CMS State PACE Market Assessment Report For the State of Iowa

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SECTION 1: EXECUTIVE SUMMARY

Programs of All-inclusive Care for the Elderly (PACE) serve people aged 55 and older who live in an established geographic service area, qualify for state nursing home level of care, and can be safely cared for in a community setting at the time of enrollment. Rather than place people in nursing homes, PACE programs provide a comprehensive range of services that enable the people they serve to continue living in the community. PACE programs receive a capitated monthly payment from Medicare and Medicaid in exchange for all health and aging services required to meet the needs of the people they serve. PACE is a permanent provider under the Medicare program and a state option under state Medicaid programs.

The State of Iowa is participating in a study funded by the Centers for Medicare and Medicaid Services (CMS) that evaluates the barriers and opportunities for developing PACE at the state level and in identified service areas. The Iowa Department of Elder Affairs worked with staff from the National PACE Association (NPA) to conduct the project, with the technical assistance of Rob McCommons of Integrated Care Solutions, LLC, and Larry McNickle, a housing consultant.

This project is important to the State of Iowa, due in part to recent changes to its long term care priorities. Historically, the state relied extensively on nursing home care. In the mid-90s, the state began placing more emphasis on home and community based services. Between 1996 and 2001, the percent of total budgetary long term care spending on home and community-based services almost doubled The state views PACE as a long term care option that will further their commitment to community based long term care.

The State of Iowa has already submitted an approved State Plan Amendment (SPA) for PACE. The state has also enacted legislation supportive of PACE. However, state officials anticipate additional legislative action will be needed to address specific administrative issues, provide for adequate state staff to oversee development of the program, appropriate funding for services, and to clarify the availability of start-up funds from the Senior Living Trust Fund.

Through its participation in the study, the State of Iowa is evaluating:

1. the demand for services provided by PACE;
2. the interest and capacity of provider organizations to operate a PACE program; and
3. the readiness of state agencies to support PACE development.

The first two issues, demand for services and provider interest and capacity, are considered in the context of two potential market areas for PACE in Iowa: Cedar Rapids and Des Moines. The Cedar Rapids market initially was defined to include Linn and Johnson Counties. Given the low population density of these two counties, the Cedar Rapids market was subsequently expanded to include Benton, Cedar, Iowa, Muscatine, Tama and Washington Counties for purposes of the demographic market analysis section of this report. The Des Moines market initially included Polk, Warren and Dallas Counties and was subsequently expanded to include Madison County for the demographic market analysis section of this report.

For the third issue, state readiness, the study examines Iowa's role in supporting a PACE program, the understanding of that role across relevant state agencies, and the factors determining how the state approaches PACE development.

Based on the demographic analysis outlined in this report, we estimate the range of potential PACE eligibles in the Cedar Rapids region to be from 1,306 (estimate based on 65+ population self –reporting "2+ADLs one of which is self-care") to 2,928 (estimate based on 65+ population self-reporting "go-outside-the-home disability"), with the mid-point being **2,117** potentially eligible individuals age 65 and older. In the Des Moines region, we estimate the range of potential PACE eligibles to be from 1,441 (estimate based on 65+ population self –reporting "2+ADLs one of which is self-care") to 3,212 (estimate based on 65+ population self-reporting "go-outside-the-home disability"), with the mid-point being **2,327** potentially eligible individual 65 and older. Based on our understanding of Iowa's functional and financial eligibility criteria for Medicaid long-term care services, we believe there is a sufficient demographic base from which to establish an enrollment stream for PACE in both the Des Moines region (either Polk/Warren/Dallas/Madison counties or in Polk county alone) and Cedar Rapids region (Linn/Johnson/Benton/Iowa counties or Muscatine/Cedar/Johnson/ Washington counties).

Additionally, there appears to be market opportunity for the development of PACE given the following factors: the relatively low penetration of Medicaid/Medicare managed care in both regions; an apparent strong desire for elder Iowans to avoid institutional settings for long-term care service delivery evidenced by AARP research; the popularity of Iowa HCBS waiver programs; and relatively low nursing home occupancy across the state.

In addition to a sufficient population base and market factors to support PACE development, we have also found: (1) provider interest exists in both the Des Moines and Cedar Rapids markets; and (2) the state is prepared and motivated to support PACE development in Iowa.

A number of developments reflect Iowa state staff's strong capacity for PACE. A broad range of state agencies have been included in the decision making process for PACE, including the Iowa Department of Human Services, Department of Elder Affairs (DEA), Department of Inspections and Appeals, the Iowa Finance Authority (which also acts as Iowa's Housing Authority), and the Department of Public Health. These agencies are working closely with the state's Senior Living Coordinating Unit (SLCU), which includes members of the governor's cabinet, the general assembly and consumer representatives. State staff, particularly those within the Department of Elder Affairs (DEA), have a strong understanding of PACE development issues and the potential

challenges they will face, including the need to acquire legislative support, licensing and certification, rate setting, oversight, and monitoring.

The State of Iowa already has elected PACE in its SPA, which was approved in 1999. The state has experience with two state Medicaid managed care programs (MediPASS and Iowa Plan) and three private HMO's under contract with Iowa Medicaid. In addition, the state has actively sought to build provider interest in PACE since 1997. Given this experience and the activities that have already been undertaken thus far, the state is well positioned to develop PACE. NPA recommends the following next steps to the State of Iowa:

- Determine which state agency will serve as the administering agency for PACE;
- Identify all issues requiring legislative action and develop strategies and a timeline for obtaining the necessary legislative support for PACE;
- Secure funding, authorization, and support from state legislature to move forward with PACE;
- Update the upper payment limit (UPL) and rate setting methodology by defining a comparable population for PACE in "fee-for-service" (FFS), pulling claims data, and establishing a draft (or estimated) rate to share with prospective providers;
- Determine availability of grant funds from the Senior Living Trust Fund that could be requested for PACE development;
- Finalize licensing and/or certification requirements for PACE; and
- Secure commitment from prospective providers to complete a provider application.

SECTION 2: OVERVIEW OF PROJECT

Iowa is one of eight states funded by CMS through the National PACE Association (NPA) to identify barriers and opportunities related to PACE development. NPA's assessment of barriers and opportunities for PACE development in Iowa examined the potential need for services across two potential service areas; the likelihood of health, aging services and housing providers initiating a Program of All-inclusive Care for the Elderly (PACE); and the role of state agencies in supporting the development of a PACE program. A consistent assessment methodology is being used across all states (See, ***Attachment 1: Market Assessment Protocol***).

NPA, Integrated Care Solutions, and state staff identified two potential service areas that may have the frail elderly market to support PACE as well as one or more providers with the capacity and interest to develop PACE. The first market, hereinafter the Cedar Rapids market, initially was defined to include Linn and Johnson Counties. Given its small population density, the Cedar Rapids market was subsequently expanded to include Benton, Cedar, Iowa, Muscatine, Tama and Washington Counties for purposes of the demographic market analysis section of this report. The second market, hereinafter the Des Moines market, initially included Polk, Warren and Dallas Counties. The Des Moines market was subsequently expanded to include Madison County for the demographic market analysis section of this report.

