Study of the Program of All-Inclusive Care for the Elderly

Session Law 2017-57 Section 11H.25.(b)

Legislative Report to

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

By

NC Department of Health and Human Services

March 14, 2018

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I. Introduction

Session Law 2017-57, Sections 11H.25(a)–(b) (see ***Appendix A***) require the Division of Medical Assistance to conduct a study of the efficacy of the Program of All-Inclusive Care for the Elderly (PACE), including some elements under Session Law 2017-100, Sections 12H.34. (a)–(b) (See ***Appendix B***), and submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2018.

PACE is a capitated managed care program for frail, elderly adults who are enrolled in Medicaid, enrolled in Medicare, dually enrolled in Medicaid or Medicare, or able to pay privately. It enables older individuals who would otherwise need nursing home care to live as independently as possible in the community. The program features a comprehensive service delivery system and integrated Medicare and Medicaid financing for beneficiaries enrolled in both programs.

Under the program, services are provided by PACE organizations. Each PACE organization is required to enter into a three-way agreement with CMS and the State Administering Agency. North Carolina's State Administering Agency is the NC Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA). Monthly capitation fees from Medicaid and Medicare are combined by PACE organizations into a common pool from which all health care expenses are paid.

PACE organizations assume full financial risk for the costs of all medical care for their participants, including nursing home care, long-term care services, inpatient hospital services, outpatient hospital services, physician services, laboratory and radiology services, pharmacy, transportation, durable medical equipment (DME), and hospice services. See ***Appendix C*** for a full list of PACE services. Since PACE organizations assume full risk for patient care at a fixed monthly rate, the cost to the State per beneficiary does not change during the year in response to changes in a participant's health status or service setting so long as the beneficiary remains enrolled in the program.

This report evaluates elements of the existing PACE program (including individuals served, cost, structure, and clinical outcomes), assesses the need for program changes (by looking at other states, assessing the regulatory environment, and engaging stakeholders), and makes recommendations.

II. Evaluation of Existing Program

A. Number of Individuals Served in Each PACE Service Area

As of January 2018, there were 2,034 Medicaid beneficiaries enrolled in PACE organizations throughout North Carolina. The table below shows current PACE enrollment by organization and the operational dates of each organization. There are eleven PACE organizations serving twelve sites. Piedmont Health Senior Care has two sites, one in Burlington and one in Pittsboro.

PACE Enrollment by Organization: January 2018		
PACE Organization	**Operational Date**	**Current Enrollment**
LIFE St. Joseph of the Pines (Fayetteville)	April 2011	287
PACE @ Home (Hickory)	January 2012	134
Carolina SeniorCare (Lexington)	October 2012	205
Senior Community Care of NC (Durham)	September 2013	185
Piedmont Health SeniorCare (Burlington),	November 2008	180
Piedmont Health Senior Care (Pittsboro)	January 2014	139
Elderhaus (Wilmington)	February 2008	119
PACE of the Triad (Greensboro)	July 2011	204
Senior Total Life Care (Gastonia)	January 2014	192
PACE of the Southern Piedmont (Charlotte)	July 2013	140
Randolph Health StayWell Senior Care (Asheboro)	December 2014	106
CarePartners PACE (Asheville)	March 2015	143
Total:		2034

The table below shows the service area of each program by county. 42 U.S.C. § 1395eee(e)(2)(B) gives federal authority, with State agency consultation, to prohibit overlap of PACE organization service areas to avoid duplication of services and preserve the area's capacity to serve eligible individuals.

PACE Organization Service Areas by County: January 2018	
Organization Name	**Service Area**
Elderhaus	New Hanover County, Brunswick County, and portions of Pender County
Piedmont Health SeniorCare (Burlington)	Alamance County, Caswell County, Lee County,
Piedmont Health Senior Care (Pittsboro)	Chatham County, Orange County, and a portion of Durham County
LIFE St. Joseph of the Pines	Cumberland County and portions of Harnett, Robeson, Moore, and Hoke Counties
PACE of the Triad	Guilford and Rockingham Counties
PACE @ Home	Catawba County and portions of Lincoln, Burke, Caldwell, and Alexander Counties
Carolina SeniorCare	Rowan, Davidson, Davie and Iredell Counties
PACE of the Southern Piedmont	Mecklenburg County, Cabarrus County, Union County, and a portion of Stanly County
VOANS Senior CommUnity Care of NC	Durham County, Wake County, and a portion of Granville County
Senior Total Life Care	Gaston County and portions of Cleveland and Lincoln Counties
Randolph Health StayWell Senior Care	Montgomery, Moore, and Randolph Counties
CarePartners PACE	Buncombe and Henderson Counties

B. Program Enrollment Criteria and Process

Medicaid beneficiaries or their authorized representatives who are interested in PACE may initiate contact with their local PACE organization to be screened for eligibility. An individual must meet the minimum criteria set forth in 42 CFR § 460.150:

- Be 55 years of age or older;
- Be determined to need the level of care required under the Medicaid State Plan for coverage of nursing facility services;
- Reside in the PACE organization's service area;
- Be able to live in a community setting at the time of enrollment without jeopardizing his or her safety; and
- Meet any additional criteria set forth in the program agreement.

Once deemed minimally eligible, the beneficiary undergoes a comprehensive health assessment by eight of the eleven members of the PACE organization's Interdisciplinary Team (IDT) using a standardized health risk assessment form developed or adopted by the PACE organization. After the assessment, the IDT makes a recommendation for PACE eligibility and submits DMA's Long-Term Care (FL-2) form for a determination of the level of care needed.

The FL-2 form documents the current and recommended levels of care needed based on an individual's medical status and functional ability in activities of daily living (ADLs). It is reviewed by DMA staff for confirmation that eligibility criteria are met. Once DMA confirms eligibility, the PACE organization offers the beneficiary or authorized representative an enrollment agreement. The enrollment agreement contains:

- the participant's demographic data and health insurance status;
- a description of benefits;
- the effective date;
- an explanation of the premiums;
- an emergency care protocol; and
- the participant's rights and responsibilities, including conditions for enrollment and disenrollment.

Once the enrollment agreement is signed by both parties, the PACE organization notifies the local Department of Social Services of the beneficiary's PACE enrollment.

Enrollment in the PACE program is voluntary. PACE enrollees must defer their Medicare Part A, B, and D benefits (if applicable), and the PACE organization becomes their sole health care insurer. A participant's enrollment in PACE is effective on the first day of the calendar month following the date the PACE organization receives a signed enrollment agreement. Enrollment in the PACE program continues until the participant's death, unless the participant voluntarily disenrolls or the PACE organization involuntarily disenrolls him or her. Participants may voluntarily disenroll without cause at any time. PACE organizations may involuntarily disenroll participants for reasons allowed under 42 CFR § 460.164, including but not limited to failure to pay premiums, disruptive or threatening behavior, or no longer needing nursing facility level of care. DMA reviews all disenrollments and determines whether a PACE organization has sufficiently documented the basis for the disenrollment. When sufficient information to affirm the PACE organization's request for disenrollment is not provided, DMA provides technical guidance to the PACE and the beneficiary continues to receive PACE services.

C. Program Expenditures SFYs 2015 – 2017

In collaboration with the PACE organizations, DMA began developing e-PACE, a new web-based dashboard reporting process, in November 2014. It allows organizations to self-report operational financial data monthly. Using e-PACE, DMA can track and monitor PACE enrollment activities, expenses, revenues, and quality indicators.

The table below summarizes total PACE-related expenditures from SFY 2015 to SFY 2017. It also displays the Federal Medical Assistance Percentage (FMAP) or federal matching rate for each fiscal year and the State and federal expenditures associated with them. PACE Organizations submit enrollment data to DMA monthly. The average PACE participant enrollment for SFY 2016 was 1,537 and for SFY 2017 was 1,872. Thus far in SFY 2018 (July 2017 – January 2018), an average of 2,026 participants have been enrolled in the PACE program.

PACE Medicaid Expenditures by State Fiscal Year (SFY)				
($ millions)	SFY2015	SFY2016	SFY2017	SFY2018**
State Dollars	$ 15.2	$ 19.8	$ 24.4	$ 28.2
Federal Dollars	$ 29.3	$ 38.7	$ 48.9	$ 58.3
FMAP Rate*	65.86%	66.15%	66.72%	67.43%
Total Expenditures	$ 44.4	$ 58.6	$ 73.3	$ 86.5

*Due to differences between North Carolina State and Federal Fiscal Years, the FMAP rates are weighted average across the months.

