfront investment of time, capital, and resources. PACE organizations do not receive any payment from Medicare, Medicaid, or the private payor until their program has been approved by the CMS. PACE organization implementation can take up to three years. Once operational, it often takes between three and six years to ramp up program enrollment to sustainable levels so that the PACE organization can break even financially.

[54] Encounter data consists of data collected when a provider submits a claim to a managed care entity This data includes detail on patient, diagnosis, procedures, and billing.

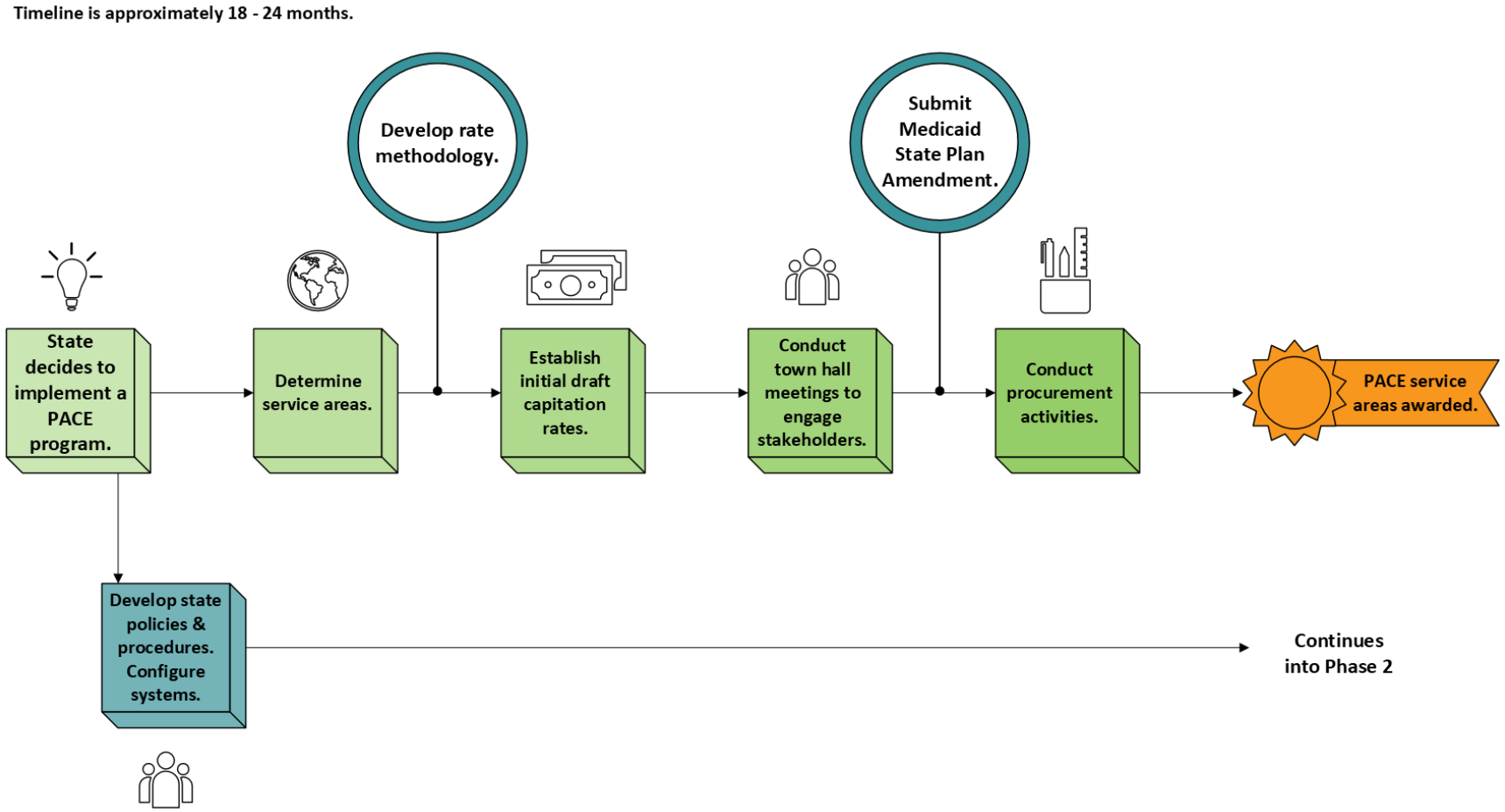
Appendix A: List of Acronyms

ABI	Acquired Brain Injury
ACS	American Community Survey
ADL	Activities of Daily Living
ARPA	American Rescue Plan Act
ASO	Administrative Service Organizations
AWOP	Amount that Would Otherwise have been Paid
BBA	Balanced Budget Act
CHCPE	Connecticut Home Care Program for Elders
CHESS	Connecticut Housing Engagement and Support Services
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CT-ORH	Connecticut State Office of Rural Health
DCW	Direct Care Workforce
DSS	Connecticut Department of Social Services
FORHP	Federal Office of Rural Health Policy
FQHC	Federally Qualified Health Centers
FTE	Full-Time Equivalent
HCBS	Home and Community-Based Services
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
ICF	Intermediate Care Facilities
IDT	Interdisciplinary Team
IID	Individuals with Intellectual Disabilities
IT	Information Technology
LOC	Level of Care
MFP	Money Follows the Person
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NF	Nursing Facility
NPA	National PACE Association
PACE	Program of All-Inclusive Care for the Elderly
PETI	Post-Eligibility Treatment of Income
PHI	Paraprofessional Healthcare Institute
PMPM	Per Member, Per Month
RAI	Requests for Additional Information
RWJF	Robert Wood Johnson Foundation

SAA	State Administering Agency
SNF	Skilled Nursing Facilities
SPA	State Plan Amendment
SRR	State Readiness Review

Appendix B: Implementation Chart

Figure 16. Implementation Overview: Phase 1



The initial phase of implementation generally requires 18-36 months.

Figure 17. Implementation Overview: Phase 2