The demographic market analyses utilize U.S. Census Bureau 2000 demographic data. Within each service area, the analyses estimate the potential number of people that would be eligible for PACE based on age, disability and income factors.

To examine provider interest in developing a PACE program, health, aging services, and housing providers, as well as local agencies serving the selected market areas, were identified. Each of these organizations received an outreach letter indicating the state's interest in developing PACE and inviting the organization to participate in an educational conference call and subsequent statewide summit on PACE. Each organization's interest in PACE was evaluated based on its individual response to the outreach letter and subsequent registration for future events that were outlined in the letter. The events included an educational conference call and statewide PACE summit for providers.

State readiness and capacity to support PACE interest was reviewed through training sessions during which staff from NPA met with state staff and through phone interviews. The primary purpose of the state capacity building training was to educate a wide range of state agencies in Iowa about the PACE model of care and the federal PACE regulation. In addition, the training stimulated a dialogue among those agencies about a wide range of state specific development issues including: funding, rate setting, licensing, eligibility and enrollment issues and provided an opportunity for these agencies to collaborate on a work plan.

SECTION 3: OVERVIEW OF PACE

The PACE concept developed in the early 1970s as a way for San Francisco's Chinatown residents to provide care and services to their elders in a culturally appropriate way. Asian families preferred to have their elders live at home but were worried about their safety during the day. An area social worker proposed a British day hospital concept, transporting seniors to a community center during the day and returning them home at night. The center opened in 1973 was called "On Lok," which means "peaceful happy abode" in Cantonese.

Providing "one-stop" comprehensive health and social services for its clients, the On Lok program inspired a Medicare and Medicaid demonstration program called PACE in 1987. In 1997, the Balanced Budget Act authorized PACE as a permanent Medicare and Medicaid provider, opening the door to greater expansion of the model. As of 2003, all PACE demonstration programs completed the transition to permanent provider status.

To be eligible to enroll in PACE a person must be 55 years old or older, meet the state's nursing home eligibility requirements, live in a PACE service area, and be able to live independently in the community with the assistance of PACE services at the time of enrollment.

PACE is a fully capitated managed care program, and PACE providers have the flexibility to tailor care and services to meet the unique individual needs of each individual enrollee. Because PACE is financially at risk for all the care and services enrollees need, the clinical and financial incentives for providing high quality care and services are aligned. One result is that care is much more focused around prevention of health status decline so that people can continue to live as independently as possible. A key difference between PACE and other managed care models is that in PACE, the actual providers of care and services are the ones that make the decisions for each person, utilizing an interdisciplinary team process. Care is managed for participants, taking into account the circumstances of their health, ability to care for themselves, the complexity of family relationships, and participant goals and desires.

SECTION 4: STATE ENVIRONMENT

PACE development and implementation requires state agencies to be involved in provider selection, the federal PACE application process, grievance and appeals processes, Medicaid rate setting, and ongoing monitoring and oversight, as well as other administrative functions. The purpose of this analysis is to identify areas where the state is well positioned to implement the PACE model as well as to identify areas that may necessitate further policy and administrative consideration.

The Iowa legislature recognizes the importance of multi-agency integration in the development of a cohesive long term care system for Iowa's elderly and disabled. To insure this integration, the legislature established the Senior Living Coordinating Unit (SLCU). Section 231.58 of the Iowa Code places the SLCU within the DEA. The membership of this Unit consists of the Directors of the Departments of Human Services, Elder Affairs, Public Health, and Inspections and Appeals. These directors serve as members of the governor's cabinet. Two consumer representatives appointed by the governor and four members of the general assembly also serve as ex-officio, non-voting members.

The intra-agency Iowa SLCU has many functions, including development of common definitions and procedures for long term care services across Iowa, and is clearly a key element in moving the PACE model forward within the state.

Historic and Current Long Term Care Service Delivery Systems

Historically, the state relied extensively on nursing home care. In fact, in 2001, Iowa ranked 1st in the nation in the percentage of individuals aged 65 and older residing in nursing homes (6.7%). This reliance on nursing homes for long term care has had an impact on Iowa's long term care budget. In 2001, Iowa ranked 11th in the nation in terms of the percentage of the total Medicaid budget spent on long term care.[1] In the mid-90s, the state began placing more emphasis on home and community based services. Between 1996 and 2001, the percent of total budgetary long term care spending on home and community-based services almost doubled. During this same time, the percent of the total budget spent on nursing facilities fell from 52.1% to 49.4%. The state views PACE as a long term care option that will further their commitment to community based long term care.

Nursing homes and other residential settings

In 2001, there were 28,825 nursing home residents in Iowa. Between 1996 and 2001, the state experienced a 4.2% decrease in the number of nursing facility residents. Iowa also ranked 1st in the nation in terms of nursing facility beds per 1000 individuals 65 and older (91/1000). The average nursing facility occupancy rate for this same time was 78%. A Certificate of Need (CON) program was implemented in Iowa for residential care and nursing facilities. The CON applies to the construction and expansion of these facilities.

Clear state policy level decisions regarding PACE may be necessary to help mitigate some of the concern in the provider community inherent in the likely changes to the long term care landscape

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[1] Across the States: Profiles of Long-Term Care; AARP Public Policy Institute, 2002.

upon the introduction of PACE. Many nursing home providers in communities with PACE programs have benefited from developing referral and service relationships with PACE providers since the nursing home benefit and service is part of the PACE benefit package.

Home and community-based services

As a consequence of efforts to reduce reliance on institutional care, Iowa has developed several community-based programs for populations at risk of nursing home placement. There are currently six waiver programs:

1. Ill and handicapped;
2. AIDS/HIV;
3. Mental Retardation;
4. Elderly;
5. Brain injury; and
6. Physical Disability.

The Iowa Medicaid Elderly Waiver program provides service funding and individualized supports to eligible consumers who otherwise would require nursing facility level of care in order to maintain them in their own homes or communities. The total costs of elderly waiver services to the individual cannot exceed $1052 per month for a nursing level of care or $2480 per month for a skilled level of care. The Elderly Waiver requires ongoing case management for frail elders, which is administered by the DEA. The Elderly Waiver is accessed through the DHS, which is the single state Medicaid agency.

The population eligible to enroll in both HCBS and PACE programs is the same (i.e., functionally and financially qualified for long term care services). While the eligibility requirements are consistent, the populations these two programs actually serve may differ. When profiling enrollment characteristics between PACE and HCBS programs, PACE organizations typically are providing care to a diagnostically and functionally frailer population than normally is found enrolled in HCBS programs. As much as it is critical that the state position PACE in the continuum of long term care services and develop policy perspectives that support this, it is likewise critical for providers to position PACE as part of the long term care continuum within the communities they plan to serve. To the extent possible, developing effective collaborative and working relationships with HCBS providers likely will contribute to the success of the PACE organization.