**Projected SFY2018 Expenditure Data

Total expenditures in SFY 2017 were $73.3 million and projected to be $86.6 million in SFY 2018.

D. Per Member Per Month Cost

DMA pays PACE organizations an all-inclusive (capitated) per member per month (PMPM) rate for two distinct groups: 1) Medicaid-only beneficiaries; and 2) dual-eligible beneficiaries. DMA contracts with Mercer Government Human Services (Mercer) to develop the capitated payment rates for both groups. The current PMPM rate for a Medicaid-only beneficiary is $3,562 and for a dually-eligible beneficiary is $3,310. The table below provides an update of DMA's annual expenditures by PACE organization and the projected expenditures for SFY 2018.

PACE Organization Medicaid Expenditures by State Fiscal Year (SFY) *($ millions)*				
PACE Organization	**SFY2015**	**SFY2016**	**SFY2017**	**SFY2018**
VOANS SENIOR COMMUNITY CARE OF NORT	$ 3.2	$ 5.2	$ 7.6	$ 7.9
SENIOR TOTAL LIFE CARE, INC.	2.9	4.7	6.5	6.9
CAROLINA SENIORCARE	5.6	6.3	8.2	9.9
PIEDMONT HEALTH SERVICES INC	0.3	1.1	2.9	2.1
COMMUNITY CAREPARTNERS, INC.	0.1	2.0	3.8	3.0
ELDERHAUS INC	4.5	5.0	4.2	6.7
PACE OF THE SOUTHERN PIEDMONT	3.4	4.4	5.1	6.4
PACE AT HOME INC	3.7	4.1	5.2	6.3
LIFE ST JOSEPH OF THE PINES INC	8.4	8.3	9.0	12.7
STAY WELL SENIOR CARE	0.3	2.7	4.2	3.5
PIEDMONT HEALTH SERVICES INC	6.3	7.3	9.0	11.1
PACE OF THE TRIAD	5.8	7.5	7.5	10.2
TOTAL	**$ 44.4**	**$ 58.6**	**$ 73.3**	**$ 86.5**

To initiate the PACE PMPM rate development process, the vendor develops separate rates based on projected claims expenditures for both institutional (nursing home) and home and community based services (HCBS) among Medicaid beneficiaries. Providers bill for these services on a fee-for-service (FFS) basis. The claims costs for the two Medicaid service categories are blended using a weighted average relative to the number of beneficiaries using each service category. The vendor then produces a single blended rate for each group.

SFY 2017 Per Member Per Month Calculations

Groups	Community (HCBS)	Institutional (NH)	Blended
Dually-eligible	$2,193.90	$3,650.88	$3,301.20
Medicaid only	$3,995.12	$6,191.18	$5,356.68

Claims costs are then combined with a projected administrative expense to develop the Upper Payment Limit (UPL) of costs. The UPL is an estimated statewide PMPM for equivalent level services in a nursing home and encompasses a comprehensive benefit package, including nursing home services, long-term care services, inpatient hospital services, outpatient hospital services, physician services, laboratory and x-ray services, pharmacy, transportation, durable medical equipment (DME), and hospice services. It represents the expected cost of providing services to individuals if they remain in the FFS environment.

The vendor calculates a projected administrative expense as a percent of total medical expenses. The projection reflects the State's average administrative costs over the 3 previous years.

SFY17 Upper Payment Limits (UPLs) per PACE Participant, per Month

Groups	PACE PMPM Rate	Blended Claims Costs	Administrative Expenses	UPL
Dually-eligible	$3,310.02	$3,301.20	$294.62	$5,651.29
Medicaid only	$3,561.86	$5,356.68	$181.57	$3,482.77

E. Estimate of PACE Participants who would otherwise be in Nursing Homes

It is difficult to forecast with certainty the number of PACE participants that would enter a nursing home if they were not enrolled with the PACE program due to the different variables impacting the well-being of a PACE participant, such as primary caregiver circumstances, changing ADL dependency of the individual, or changes in health status. However, given that, at the time of their enrollment in PACE, the beneficiary must be certified to need nursing home level of care, it is likely that many of these beneficiaries would otherwise be in nursing homes. The total number of beneficiaries receiving nursing home services in SFY 2017 was 37,768.

F. Comparison of NC PACE to PACE Programs in Other States

The table below provides a state-to-state comparison of key PACE components. It summarizes all states within the Centers for Medicare & Medicaid Services' (CMS) Region IV that have PACE programs. There are 5 states in Region IV that have PACE – Alabama, Florida, North Carolina, South Carolina, and Tennessee. Data from Virginia was also included due to its proximity.

State Comparisons				
States	**Benefit Covered**	**Statewide Enrollment (as of 11/01/17)**	**Total Number of PACE Organizations**	**Rate Setting Methodology**
Alabama	Yes	175	1	Formula-Based
Florida	Yes	1755	4	Formula-Based
North Carolina	**Yes**	**2043**	**11**	**Formula-Based**
South Carolina	Yes	516	3	Formula-Based
Tennessee	Yes	286	1	Formula-Based
Virginia	Yes	1514	8	Formula-Based

Many states promote PACE as a federally acceptable community-based alternative to institutional services that meets the requirements of the US Supreme Court's *Olmstead* case, which held that individuals with intellectual disabilities have the right to live within the community if such placement is appropriate and preferred by the individual and can be reasonably accommodated. States also have committed to grow PACE as an alternative, capitated, integrated-care option in Medicaid.

Generally, states have adopted one of the following two methodologies to the rate setting process:

1. a *formula-based model* in which a population comparable to PACE is identified and its total costs to Medicaid are calculated (North Carolina); or

2. a *cost-based model* where PACE organizations present a proposal based on the estimated costs of delivering PACE services.

States then negotiate the rate with PACE organizations. The negotiated rate is subject to annual review by the state for reasonableness and adherence to the upper payment limit. In its review, DMA found North Carolina's formula-based model is consistent with other states in the region. DMA submits the rate to CMS for final approval.

G. Update on 2015 Recommendations to make PACE Sustainable

Recommendation 1: Establish slot allocation to provide budget predictability to the State and local PACE organizations

Update: In May 2014 slot allocations were placed on the PACE organizations to ensure budget predictability towards future growth of the program. A slot allocation formula to determine each organization's enrollment "ceiling" was developed to assist in this goal. For those PACE organizations under three years old, six new participants could be enrolled each month. For those organizations over three years of age, three new participants could be enrolled each month. This was increased to four new participants in mid-June 2017. A slot allotment continues to exist, however, PACE organizations were informed that they could request additional slots, if they reached their slot allocation threshold. PACE organizations were also informed that enrollments to replace vacated slots because of deaths and voluntary / involuntary disenrollment and transition placements from nursing homes to the community would not count in the enrollment allotment. Since 2014, only two requests have been submitted for additional slots, both of which were approved. Other than these two requests, no PACE organizations have come within 3 slots of their allocation threshold.

Recommendation 2: Complete a strategic plan and a Request for Application (RFA) process to target future growth towards underserved areas of the state. Future expansion of PACE will be determined by budget availability, and DHHS will not consider applications for growth or expansion of new or existing PACE organizations through SFY 2016-17.

Update: An RFA process to target future growth towards underserved areas of the state is still under development. DMA opted to implement a slot allocation process to increase the number of PACE participants served by the existing PACE organizations. DMA will post an RFA for PACE growth and expansion by the end of SFY 2018.

Recommendation 3: Require the completion of initial FL-2 by the Primary Care Practitioner (PCP) of the beneficiary seeking enrollment to the PACE organization.

Update: DMA convened a stakeholder meeting to discuss the impact of this recommendation. The recommendation of FL-2 completion by the beneficiary's PCP prior to enrolling in PACE was abandoned because DMA received substantial feedback from PACE Medical Directors that prior to enrollment in PACE many beneficiaries do not have a current relationship with a primary care provider prior to PACE. Current relationship is defined as an office visit 90 days prior to applying to PACE. Also, the completion of the FL-2 is an unreimbursed service for many physicians, which may delay participant enrollment.