Medicaid managed care

The DHS Bureau of Managed Care and Clinical Services is responsible for oversight and administration of the two managed care programs and policy review of clinical services. Medical managed care is available to Medicaid recipients within a specified group of assistance types. In general these are the Family Medical Assistance Program (FMAP) and FMAP-related assistance types. The Bureau is segmented into three general areas: Iowa Plan (mental health and substance abuse); Managed Health Care (MHC medical care) and Clinical Services. The Bureau provides oversight of the following areas: the Iowa Plan contract; MHC enrollment brokers; contracts with three HMOs; and contract with the external quality review organization (EQRO). There are over 205,000 people enrolled in the Iowa Plan and over 120,000 enrolled in the MHC program. Of the MHC enrollees, 56,400 are with the HMO option.

The presence of Medicaid managed care in the market has not necessarily been a barrier to the development of successful PACE programs. However, the success of these programs has been in large part based on the ability of PACE providers to develop effective marketing plans that focus on educating providers and consumers in the community regarding the at-risk population PACE programs serve and the unique beneficiary service package these programs provide to consumers.

Medicare managed care

March 2004 CMS Medicare data estimates the total Medicare eligible count in Iowa to be 478,853 beneficiaries, of which 18,643 are enrolled in a Medicare managed care plan (3.9% total market penetration). Table 1 displays Medicare managed care enrollment by plan for Iowa.

Table 1: Iowa Medicare Managed Care Plans by Type and Number Enrolled- March 2004[2]

Organization	Plan Type[3]	Number Enrolled
Humana	PFFS	2,097
Illinois Central Hospital Association	HCPP	180
John Deere Health Plan	Cost	8,629
Medical Associates Plan	Cost	5,268
Santa Fe Employees Hospital Assoc	HCPP	131
Sterling Life Insurance	PFFS	87
Union Pacific RR Health	HCPP	487
United Healthcare	PPO	65
United Healthcare	HMO	1,814
Unicare Life and Health	PFFS	245
Total		**18,643**

Tables 2 and 3 display the Medicare managed care enrollment by counties in the Cedar Rapids and Des Moines regions, respectively.

[2] Medicare Eligibility and Managed Care Enrollment Database; Center for Medicare and Medicaid Services (CMS); March 2004

[3] Medicare managed care plans vary according to plan type. Private Fee-for-Service (PFFS) plans are Medicare Advantage plans that allow the beneficiary to receive care from any eligible hospital or physician that is willing to provide care and accept PFFS plan's payment (no lockout provision). Medicare Cost programs differ from Medicare Advantage in that services obtained from non-network providers are covered under the fee-for-service program and the reimbursement is cost based.

Table 2: Medicare Managed Care by Plan, Enrollment and County Market Penetration
Cedar Rapids Region

COUNTY	ORGANIZATION	PLAN TYPE	ENROLLMENT	PENETRATION
				Total Benton Medicare Beneficiaries= 4,186
Benton	John Deere Health Plan	Cost	35	.84%
Benton	Humana Insurance	PFFS	37	.88%
Benton Subtotal			**72**	**1.72%**
				Total Cedar Medicare Beneficiaries= 2,968
Cedar	John Deere Health Plan	Cost	13	.44%
Cedar	Humana Insurance	PFFS	18	.61%
Cedar Subtotal			**31**	**1.05%**
				Total Iowa Medicare Beneficiaries= 2,891
Iowa	Humana Insurance	PFFS	**22**	**.76%**
				Total Johnson Medicare Beneficiaries= 10,518
Johnson	Humana Insurance	PFFS	**68**	**.65%**
				Total Linn Medicare Beneficiaries= 28,785
Linn	John Deere Health Plan	Cost	43	.15%
Linn	Humana Insurance	PFFS	1146	3.98%
Linn	Sterling Life Insurance	PFFS	12	.04%
Linn Subtotal			**1201**	**4.17%**
				Total Muscatine Medicare Beneficiaries= 6,602
Muscatine	John Deere Health Plan	Cost	44	.67%
Muscatine	Humana Insurance	PFFS	59	.89%
Muscatine Subtotal			**103**	**1.56%**
				Total Tama Medicare Beneficiaries= 3,612
Tama	John Deere Health Plan	Cost	**91**	**2.52%**
				Total Washington Medicare Beneficiaries= 4,212
Washington	John Deere Health Plan	Cost	15	.36%
Washington	Humana Insurance	PFFS	11	.26%
Washington Subtotal			**26**	**.62%**
TOTAL MEDICARE ELIGIBLE=63,744		**TOTAL ENROLLED IN MEDICARE MANAGED CARE=1,433**		**TOTAL MEDICARE MANAGED CARE MARKET PENETRATION=2.25%**

Table 3: Medicare Managed Care by Plan, Enrollment and County Market Penetration
Des Moines Region

COUNTY	ORGANIZATION	PLAN TYPE	ENROLLMENT	PENETRATION
				Total Dallas Medicare Beneficiaries= 5,441
Dallas	John Deere Health Plan	Cost	72	1.32%
Dallas	Humana Insurance	PFFS	15	.28%
Dallas Subtotal			**87**	**1.6%**
				Total Madison Medicare Beneficiaries= 2,311
Madison	John Deere Health Plan	Cost	19	.82%
Madison	Humana Insurance	PFFS	11	.48%
Madison Subtotal			**30**	**1.3%**
				Total Polk Medicare Beneficiaries= 50,367
Polk	John Deere Health Plan	Cost	716	1.42%
Polk	Humana Insurance	PFFS	245	.89%
Polk	Sterling Life Insurance	PFFS	75	.15%
Polk Subtotal			**1,036**	**2.46%**
				Total Warren Medicare Beneficiaries= 5,385
Warren	John Deere Health Plan	Cost	50	.93%
Warren	Humana Insurance	PFFS	14	.26%
Warren Subtotal			**64**	**1.19%**
TOTAL MEDICARE ELIGIBLE=63,504		**TOTAL ENROLLED IN MEDICARE MANAGED CARE=1,217**		**TOTAL MEDICARE MANAGED CARE MARKET PENETRATION=1.91%**

Similar to the presence of Medicaid managed care in the market, the occurrence of Medicare managed care can provide both benefit and caution for PACE provider development.

In markets where PACE programs have developed with high Medicare managed care enrollment, PACE organizations have benefited from having a population of Medicare beneficiaries that is familiar with many of the fundamental concepts of PACE (staff primary care physician, closed provider panels, prior authorization, etc.).

Medicare managed care enrollment levels/penetration rates in the markets under analysis do not appear to be of sufficient size to pose a significant barrier to PACE program development. However, providers in these markets may be challenged to educate providers and consumers on the core concepts of Medicare managed care and specifically PACE, due to a lack of Medicare managed care presence in the market.

Medicaid financial and functional eligibility

In order to qualify for PACE, a beneficiary must be at least 55 years of age, be deemed eligible for nursing home care and live within a designated PACE service area. In general, a vast majority of PACE enrollees (90%) are dually-eligible for both Medicare and Medicaid. As a result, it is relevant to consider both Medicaid functional and financial eligibility requirements

for nursing facility and home and community-based services in order to understand how the target market for PACE might be defined in Iowa.

Financial Eligibility

Table 4 broadly outlines the Medicaid financial eligibility for nursing facility and home and community-based services. Eligibility for other programs may differ and will need to be examined in the context of the program's specific requirements. Generally, Medicaid financial eligibility for PACE corresponds with financial eligibility criteria for HCBS.

Table 4: Iowa Medicaid Financial Eligibility Standards by Resource Category

	Nursing Home	HCBS
Maximum Assets	$2000	$2000
Income Criteria[4]	300% SSI Payment	300% SSI Payment
Medically Needy Criteria	No	No
Spousal Protection- Income	$2319	Protected resources not incomes of community spouse
Spousal Protection- Resources	$92,760	$92,760
Personal/Maintenance Needs Allowance	$30	300% of SSI

Functional Eligibility

The Iowa Department of Human Services (DHS) contracts with the Iowa Foundation for Medical Care (IFMC) to perform utilization review of health care provided to Medicaid individuals. The IFMC reviews individuals to determine level of care provided or determine whether the level of care to be provided is appropriate based on Medical necessity. Assessment and Services Evaluation (ASE) criteria are screening criteria for use by review coordinators. Review coordinators use these criteria in addition to their knowledge and expertise when making a determination. When an individual has been determined not to meet the eligibility criteria, a referral is made to an IFMC physician reviewer. Only physician reviewers may make a denial determination.

The eligibility criteria utilized by review coordinators consist of 10 sets:

1. Cognitive/Mood/Behavior Patterns;
2. Physical functioning;
3. Skin Condition;
4. Pulmonary Status;
5. Continence;
6. Dressing and Personal Hygiene;
7. Physical Functioning-Eating;
8. Medications;
9. Communication/Hearing Patterns/Vision Patterns; and
10. Prior Living Circumstances-Psychosocial.

[4] Most individuals who meet SSI income and asset limits are financially eligible for Medicaid except for "209(b)" states which are allowed to exercise more restrictive financial eligibility. 209(b) states are required to allow individuals to spend down to Medicaid eligibility in one of two ways: (1) Medically-needy programs for the aged, blind and disabled or (2) similar "209(b) spend-down" programs that allow individuals to deduct their incurred medical expenses from their monthly incomes in order to determine whether they meet the state's income standard.

Each criteria is then divided into 3 areas:

1. *Level of care-* This area is the level reviewed and a determination is made regarding skilled or intermediate level of care.
2. *Screen-* This area identifies the strength of the individual and serves as a tool to help the reviewer decide whether a physician referral is indicated.
3. *Evaluation of services provided-* This area defines the services provided by the caregiver, identifies the necessity of the service provided and indicates an appropriate number of days for selective criteria. Physician review is indicated when specific criteria are not met.

Intermediate level of care
Intermediate level of care can be approved by a staff review coordinator if the individual requires daily supervision with dressing and personal hygiene, and also can be approved by a review coordinator if the individual requires limited or extensive assistance or total dependence to perform dressing and personal hygiene. These activities of daily living (ADLs) require physical assistance by one or more persons.

Skilled level of care
The following conditions must be present for a skilled level of care determination:

- The individual must require skilled nursing services OR skilled rehabilitation services; AND
- The individual must require and receive those skilled services on a daily basis (nursing services must be provided seven days a week and therapy services must be provided a minimum of five days per week).

Legislative Authority for PACE
The state already has submitted an approved State Plan Amendment (SPA) for PACE. Submission of the SPA indicates to CMS that Iowa has elected PACE as an optional Medicaid benefit. State officials report this was completed several years ago and may need further review based on PACE administrative changes that have occurred since the original submission.

Iowa Senate Bill 2193 (signed into law in March 2000) outlines the definitions of PACE and "pre-PACE" in statutory form and stipulates a PACE organization must have a contract with the Iowa DHS as well as the U.S. Health Care Financing Administration (HCFA, now CMS) in order to qualify for PACE provider status. This statute also provides exemptions to health maintenance organization (HMO) regulation under Iowa statutes Chapter 514B.

In legislation dated October 2001 (Chapter 162: Nursing Facility Conversion and Long-Term Care Services Development Grants) a "pre-PACE" program is defined as "… a program in the initial start-up phase that provides the same scope of services as a PACE program." It may be beneficial to alter the language of this legislation since the Medicaid prepaid health plans known as "pre-PACE" do not provide the same service package as mandated in PACE regulation.

From a legislative perspective, it appears the state has enacted legislation to sufficiently develop the administrative components necessary to oversee PACE. However, Iowa officials involved

with this project report there may be need for further enabling legislation as the administration of the program becomes better understood.

Budget Resources
Systems for developing budget resources for implementing PACE vary significantly from state to state. Iowa state officials report that should a prospective provider elect to move forward with program development, DHS does not have authority to appropriate funds for PACE. Officials report there is a need for a legislative appropriation.

SECTION 5: MARKET ANALYSIS

The purpose of the market analysis is to estimate the potential number of individuals that could be served by a PACE program in the Des Moines and Cedar Rapids service areas.

The counties considered in the Des Moines market assessment were Dallas, Madison, Polk and Warren Counties, consistent with the counties included in the study's provider outreach (see Map 1). While provider outreach regarding PACE in the Cedar Rapids area was limited to Johnson and Linn counties, the market assessment for this area considered additional adjacent counties (see Map 2). This was done because of the low population density of Linn and Johnson counties and the likelihood that individuals residing in the adjacent counties (Benton, Cedar, Iowa, Muscatine, Tama and Washington) could also be served by a PACE program based in the Cedar Rapids area.

The data source for the analysis is 2000 U.S. Census Bureau estimates obtained through American Fact Finder on the U.S. Census Bureau website. PACE market analyses consider three factors for enrollment: age, clinical eligibility and financial eligibility for Medicaid.

After a review of these factors, this section presents potential service population estimates for the Des Moines and Cedar Rapids areas. The estimates are followed by a discussion of the likely market penetration a PACE program could expect to achieve for the potential service populations in each area.

Map 1: Counties in Des Moines Region

Map 2: Counties in Cedar Rapids Region

Service Population Factors

The target population for a PACE program is a subset of the total population. By statute, an individual who is eligible to enroll in PACE must: (1) be at least 55 years of age; (2) have been deemed "nursing home eligible" by functional or frailty criteria established by the state in which the individual lives; and (3) reside in the community within the designated PACE service area (i.e., be non-institutionalized at the time of enrollment).

Age: The federal PACE regulations require PACE enrollees to be 55 years of age or older. PACE enrollment experience indicates that nine in ten PACE enrollees are over the age of 65. Therefore, this analysis focuses on the total population age 65 or older.