Recommendation 4: Require future programs to more thoroughly attest to and document their financial viability prior to approval of expansion plans or submission of an application to develop a new PACE organization

Update: PACE organizations currently self-report financial information via e-PACE, which is monitored and analyzed by the State. Federal regulation requires PACE organizations to have reserves. With e-PACE the State can ensure compliance with these regulations. The financial information in e-PACE also assists with the assessment of a PACE organization's financial viability in the event the organization requests to expand its service area.

Recommendation 5: Execute a new two-way agreement with PACE organizations focusing on quality improvement outside of what is currently required in the existing three-way agreement between DMA, CMS and the State.

Update: With the addition of e-PACE reporting, which includes quality indicators, it was determined that a new two-way agreement was not needed.

Recommendation 6: Review and adjust current PACE per member per month (PMPM) rates.

Update: As discussed above, the PACE per member per month is reviewed on an annual basis. Under a PACE Program Agreement, DMA makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid participant. The monthly capitation payment amount is negotiated between the PACE organization and DMA and specified in the PACE Program Agreement. The amount is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program (as measured under the UPL estimate process), considers the comparative frailty of PACE participants, is a fixed amount regardless of changes in the participant's health status, and can be renegotiated on an annual basis. Mercer is contracted to assist with this annual review and adjustment utilizing historical fee-for-service (FFS) data adjusted for the populations and services covered by the PACE program.

H. Structure of PACE Organizations

Due to federal regulations established by the Centers for Medicare & Medicaid Services (CMS), all PACE organizations operating within North Carolina have similarities in organizational structure. Under 42 CFR § 460.60, all PACE organizations must be entities of either a city, county, Tribal, or State government or a private nonprofit entity organized for charitable purposes. However, in June 2015, CMS began to permit the establishment of for-profit PACE organizations, after a pilot project in Pennsylvania found no major differences in the quality of care between for-profit and nonprofit organizations. Currently all PACE organizations within North Carolina are nonprofit and, per federal regulations, must demonstrate fiscal soundness. Except for Elderhaus PACE in Wilmington, all the PACE organizations are either wholly owned by a larger provider or owned by a combination of larger providers in an equity partnership.

Each PACE organization must have key positions such as a Program Director, who is responsible for all administration and oversight of the organization, and a Medical Director, who provides participant care as well as supervision of the organization's quality assessment and performance improvement program. Per federal regulations, both positions can be contracted if it does not interfere with the delivery and

oversight of care and services. All PACE organizations must also have current organizational charts available, identifying key positions of the organization and their relationships to one another. For a sample organizational chart, see ***Appendix D***.

Any PACE organization planning a change in organizational structure, whether it be a change in ownership, the corporate board, or the program or medical director, must notify CMS and DMA in writing at least 14 days before the change takes effect.

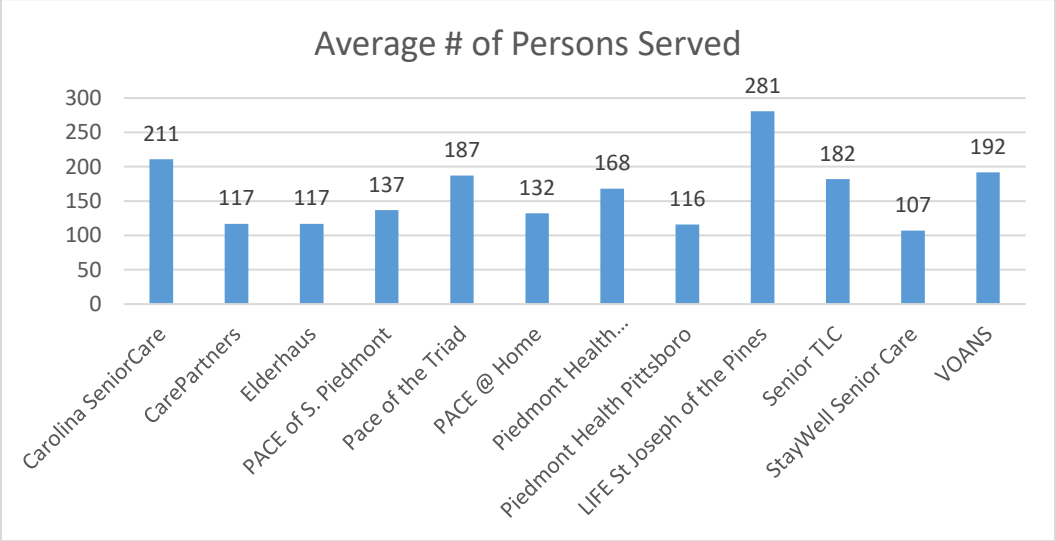
In addition to the required staff positions and updated organizational chart, each PACE organization must have a governing board that includes community representation and promotes an environment that meets participant needs and is consistent with the organization's mission.

The PACE organization must also have a physical site to provide adult day services and a clearly defined service area. At a minimum, the following services must be provided by each PACE organization: primary care services which includes physician and nursing services, social work services, restorative therapies including physical and occupational therapies, personal care services, in-home care, recreational therapy, nutritional counseling, meals, and transportation services. The PACE Interdisciplinary Team (IDT) can approve and provide additional services to improve and maintain the participant's overall health.

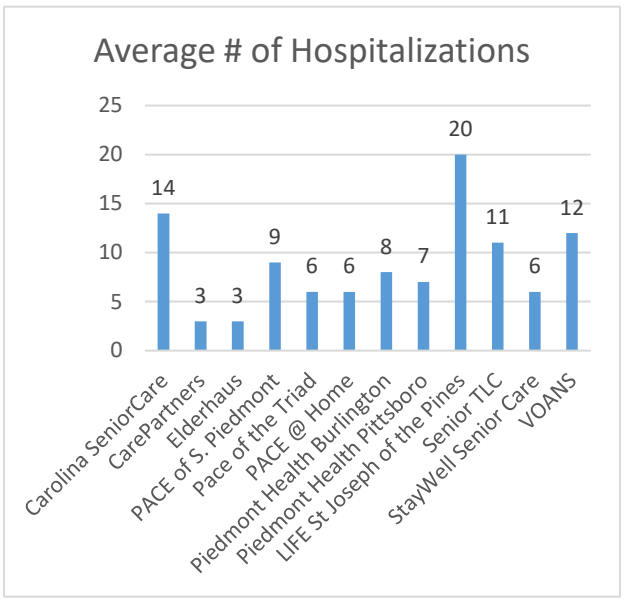
I. Clinical Outcomes or Quality Measures

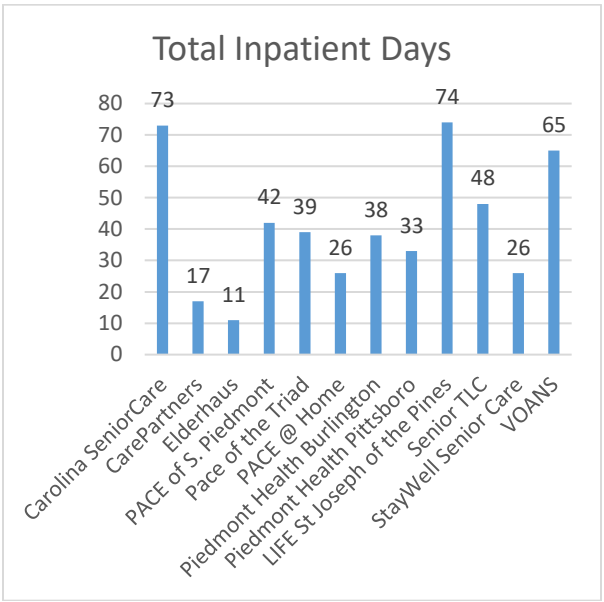
In addition to financial data, the PACE organizations also report monthly through e-PACE on the quality indicators listed below. Under each indicator is a graph depicting the performance of North Carolina's PACE organizations during December 2016 – November 2017. NC is currently collecting data that will serve as a baseline for future benchmarks defining acceptable or unacceptable levels of performance beyond the requirements articulated in the three-way agreement and PACE Readiness Assessment completed prior to PACE receiving approval from CMS and the State to commence operations.

- Average Number of Persons Served – This represents an average of the enrollment data submitted by each PACE organization.