Clinical Eligibility: Potential PACE participants must be certified as nursing home eligible by the state of Iowa before they can be enrolled in a PACE program. Iowans meet long-term care functional requirements if they require daily supervision with dressing and personal hygiene and also can meet functional eligibility if determined to need limited or extensive assistance in performing tasks related to dressing and personal hygiene.

U.S. Bureau of the Census data reports a range of disabilities related to Activities of Daily Living (ADL's), including mobility, and self-care, that are indicative of Iowa's clinical eligibility criteria for nursing home care. This analysis focuses on three specific measures of disability for those aged 65 and older:

- A disability related to two or more activities of daily living, one of which is self-care (2+ADLs, including self-care)
- A self-care disability (alone or in conjunction with other disabilities)
- A go-outside-the-home disability (alone or in conjunction with other disabilities)

These measures, though not exact matches for Iowa's clinical eligibility criteria, provide a general estimate of the 65 and older population that could be expected to potentially enroll in PACE. Attachments 2 and 3 report the estimated number of people who would be clinically eligible for PACE and over the age of 65 for each of these measures in Des Moines and Cedar Rapids service areas.

For the purposes of the analyses discussed in this section, the "2+ADLs, including self-care" measure has been used as the most representative of those likely to enroll in PACE. The "2+ADLs, including self-care" measure and the "self-care" measure provide almost identical results to one another. However, the "2+ ADLs, including self-care" measure is a considerably more conservative measure (i.e. it suggests a more limited number of potential PACE enrollees) than the "go-outside-the home measure." Specifically, for the two areas studied:

- In the Cedar Rapids area the estimated service population using the "go outside the home" measure is **2,928** while the more conservative estimate using the "2+ ADLs, one of which is self-care" is **1,306**.
- Similarly, in the Des Moines area the two measures produce a range with a high estimate of **3,212** and a low estimate of **1,441**.

Medicaid eligibility: Although Medicaid financial eligibility is **not** an eligibility requirement for PACE, historically more than ninety percent of PACE enrollees are Medicaid eligible. PACE enrollees ineligible for Medicaid must pay the monthly Medicaid capitation privately (out-of-pocket), which many potential enrollees view as cost prohibitive.

With this in mind, the potential market projections for PACE focus predominantly on a low-income population. Specifically, the projections reflect those individuals who are currently Medicaid eligible or those who are likely to spend down quickly to meet financial eligibility criteria.

Service Population Estimates

Table 5 presents summary estimates of the number of potential PACE enrollees in the two markets that could be served by a PACE program, based on the factors discussed above. Detailed estimates by county and zip code for the two service areas can be found in **Attachments 2 and 3.**

Table 5: Service Population Estimates for Des Moines and Cedar Rapids Areas

Factor	Des Moines	Cedar Rapids
Total Population Aged 65+	53,396	53,791
Estimated % who are clinically eligible (using "2+ADLs, one of which is self-care" measure)	7.8%	7.7%
Estimated number aged 65+ and medically eligible	**4,165**	**4,142**
Estimated % Financially Eligible for Medicaid[5]	34.6%	31.5%
Estimated number of Aged 65+, medically eligible for PACE and financially Eligible for Medicaid.	**1,441**	**1,306**

Detailed Des Moines Service Population Estimate

As Table 6 indicates, across the Des Moines service area there is variation by county and zip code in the concentration of individuals that could potentially be served by PACE.

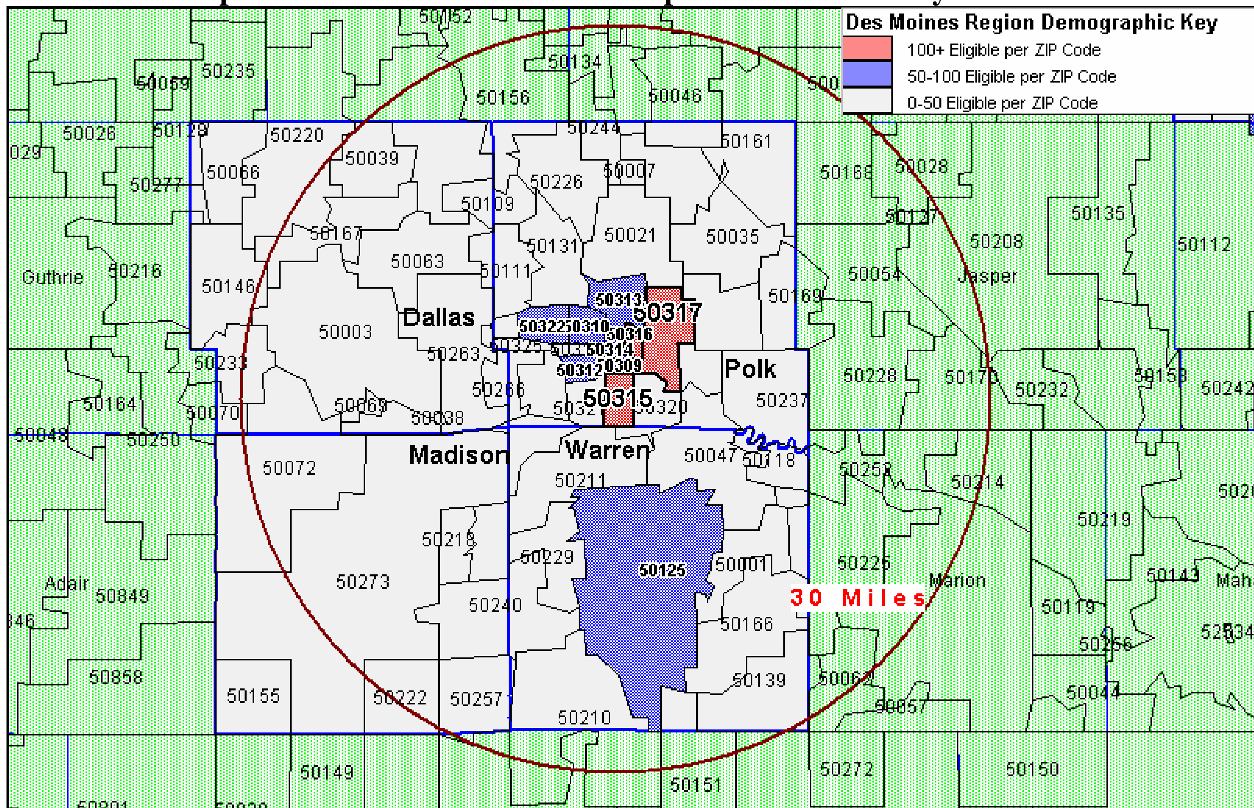
[5] The percent reported is a weighted average of the percent of households with an income below the estimated limit for Medicaid financial eligibility. The average is weighted by the number of clinically eligible individuals in each zip code.

Table 6: PACE Service Population Estimate by County for Cedar Rapids Region

County Name	Estimated Population Clinically Eligible for PACE and Financially Eligible for Medicaid
Dallas County	115
Madison County	61
Polk County	1,115
Warren County	139
Total	**1,441**

Map 3 displays the estimates for the potential PACE population in the Des Moines area by ZIP code. Map 4 displays a close-up of the same area.

Map 3: Des Moines Area Service Population Estimate by ZIP Code



Map 4: Des Moines Area Service Population Estimate - Close-up

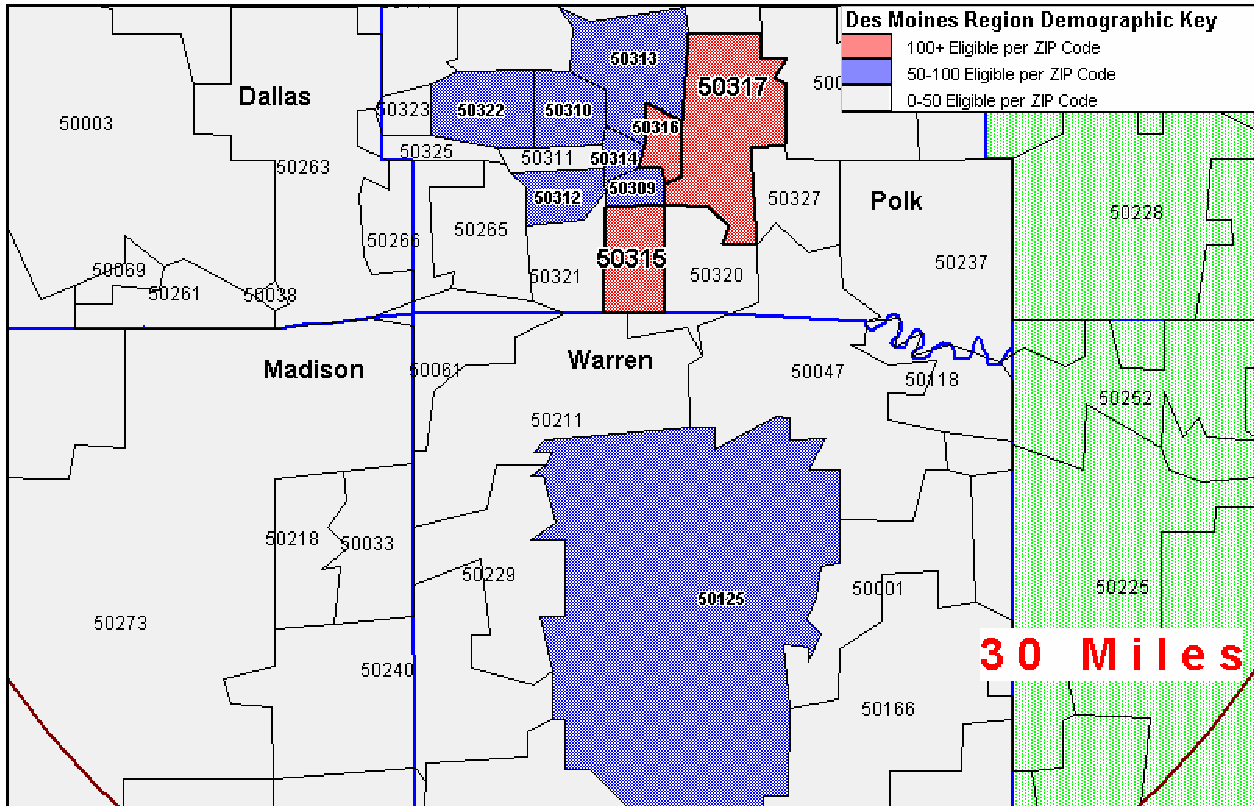


Table 7 presents service population estimates for the entire area and for Polk County only. Based on the service population estimates, the table also presents the level of market penetration for this population that a program would need to achieve in order to reach specified levels of enrollment (ranging from 100 to 200 enrollees). Similarly, the table estimates the expected enrollment a program would achieve if different market penetration rates are assumed (ranging from 5% to 20%).

Table 7: Des Moines Region and Polk County Market Penetration Measures

PACE Enrollment Target	Des Moines Service Area – All Counties	Polk County Only (within the Des Moines Service Area)
Eligible Population Base	1,441	1,115
To achieve an enrollment of:	A PACE provider would need a market penetration rate of:	
100 Enrollees	6.9%	9.0%
150 Enrollees	10.4%	13.5%
200 Enrollees	13.9%	17.9%
If the assumed demographic penetration is:	The expected PACE enrollment would be:	
PACE 1-3 Year Average		
5%	72	56
10%	144	112
PACE 4-5 Year Average		
15%	216	167
20%	288	223

The total square miles of the four counties in this region is 2,288 square miles. Although Polk County accounts for only 25% of the total square miles in this region (n=561), it contains 80% of the demographic base estimated in this analysis. As the maps and tables in this section indicate, there appears to be a demographic base to support the development of a PACE program in Polk/Warren/Dallas/Madison counties or in Polk County alone. Providers in this region would be challenged to develop PACE operations without the inclusion of Polk County in the service area given the concentrations of program eligibles in this metropolitan area.

Detailed Cedar Rapids Service Population Estimate

Similar to the Des Moines area, within the Cedar Rapids service area, the concentration of people that could potentially be served by PACE varies by county. Table 8 displays the range of eligible individuals per county in the Cedar Rapids area.