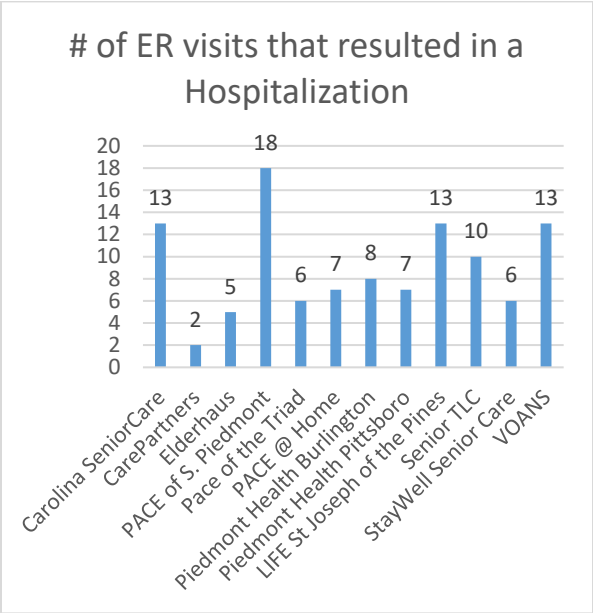


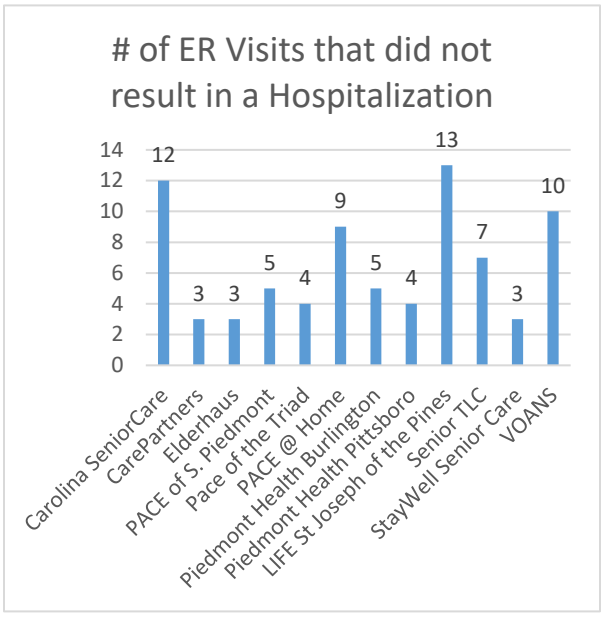
- Number of Hospitalizations – The total number of admissions lasting over 23 hours in the reporting period.
- Total Inpatient Days – The total number of hospital days for all participants discharged from an acute care/inpatient facility within the reporting period. If a participant is still in an inpatient facility at the end of the reporting month, these days are not included in the count. The days are counted in the month that the participant is discharged. Data is captured for each PACE organization, those with larger enrollments can be anticipated to have a larger number of hospitalizations.



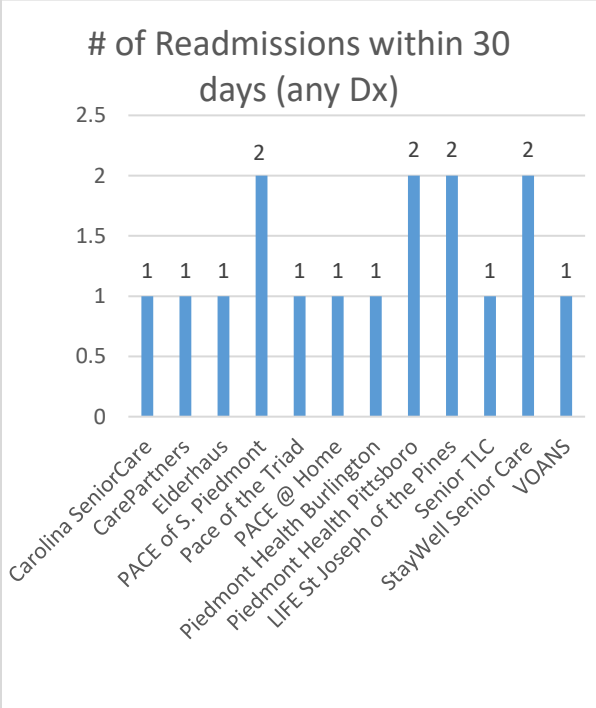


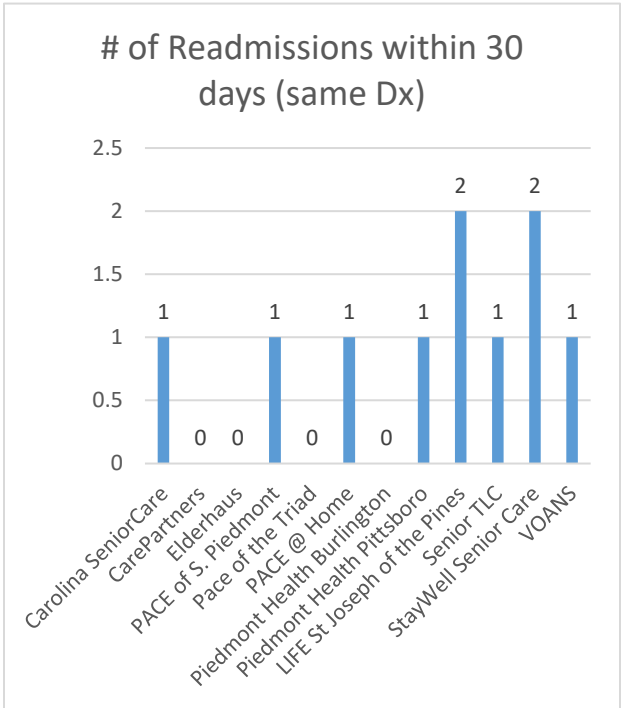
- Number of Emergency Room Visits Resulting in a Hospitalization – The total number of emergency room admissions that resulted in a hospital admission for inpatient care.
- Number of Emergency Room Visits That Did Not Result in a Hospitalization – The total number of emergency room admissions where the participant was discharged back to their primary residence.



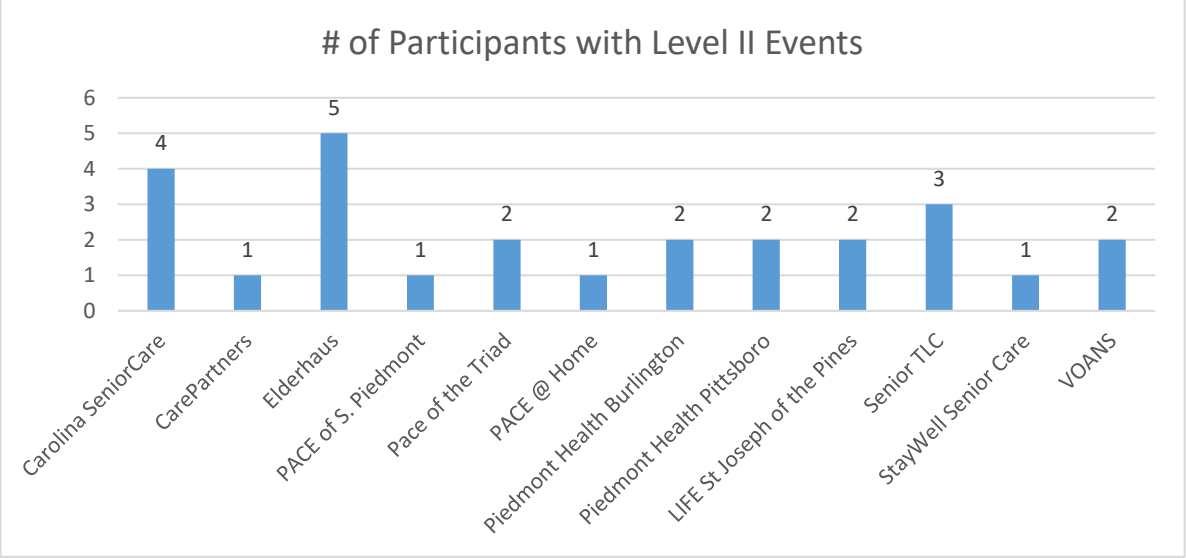


- Number of Readmissions within 30 days (Any Diagnosis) – The total number of readmissions occurring within 30 days for any diagnosis.
- Number of Readmissions within 30 days (Same Diagnosis) –The total number of readmissions occurring within 30 days for the same diagnosis





- Number of Participants with Level II Events – The total number of participants with an incident that met the federal regulations for a Level II occurrence. A Level II occurrence is an incident involving a beneficiary that put the beneficiary at risk of injury or harm or caused injury or harm.