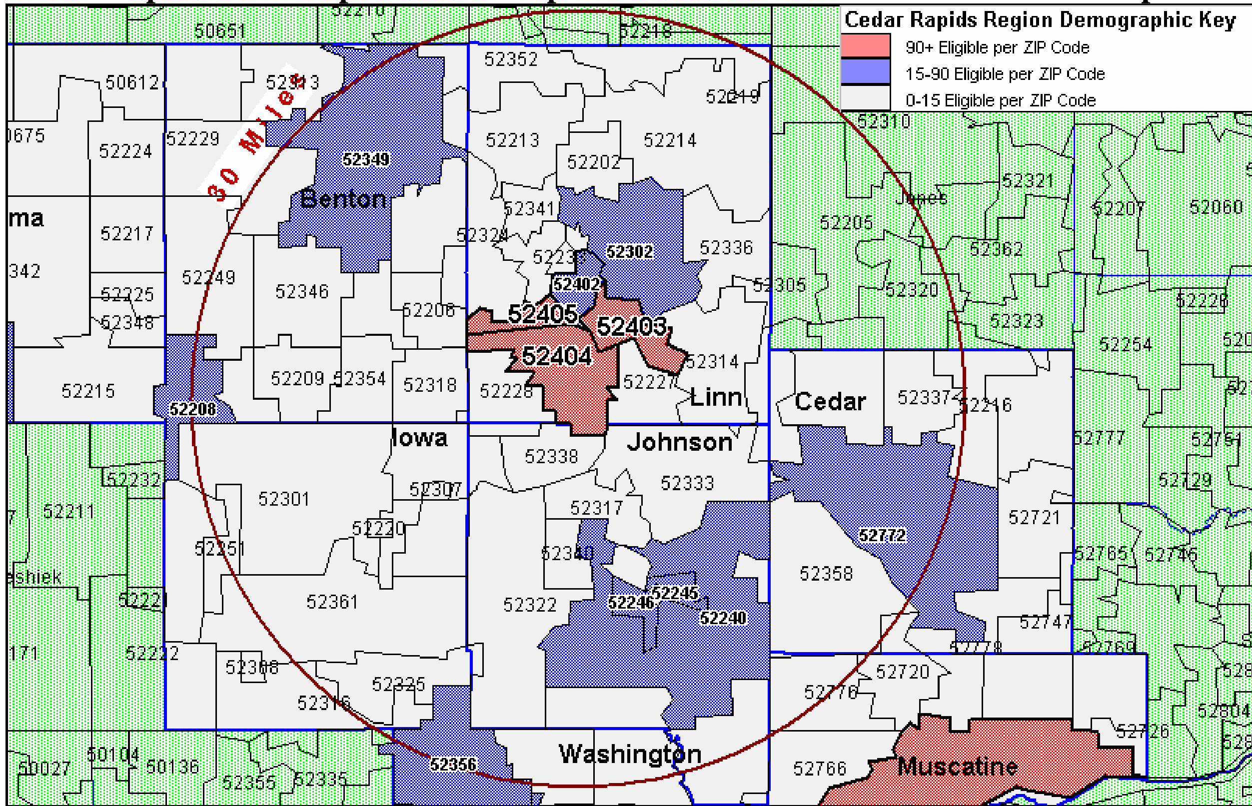
Table 8: PACE Service Population Estimate by County for Cedar Rapids Region

County Name	Estimated Population Clinically Eligible for PACE and Financially Eligible for Medicaid
Benton County	101
Cedar County	69
Iowa County	46
Johnson County	150
Linn County	570
Muscatine County	179
Tama County	79
Washington County	113
Total	**1,306**

Map 5 displays the Cedar Rapids region by ZIP codes and indicates the variation in potential service population. Map 6 presents the same information focused on the area within a 30 mile radius of Cedar Rapids.

Map 5: Cedar Rapids Area Service Population Estimate by ZIP Code

Map 6: Cedar Rapids Service Population Estimate: 30-Mile Radius Close-Up



Cedar Rapid's relatively rural service area is characterized by population paucity and dispersion. The 4,492 square miles of the area will challenge a PACE provider's ability to serve its entire population. There do appear to be contiguous concentrations of eligible individuals clustered in Linn, Johnson, Benton and Iowa Counties (2530 square miles) and clusters of eligible individuals in Muscatine, Cedar, Johnson and Washington Counties.

Table 9 presents county level service population estimates where counties have been clustered together based on geographic proximity and demographic eligibility estimates. Based on the service population estimates, the table also presents the level of market penetration for this population that a program would need to achieve in order to reach specified levels of enrollment (ranging from 100 to 200 enrollees). Similarly, the table estimates the expected enrollment a program would achieve if different market penetration rates are assumed (ranging from 5% to 20%).

Table 9: Clustered Service Population Estimates for County Groups

PACE Enrollment Target	Linn/Johnson/Benton/Iowa Counties	Muscatine/Cedar/Johnson/Washington Counties
Eligible Population Base	**867**	**511**
To achieve an enrollment of:	**A PACE provider would need a market penetration rate of:**	
100 Enrollees	11.5%	19.6%
150 Enrollees	17.3%	29.4%
200 Enrollees	23.1%	39.1%
If the assumed market penetration rate is:	**The expected PACE enrollment would be:**	
PACE 1-3 Year Average		
5%	43	26
10%	87	51
PACE 4-5 Year Average		
15%	130	77
20%	173	102

As Table 9 indicates, there appears to be a demographic base to support the development of a PACE program in Linn/Johnson/Benton and Iowa counties. Providers in this region would be challenged to develop PACE operations without the inclusion of Linn and Johnson counties in the service area given the concentrations of program eligibles in these two counties.

Market Penetration for PACE

Table 10 summarizes the service population estimates for the Cedar Rapids and Des Moines areas along with the range of market penetration scenarios.

Table 10: Service Population Market Penetration Measures

PACE Enrollment Target	**Cedar Rapids**	**Des Moines**
Estimated Service Population Base (Clinically Eligible and Financially Eligible for Medicaid)	1,306	1,441
To achieve an enrollment of:	The penetration of the demographic base would need to be:	
100 Enrollees	7.7%	6.9%
150 Enrollees	11.5%	10.4%
200 Enrollees	15.3%	13.9%
If the assumed demographic penetration is:	The expected PACE enrollment level would be:	
PACE 1-3 Year Average		
5%	65	72
10%	131	144
PACE 4-5 Year Average		
15%	196	216
20%	261	288

Both the Cedar Rapids and Des Moines areas contain a sufficient population base to support PACE program development. These population bases appear to be concentrated in either Polk/Warren/Dallas/Madison counties or in Polk County alone for the Des Moines area; and in the cluster of Linn/Johnson/Benton/Iowa counties or Muscatine/Cedar/Johnson/Washington counties for the Cedar Rapids area. In both areas, it appears it would be necessary to include the metropolitan areas as part of any PACE service area in order to create a population base large enough to establish program viability.

A PACE providers ability to serve the potential population estimated for each area will depend on how large an area its service delivery system can reach, the availability of alternative services, and the support of referral sources for the program. To cover the large, and primarily rural service areas discussed, a PACE provider will need to develop an operational approach that builds on and adapts existing PACE practices. For example, the role and functions of a PACE center across the Cedar Rapids area, which is large and very rural, may need to be reconsidered.

A future PACE program's market penetration will also be affected by the range of alternative services available in the service area. Nursing home services have been the preferred mechanism for the delivery of long term care in Iowa. Should PACE develop in either of these markets, because of the relatively low nursing facility occupancy rates, nursing home providers may present the most immediate competition for a PACE. However, nursing facilities have also

looked to PACE providers as a source of referrals and have found mutual benefit in collaboration with a PACE organization.

Home and community-based services have been implemented throughout Iowa and are available to a wide range of at-risk populations, including frail elders, in both markets. Although PACE programs historically provide care to a population which tends to be diagnostically and functionally frailer than the population in frail elderly waiver programs, because eligibility requirements are the same for the two populations, HCBS programs will likely provide some measure of market competition for PACE programs.

PACE program enrollment may be supported through collaborative relationships with existing service providers. These providers can play an important role in helping the PACE program to extend and complete their current service delivery systems.

The presence of Medicaid and Medicare managed care in the markets provides an opportunity and a challenge. On the one hand, qualified individuals may have exposure to some fundamental concepts of managed care enrollment which may increase their likelihood for enrollment in PACE and understanding of how it operates. On the other hand, enrollment rates in these managed care programs are low, suggesting that there may not be a large pool of prospective beneficiaries who would transition through the current Medicare and/or Medicaid managed care systems.