Vital Research, an independent third-party survey administrator, conducted a participant and caregiver study in 2017 for six[1] of the PACE programs in NC. Results of the study revealed the following:[2]

- 94% of participants would recommend PACE to a close friend or relative.
- 97% of participants would rate PACE care as excellent, very good, or good.
- 99% of caregivers are satisfied with the services PACE provides.
- 99% of caregivers would recommend PACE to a friend.

Several studies have also generally identified positive outcomes of the PACE program:

- C. Boult, et al., (2010), identified 3 models of care that appeared to improve the effectiveness and efficiency of complex primary care. PACE was one of the models.[3]
- M.J. Meunier, et al., (2016), concluded that disenrollment from PACE led to higher rates of ED visits, hospitalizations, and nursing home placements. However, PACE versus post-PACE differences in ADL and instrumental ADL scores were not significant, nor were death rates. Higher satisfaction existed with PACE versus non-PACE care.[4]

[1] The six PACE programs were CarePartners, PACE of the Southern Piedmont, PACE of the Triad, Piedmont Health SeniorCare Burlington, and Piedmont Health SeniorCare Pittsboro, and StayWell.
[2] Vital Research data provided by the NC PACE Association.
[3] Boult C., & Wieland GD (2010). Comprehensive primary care for older patients with multiple chronic conditions: "Nobody rushes through". *The Journal of the American Medical Association.* Vol. 304, Issue 17, 1936 - 1943.
[4] Meunier M., & Brant J., & Audet, S., & Dickerson D., & Gransberry K., & Ciemans E. (2016). Life after PACE (Program of All-Inclusive Care for the Elderly). A retrospective/prospective, qualitative analysis of the impact of closing a nurse practitioner centered PACE site. *Journal of the American Association of Nurse Practitioners.* Vol. 28, Issue 11, 596-603.

- Micah Segelman, et al., (2014), concluded PACE enrollees experience lower rates of hospitalization, readmission, and potentially avoidable hospitalizations than similar populations.[5]
- Micah Segelman, et al., (2015), found that PACE may be more effective than 1915(c) aged and disabled waiver programs in reducing long-term nursing home use and may be particularly well suited to supporting cognitively impaired individuals, enabling individuals to remain in the community longer.[6]

III. Statewide Assessment of Long-Term Care Needs in Next 10 Years

The State Demographics branch of the North Carolina Office of State Budget and Management produces population estimates and projections. In 2016 there were 2,844,258 individuals in the State who were 55 years of age and over. This is projected to increase to 4,015,546 by the year 2036, an increase of 41%. It is reasonable to anticipate that long-term care needs will see a similar increase. Please see ***Appendix E*** for a full list of demographic estimates and projections broken down by county for ages 55 and over for the timeframe covering 2016 – 2036.

The NC DHHS, Division of Health Service Regulation (DHSR) completes a State Medical Facilities Plan each year.[7] The plan includes projections of nursing care bed needs for each county as well as the need for additional beds statewide. The 2017 State Medical Facilities Plan reports that the total inventory of nursing care beds in the State in 2016 was 46,488. For purposes of planning, this inventory is reduced by 3,060 beds to a total of 43,428 to exclude specialty care units, state operated facilities, out-of-area placements in non-profit religious or fraternal facilities, qualified nursing care beds in continuing care retirement communities, and beds transferred from State Psychiatric Hospitals.

Based on analysis of the data for the 2017 State Medical Facilities Plan, it was determined that the nursing care bed need projections for 2020 is zero.

IV. Review of PACE Experiences in Other States

Like the PACE Legislative Report presented to the General Assembly in early 2015, the analysis of PACE experiences in other states for this report will focus primarily on the 5 CMS Region IV states with PACE programs: Alabama, Florida, North Carolina, South Carolina, and Tennessee. Additionally, for comparison, the analysis will include 4 other states with PACE census and growth rates comparable to North Carolina: Virginia, New Jersey, Pennsylvania, and Colorado.

DMA contacted the State Medicaid Agency of each state and requested responses to the 6 questions listed below. State responses are listed immediately beneath each question.

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[5] Segelman M., &Szydlowski J., & Kinosian B., McNabney M., & Raziano D., & Eng C., & Van Reenan C., & Temkin-Greener H (2014). Hospitalizations in the Program of All-Inclusive Care for the Elderly. *Journal of the American Geriatrics Society.* Vol. 62, Issue 2, 320-324.

[6] Segelman M., & Xueya C., & Van Reenen C., & Temkin-Greener H., (2015). Transitioning from Community-Based to Institutional Long-Term Care: Comparing 1915 (c) Waiver and PACE Enrollees. *The Gerontologist.* Vol. 57, Issue 2, 300-308.

[7] Available at https://www2.ncdhhs.gov/dhsr/ncsmfp/2017/2017smfp.pdf.

1. *Are there any regulatory requirements for PACE within your state?*

Region IV States	
Alabama	None
Florida	Required to be licensed as an adult day care or adult day health program.
North Carolina	Required to be licensed as an adult day health program.
South Carolina	Required to be licensed as an adult day care or adult day health program.
Tennessee	No information provided.
Other States	
Colorado	Required to be licensed as a home health agency and have a cash reserve fund.
New Jersey	Required to be licensed as an ambulatory care facility.
Pennsylvania	As of 2016, no longer required to be licensed as Older Adult Living Centers, but certain additional requirements are imposed by contract, including membership in the National PACE Association (NPA) and state trade association.
Virginia	As of 2016, no longer required to be licensed as an adult day program

2. *What is your state growth rate, including the number of programs and overall statewide participant census (as of 11/01/17)?*

Region IV States	
Alabama	1 PACE organization; 175 participant enrollment cap
Florida	4 PACE organizations; 1,755 participants Described growth since program began in 2003 as slow.
North Carolina	11 PACE organizations (12 sites); 2,034 participants
South Carolina	3 PACE organizations; 516 participants Described growth over the almost 30 years since the program began as minimal.
Tennessee	1 PACE organization; 286 participants
Other States	
Colorado	4 PACE organizations; 3,855 participants RFAs currently under review to add 3 new PACE organizations in the next 3 years.
New Jersey	6 PACE organizations; 1,000 participants
Pennsylvania	19 PACE organizations; 6,176 participants 41 of 67 counties served. Recent authorization to expand to 4 additional counties.
Virginia	8 PACE organizations; 1,514 participants

3. *Is your state in the process of becoming or is it already a managed care state?*

Region IV States	
Alabama	No plans to implement Medicaid managed care.
Florida	Implemented Medicaid managed care in 2013.
North Carolina	Plan to implement Medicaid managed care.
South Carolina	65% enrolled in Medicaid managed care. 35% enrolled in fee-for-service.
Tennessee	No information provided.
Other States	
Colorado	No plans to implement Medicaid managed care.
New Jersey	Implemented Medicaid managed care in 2014.
Pennsylvania	Implemented Medicaid managed care. Will expand in 2018 to dual eligibles and waiver enrollees in mandatory managed care long-term services and supports (Community HealthChoices), but PACE is excluded.
Virginia	Implemented Medicaid managed care (Commonwealth Coordinated Care Plus) on January 1, 2018, but PACE is excluded.

4. *Does your state complete regularly scheduled satisfaction surveys?*

Region IV States	
Alabama	No
Florida	No
North Carolina	Yes, completed the National Core Indicators for Aging and Disabled (NCIAD) survey in 2015-206
South Carolina	No
Tennessee	No information provided.
Other States	
Colorado	No
New Jersey	Yes, conducted the National Core Indicators for Aging and Disabled (NCIAD) survey in 2015 and 2016. *Please see below for more information on NCIAD.
Pennsylvania	No, but PACE organizations complete their own internal reviews as part of their quality assessment (QAPI) process.
Virginia	Yes, conducts a 7-question survey quarterly with random participants enrolled in their PACE organizations.

* The NCIAD is a voluntary effort by state Medicaid, aging, and disability agencies to measure and track performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. North Carolina participated in the 2015-2016 NCIAD survey.

5. *What are your state's current monthly capitation rates for Medicaid-only and duals (Medicaid and Medicare) participants?*

Region IV States	
Alabama	Medicaid-only: $3,330.00; Dual: $3,330.00
Florida	Varies based on geographic area, ranging from $7,200.00 – $7,600.00
North Carolina	Medicaid only: $3,562; Dual: $3,310
South Carolina	Medicaid-only: $3,940.16; Dual: $2,540.51
Tennessee	No information provided.
Other States	

Colorado	Varies based on geographic area, ranging from $3,500.00 – $5,000.00
New Jersey	Medicaid-only: $4,062.12; Dual: $5,649.39
Pennsylvania	Medicaid-only: $3,717.08; Dual: $4,905.08
Virginia	Varies based on geographic area, ranging from $3,322.32 – $6,336.61

6. *Does your state collect quality measure indicators from PACE organizations such as the number of hospitalizations, emergency room visits, and inpatient hospital stays?*

Region IV States	
Alabama	Quality measures collected during monthly phone calls with PACE organizations and CMS.
Florida	Quality measures collected during monthly phone calls with PACE organizations and CMS.
North Carolina	Quality measures collected monthly via e-PACE
South Carolina	Quality measures collected during quarterly visits to PACE organizations.
Tennessee	No information provided.
Other States	
Colorado	Quality measures collected monthly.
New Jersey	Quality measures not collected.
Pennsylvania	Quality measures collected in quarterly activity and financial reports.
Virginia	Until August 2017, quality measures were collected through the NPA DataPACE system. Currently developing an internal reporting system.

V. Evaluation of State Regulation of PACE Providers

A. Duplication of Monitoring

PACE services are delivered in a PACE Center. 42 CFR § 460.6 defines a PACE Center as "a facility which includes a primary care clinic, and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining, and which serves as the focal point for coordination and provision of most PACE services." The physical environment of the PACE Center must be designed and maintained to provide for the physical safety of participants, personnel, caregivers, and visitors.

In the state of NC, facilities providing group care and supervision to adults who may be physically or mentally disabled in locations other than their usual place of abode on a less than 24-hour basis are "adult day care programs" and must be certified and annually monitored by the NC DHHS Division of Aging and Adult Services (DAAS) as outlined in N.C.G.S. 131D-6.

PACE Centers are certified as adult day care programs. As a result, PACE organizations not only fall under the regulatory authority of CMS and DMA, but also under the regulatory authority of DAAS. Consequently, all three of the regulatory bodies complete monitoring to determine compliance with either federal or state regulations and duplication in monitoring may occur.

To identify the regulatory requirements that are duplicative, a regulatory review and crosswalk was completed by a workgroup composed of DHHS staff, the NC PACE Association, and staff from NC PACE organizations. This workgroup identified the following requirements that are currently being monitored by all 3 agencies (CMS, DMA, and DAAS) that could be addressed under the monitoring activities completed by CMS or DMA:

PACE Program Regulatory Requirement	Code of Federal Regulation
Contracted Services	460.70
Fiscal Soundness	460.80
Initial and Recertification Budget	N/A
Voluntary Disenrollments	460.162
Involuntary Disenrollments	460.164
PACE Service Delivery	460.98
Grievances	460.120
Appeals	460.122 & 460.124
Interdisciplinary Team (staffing, training, etc.)	460.102
Participant Assessment	460.104
Plan of Care	460.106
Oversight of Direct Participant Care	460.71
Dietary Services	460.78
Transportation Services	460.76
Emergency Care	460.100
Internal Quality Assessment and Performance Improvement Activities	460.136
Infection Control	460.74
Training	460.66

The workgroup also identified the following additional regulatory areas where there is duplication.

- Enrollment Process & Participant Rights
- Newly Hired Employee Medical Statement
- Submissions of Licenses for Licensed Personnel
- DAAS Incident Reporting
- Physical Environment

DMA will continue to review and revise monitoring and technical assistance processes based on stakeholder engagement and data analysis to assure pro-active administration of PACE and support the shared goal with PACE Providers of assuring the health safety and wellbeing of beneficiaries.

B. Delivery of In-Home Services

As required by 42 CFR § 460.98 (b) (2) the PACE program must arrange for all in-home and referral services that may be required for each PACE participant. Per DMA PACE Clinical Coverage Policy 3B, the PACE organization can deliver in-home services only if the PACE organizations are licensed as a home care agency or contracts with a licensed community home care agency to deliver the service. Home care agencies must meet state and federal regulations that govern the delivery of home care services. Data submitted by the NC PACE Association identified 8 out of 31 states which require PACE organizations to possess a home care license.

In North Carolina, home care agencies are licensed under the oversight of DHSR. Only three PACE organizations are currently licensed as home care agencies: Elderhaus, VOANS, and Senior TLC are licensed as Home Care Agencies. There is a moratorium on home care agency licensure in the State until June 30, 2019.

VI. Assessment of the Role of PACE in the Continuum of Care and Opportunities to Apply the Model to Additional Populations under the PACE Innovations Act

The PACE Innovations Act of 2015 provides authority to waive certain provisions of Section 1934 of the Social Security Act to test application of PACE-like models for additional populations, including populations under the age of 55 and those who do not qualify for a nursing home level of care under Section 1115A of the Social Security Act. Please see ***Appendix F*** for information about the PACE Innovations Act.

Currently Assisted Living Facilities are not considered appropriate residential settings for PACE participants, since PACE participants require a level of care higher than these facilities are legally qualified to provide. The NC PACE Association and NC PACE Organizations have raised concerns regarding PACE participants being restricted from residing in Assisted Living Facilities on a long-term basis and the impact the restriction has on cost and participants' choice of living arrangement. The PACE Innovations Act may provide an opportunity to apply the PACE model to populations residing in assisted living facilities.

DMA intends to continue investigating and consulting with the Medicare-Medicaid Coordination Office regarding the PACE Innovations Act to discuss strategies to adapt the PACE model of care to serve populations currently ineligible for PACE and diagnostic criteria other than nursing home level of care.

VII. Stakeholder Engagement

The Department of Health and Human Services (DHHS) conducted three state-wide public listening sessions on the North Carolina Program of All-Inclusive Care for the Elderly (PACE). These listening sessions were held at PACE centers in Charlotte, Fayetteville, and Pittsboro between October 26 and November 6, 2017.

The listening sessions included a brief presentation on PACE as well as comments from a variety of stakeholders including existing PACE organizations, past and present PACE consumers, and the public. For those who were unable to attend, comments could be submitted through the U.S. mail, physical drop-off at the DHHS campus, or through secure email directly to DHHS.

While speakers were encouraged to share their insights, recommendations, and concerns at the sessions, DHHS was especially interested in comments regarding the following:

- How PACE has benefitted participants and their families;
- Recommendations for improvement;
- Amount of involvement participants and their families have in care decisions; and
- Participant enrollment experiences.

Upon review of the 22 emails sent to DHHS (as of 12/01/17) and comments made in person by 43 speakers at the listening sessions, several repeating themes were identified:

- Enrolling in PACE has kept many beneficiaries at home with family and out of nursing homes.
- Caregivers feel less stressed and can focus on work and other activities because of enrolling their family member in PACE.

- PACE needs to be expanded to more counties throughout North Carolina, particularly in rural areas.
- The PACE model is "person centered" because the PACE Interdisciplinary Team focuses on the whole person.
- PACE has helped in decreasing repeated hospitalizations.

DMA also established workgroups to gain stakeholder input on the development of this report. The workgroups were composed of DHHS staff, NC PACE Association staff and the staff from the PACE organizations. Staff from eight out of the eleven PACE organizations participated on the workgroups. The Eastern Band of Cherokee Indians were also informed of the study and given an opportunity to provide input.

VIII. Next Steps and Recommendations

A. Next Steps

1. Consider Expansion of PACE

Currently there are 11 PACE organizations with 12 sites in NC. 36 counties have at least one zip code served by a PACE program, but 64 counties have no access. The last year a PACE organization was established in NC was 2015. We believe the state should consider expanding PACE, including adding additional sites and expansion of zip code specific service areas for existing PACE organizations. The State intends to accept applications for expansion through the following mechanisms:

- During Calendar Year 2018, Medicaid will solicit and approve up to 3 applications for the expansion of zip code specific service areas for existing PACE organizations. These approvals are based on current funding appropriated for PACE in the current biennium, SFY 18-19.
- Additional PACE expansion and growth to unserved and underserved counties will be considered based on future funding appropriations for PACE.
- Medicaid will increase opportunities for PACE participants to receive some (but not all) PACE center services at alternative care centers on a fixed basis during usual and customary PACE center hours of operation. The services at an alternative care setting should supplement and not replace services provided at the PACE center. An alternative care setting is any physical location in the PACE organization's existing service area other than the participant's home, an inpatient facility, or PACE center. Currently, NC has one approved alternative care setting operated by PACE of the Triad. The alternative care setting was approved on 5/1/17. The development of additional alternative care settings will assist with improving access to PACE services and increasing the number of beneficiaries served. The State will consult with CMS to discuss options related to increasing the number of alternative care settings in NC.
- Medicaid will investigate options for delivery of care under the PACE Innovations Act. DMA will consult with the Medicare-Medicaid Coordination Office regarding the PACE Innovations Act to discuss strategies to adapt the PACE model of care to serve populations currently ineligible for PACE and diagnostic criteria other than nursing home level of care.

2. Reduce PACE state regulatory requirements by waiving state regulations which mirror or duplicate federal regulations

The State will operationalize the recommendations that have been identified to address the duplication of regulatory monitoring by CMS, DMA, and DAAS. The State will also evaluate DMA and DHSR rules regarding delivery of in-home services to see if there is overlap with CMS regulations that will allow state requirements to be simplified or waived.

B. Recommendations

1. Consider expanding PACE sites in unserved and underserved counties, which would require additional funding.

2. Study the expansion of the long-term care ombudsman role to assist PACE participants with exercising their rights and resolving grievances involving the PACE organizations. The North Carolina Long-Term Care Ombudsman Program assists residents of long term care facilities to exercise their rights and assists with resolving grievances between the residents, families, and facilities. Currently PACE participants and their families do not have an impartial entity to assist with grievances or complaints involving a PACE organization. This is particularly important because PACE organizations manage all the care for the individual. DMA will collaborate with DAAS to consider whether expanding the scope of the Long -Term Care Ombudsman Program to PACE would be beneficial for the participants and their families and enable them to know and exercise their rights.

IX. Conclusion

PACE provides quality care for frail and elderly individuals through its comprehensive medical and social delivery system and has been proven to produce positive outcomes for the individuals enrolled in the program. As of June 1, 2017, 31 states have PACE programs, and PACE enrollment nationwide is more than 42,000.[8] As North Carolina's population of 55+ year old residents grows over the next several decades (at a projected rate of 41%), PACE may provide a viable option to provide high quality, cost efficient care that meets both the medical and social needs of individuals. However, to serve this growing population, North Carolina will need to expand the program.

[8] National PACE Association, http://www.npaonline.org/

Appendix A: Session Law 2017-57, Section 11H.25. (a)–(b)

STUDY PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

SECTION 11H.25. (a) The Department of Health and Human Services, Division of Medical Assistance (Department), shall conduct a study of the efficacy of the Program of All-Inclusive Care for the Elderly (PACE). In conducting the study, the Department shall engage a variety of stakeholders, including existing PACE organizations, PACE consumers, and the general public. The study shall consist of the following:

(1) An evaluation of the existing program to include information on and an assessment of the following:
   a. An update on all of the information required to be reported on under Section 12H.34(b) of S.L. 2014-100.
   b. The structures of the various PACE organizations.
   c. Any clinical outcome or quality measures available for each PACE service or PACE organization.

(2) A statewide assessment of anticipated long-term care needs over the next 10 years, broken down by county.

(3) A review of PACE experiences in other states, including an analysis of costs and quality.

(4) An evaluation of State regulations placed upon PACE providers. The study shall include the identification of any regulations that could be eliminated in order to reduce cost or unnecessary duplication.

(5) An assessment of the role of PACE in the continuum of care, including opportunities to apply the PACE model to additional populations under the PACE Innovations Act of 2015, P.L. 114-85.

SECTION 11H.25. (b) No later than March 1, 2018, the Department shall submit to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice a report containing the information outlined in subsection (a) of this section, as well as any recommendations and proposed legislative changes that further the goal of providing the highest quality programs at a low cost to keep aging individuals in their homes.

Appendix B: Session Law 2014-100, Section 12H.34. (a)–(b)

REPORT ON PACE PROGRAM

SECTION 12H.34. (a) By October 1, 2014, the Department of Health and Human Services, Division of Medical Assistance, shall report to the Joint Legislative Oversight Committee on Health and Human Services with the following information on the Program of All-Inclusive Care for the Elderly (PACE):

(1) The number of individuals being served in each of the PACE service areas.
(2) A description of the program enrollment criteria and enrollment process.
(3) Detailed figures showing how funding for the program has been spent during the past two fiscal years.
(4) The per member per month cost of serving individuals through the PACE program compared to the cost of serving individuals in a nursing home.
(5) An estimate of how many PACE participants would enter a nursing home if they were not enrolled with the PACE program.

SECTION 12H.34. (b) By January 1, 2015, the Department of Health and Human Services, Division of Medical Assistance, shall submit an additional report to the Joint Legislative Oversight Committee on Health and Human Services with the following information on the Program of All-Inclusive Care for the Elderly (PACE):

(1) An update on all of the information required by subsection (a) of this section.
(2) A comparison of North Carolina's PACE program to PACE programs in other states.
(3) Recommendations for how to make the program sustainable.

Appendix C: PACE Service Package

PACE Center

PACE provides a local center which houses a primary care clinic, an adult day health program, areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining that serve as the focal point for coordination and provision of most PACE services.

In-Home Care

PACE includes coverage for additional services to the individual in the home, such as In-Home Personal Care Services and home health care.

Acute, Emergency Care and Long-Term Care Services

The PACE organization arranges, manages, and pays for all care referred to community providers, including hospital services, nursing facility care, emergency room services, physician visits and ancillary services.

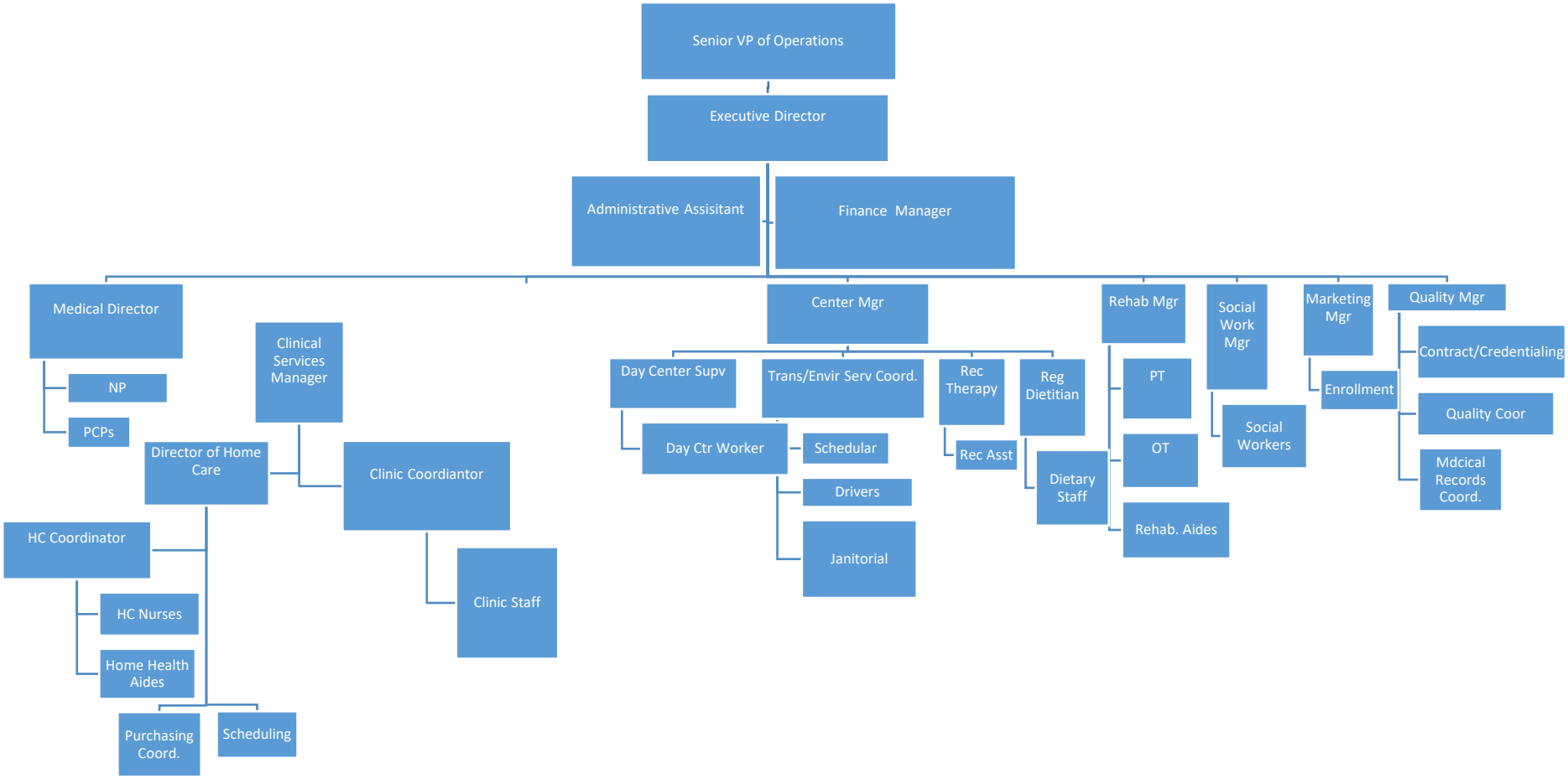
Federal regulations require all PACE organizations to provide a comprehensive array of services that include the following:

- All Medicaid-covered services, as specified in the Medicaid State Plan;
- Multidisciplinary assessment and treatment planning;
- Primary care, including physician and nursing services;
- Social work services'
- Restorative therapies, including physical therapy, occupational therapy and speech-language pathology services;
- Personal care and supportive services;
- Nutrition counseling;
- Recreational therapy;
- Transportation;
- Meals;
- Laboratory tests, x-rays, and other diagnostic procedures;
- Drugs and biologicals;
- Prosthetics, orthotics, durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items;
- Acute inpatient care to include:
    - Ambulance;
    - Emergency room care and treatment room services;
    - Semi-private room and board;
    - General medical and nursing services;
    - Medical surgical, intensive care, and coronary care unit;
    - Laboratory tests, x-rays and other diagnostic procedures;
    - Drugs and biologicals;
    - Blood and blood derivatives;
    - Surgical care and anesthesia;
    - Oxygen;

    - Physical, occupational, respiratory therapies, and speech language pathology services and;
    - Social services
- Nursing facility care to include:
    - Semi-private room and board;
    - Physician and skilled nursing services;
    - Custodial care;
    - Personal care and assistance;
    - Drugs and biologicals;
    - Physical, occupational, recreational therapies, and speech language pathology, if necessary;
    - Social services; and
    - Medical supplies and appliances

Other services determined necessary by the PACE organization Interdisciplinary Team to improve and maintain the participant's overall health status may also be provided

Appendix D: PACE Organization – Sample Organizational Chart



Appendix E: Demographic estimates and projections for ages 55 and over (2016-2036)

	55+ (2016)	55+ (2036)	% Change 55+ (2016-2036)
Alamance	46,448	67,498	45%
Alexander	12,506	15,371	23%
Alleghany	4,435	4,625	4%
Anson	7,723	8,740	13%
Ashe	10,696	10,993	3%
Avery	6,302	7,498	19%
Beaufort	18,183	18,849	4%
Bertie	6,738	7,286	8%
Bladen	11,632	9,000	-23%
Brunswick	56,282	92,204	64%
Buncombe	84,691	118,821	40%
Burke	29,851	35,936	20%
Cabarrus	49,246	85,762	74%
Caldwell	26,954	34,067	26%
Camden	3,074	3,977	29%
Carteret	27,661	33,997	23%
Caswell	8,325	8,823	6%
Catawba	47,273	57,162	21%
Chatham	28,732	49,162	71%
Cherokee	12,474	16,785	35%
Chowan	5,419	4,307	-21%
Clay	5,083	6,574	29%
Cleveland	31,025	33,951	9%
Columbus	17,998	19,025	6%
Craven	29,807	28,792	-3%
Cumberland	75,742	88,957	17%
Currituck	8,036	12,860	60%
Dare	13,120	16,276	24%
Davidson	51,137	63,793	25%
Davie	14,288	20,341	42%
Duplin	17,586	18,092	3%
Durham	68,716	109,636	60%
Edgecombe	17,928	16,828	-6%
Forsyth	102,306	134,200	31%
Franklin	19,585	30,853	58%
Gaston	61,627	81,499	32%

	55+ (2016)	55+ (2036)	% Change 55+ (2016-2036)
Gates	3,967	4,410	11%
Graham	3,296	3,224	-2%
Granville	17,794	26,445	49%
Greene	6,226	7,653	23%
Guilford	139,265	183,969	32%
Halifax	17,962	16,593	-8%
Harnett	29,419	46,682	59%
Haywood	24,231	29,864	23%
Henderson	45,520	61,046	34%
Hertford	7,858	7,396	-6%
Hoke	9,963	19,204	93%
Hyde	1,905	2,194	15%
Iredell	49,005	79,895	63%
Jackson	13,130	16,783	28%
Johnston	46,408	90,389	95%
Jones	3,707	3,518	-5%
Lee	16,651	18,877	13%
Lenoir	19,296	18,298	-5%
Lincoln	25,419	40,462	59%
McDowell	15,442	17,851	16%
Macon	14,858	17,494	18%
Madison	8,100	11,272	39%
Martin	8,823	7,615	-14%
Mecklenburg	225,579	414,765	84%
Mitchell	5,743	5,386	-6%
Montgomery	9,230	10,499	14%
Moore	37,590	49,245	31%
Nash	30,246	33,988	12%
New Hanover	64,312	95,241	48%
Northampton	7,826	5,970	-24%
Onslow	33,395	45,576	36%
Orange	36,002	53,060	47%
Pamlico	5,782	5,980	3%
Pasquotank	11,248	12,415	10%
Pender	18,783	29,333	56%
Perquimans	5,556	6,425	16%
Person	13,217	15,035	14%
Pitt	40,695	53,120	31%
Polk	9,400	10,601	13%
Randolph	43,160	54,985	27%

	55+ (2016)	55+ (2036)	% Change 55+ (2016-2036)
Richmond	13,725	14,334	4%
Robeson	34,972	37,286	7%
Rockingham	31,200	33,203	6%
Rowan	42,386	54,034	27%
Rutherford	23,291	24,951	7%
Sampson	18,939	20,181	7%
Scotland	10,948	11,180	2%
Stanly	19,573	27,267	39%
Stokes	16,097	18,411	14%
Surry	23,729	25,439	7%
Swain	4,834	5,737	19%
Transylvania	15,247	19,130	25%
Tyrrell	1,406	1,560	11%
Union	53,151	97,841	84%
Vance	13,607	13,826	2%
Wake	226,671	451,166	99%
Warren	7,562	7,529	0%
Washington	4,720	4,006	-15%
Watauga	14,364	19,009	32%
Wayne	34,905	42,112	21%
Wilkes	24,365	29,972	23%
Wilson	24,734	31,388	27%
Yadkin	12,239	13,542	11%
Yancey	6,955	7,144	3%
State	2,844,258	4,015,546	41%

Source: NC Office of State Budget and Management, Current estimates and projections

Retrieved on 10/19/2017

Appendix F. PACE Innovation Act

The Programs of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. An interdisciplinary team of health professionals works with PACE participants to coordinate care. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home. Financing for the program is capitated, which allows providers to deliver all services participants need, rather than only those reimbursable under Medicare and Medicaid fee-for-service.

The PACE Innovation Act of 2015 (PIA) provides authority to waive certain provisions of Section 1934 of the Social Security Act in order to test application of PACE-like models for additional populations, including populations under the age of 55 and those who do not qualify for a nursing home level of care, under Section 1115A of the Social Security Act.

In order to inform possible development of a model test under the PIA, we released a Request for Information (RFI) on December 23, 2016. This RFI has two parts.

In the first part, we requested comment on potential elements of a five-year PACE-like model test for individuals dually eligible for Medicare and Medicaid, age 21 and older, with disabilities that impair their mobility and who are assessed as requiring a nursing home level of care and meet other eligibility criteria. We have provisionally named this model "Person Centered Community Care" or P3C. This potential model is designed to meet the requirements of a model test under Section 1115A of the Social Security Act and to adapt the PACE model of care for one population of focus. In addition to feedback on the potential elements of the P3C model described below, we ask for comment on the types of technical assistance that potential P3C organizations and states would require to participate in the model test.