There are limitations to this service population analysis. The analysis is most beneficial at a macro or aggregate level. The analysis has significant limitations when applied to a very specific market segment. This is especially true when applied to geographies with smaller population bases where broad analysis may not capture the nuances of the market fully. The methodology in this analysis is meant to provide a broad estimate of whether a population base for program development exists in two regions of Iowa. Further analysis may be beneficial in determining whether the population base identified in these markets would enroll in the program should it develop.

SECTION 6: PROVIDER INTEREST

In addition to representatives from a variety of state agencies and statewide health care associations, 118 aging, social service and health care providers, along with 54 senior housing providers, were invited to participate in the provider education call held June 16, 2004 and the State PACE Summit held July 22, 2004. Thirteen providers responded to the mailing with interest in PACE. Twelve of these providers indicated their intent to participate in the provider education call and attend the state summit. However, attendance at the state summit was even better than anticipated.

Within the Cedar Rapids Region, which includes Linn and Johnson Counties, there are four prospective providers, who responded to the outreach mailing:

- The Meth-Wick Community;
- Aging Services, Inc.;
- Premier Health Associates; and

- Cedar Rapids Hospice.

Within the Des Moines Region, which includes Polk, Warren and Dallas Counties, there are three prospective providers who responded to the outreach mailing:
- Wesley Retirement Services;
- New Horizons Adult Day Services; and
- Premier Health Associates.

One provider, who responded to the outreach mailing, expressed interest in counties outside the markets being analyzed for purposes of this report. This provider is interested in developing PACE in Woodbury, Plymouth, Sioux, Ida, Monona and Cherokee Counties. This provider, Hospice of Siouxland, recently completed an organizational self assessment and participated in a Rural PACE Workshop in Milwaukee, Wisconsin, which was sponsored by NPA.

Three additional providers with service delivery areas outside the selected markets also expressed an interest in PACE in response to the outreach mailing:
- Allen Memorial Hospital;
- Prime Time Adult Health Services; and
- Lending Hands, Inc.

Another provider with a statewide service area expressed an interest in PACE:
- The University of Iowa Hospitals and Clinics

One provider, Iowa Health Des Moines, expressed an interest in PACE but was non-responsive regarding their current service delivery area when they completed their registration form.

Provider interest during the educational conference call on June 16 was difficult to gauge. Although there were many participants, most appeared to either have their questions answered regarding programmatic issues as a result of the PACE overview section of the conference call or were reluctant to ask questions perhaps because other participants on the call were potential competitors in their present operations.

Provider interest during the Iowa PACE Summit was significantly more telling. Forty participants attended the summit, including providers, association representatives, state staff, and advocacy groups. Among the providers attending the summit, there were providers from both of the market areas being assessed for this report as well as providers from outside those market areas, who were interested in PACE. Those in attendance at the summit actively participated in the afternoon dialogue about potential opportunities, challenges, strategies for overcoming challenges, and next steps.

Eleven participants at the summit completed a Participant Response and Follow-up form requesting additional information about PACE. Four of these providers requested information about any future development or state activities related to PACE, while the remaining seven providers requested additional information about opportunities to either develop a PACE program or partner with a PACE program in their service area.

With respect to those provider organizations that are moving forward, the University of Iowa Hospitals and Clinics are evaluating PACE and the potential fit with their existing hospital strategy and patient base. Hospice of Siouxland is completing a feasibility assessment. Premier Health Associates indicated an interest to move forward either as a partner or a direct provider of PACE. Michael-Lilly Private Home Services also indicated an interest in opportunities to partner with a PACE program in their service area. Mercy Medical Center is interested in speaking further with existing PACE providers about financial risk and are interested in visiting a PACE program. Iowa Health in Des Moines plans to evaluate the feasibility of PACE for their organization, as well. It will be important for state staff to keep these providers informed and involved as the state moves forward with incorporating PACE into their long term care system.

Section 7: Housing and PACE Potential Partnerships

This section examines the potential relationship of PACE with multifamily senior housing, particularly federally subsidized housing for low-income older persons. After a brief overview of the relationship of existing PACE programs with senior housing, there is a discussion of housing programs in the Cedar Rapids and Des Moines market areas and the potential impact of these programs on a PACE program.

Relationship of Existing PACE Programs with Senior Housing

While housing is not a part of the PACE benefit package, PACE providers recognize the importance and mutual benefits of safe, decent and affordable housing in promoting wellness and quality of life for older persons. Consistent with the Supreme Court's Olmstead decision and the federal Administrations' New Freedoms Initiative, the PACE philosophy is to maintain frail elderly in their homes and neighborhoods as long as physically, socially and economically possible.
As indicated in a recent NPA survey, nearly all of the PACE programs nationwide serve PACE enrollees who reside in a multi-family senior housing facility and/or collaborate with housing sponsors to assist PACE participants to obtain affordable housing. Further, nearly one-third of PACE programs have co-located a PACE center with senior housing. Less than one third of PACE programs own either affordable senior housing or assisted living facilities; of these, most have used the HUD Section 202 program.

For PACE providers, collaboration with senior housing provides an opportunity to:
- Increase their participants access to affordable housing
- Increase enrollment in the PACE program
- Lease or own suitable space in or adjacent to the senior housing facility for PACE centers or a subset of PACE services
- Increase community visibility for marketing efforts; and
- Reduce transportation and operational costs.

From a housing perspective, collaboration with PACE provides an opportunity to address care and service needs of aging residents without the housing sponsor's direct involvement in service delivery. This allows housing providers to focus on housing issues without diverting resources to services with which they are unfamiliar and for which they would require additional licenses.

Housing Needs and Priorities in Iowa

Iowa's State Plan for housing indicates that elderly renters are significantly poorer than other renters, with 60% of elderly renters on a very low income (below 51% of the median family income or MFI). Fifty-nine percent of elderly households with extremely low incomes, defined as less than 30% of MFI, experience housing problems.[6] In addition to financial challenges, elderly Iowans are dealing with clinical and functional health care needs in order to remain in their homes and communities. Iowa's Division of Economic Development (IDED) estimates 27,672 to 38,738 persons older than 60 need help carrying out daily living tasks.

The Iowa Department of Human Services advocates for "housing as homes" with an option for services on an as needed basis rather than as a planned housing component. The state does not directly operate public or assisted housing. IDED has established priorities of "aging in place" and housing choice for elderly clients. While a portion of the continuum of care includes supportive living in a planned housing development, in-home services and home care are preferred to planning supportive housing units. Many providers stress the need for a wide array of housing options, ranging from independent living to specialized care. Service providers must work toward consensus on the appropriate range of options and cooperative funding for them. Beyond the issue of "bricks and mortar" is the need to blend support services with housing requirements.

Any future collaborative options between PACE and senior housing must be assessed in the context of the needs and resources of the local community (market area), including the mission and capacity of the PACE program, consumer preferences, and the leadership and experiences of public and private organizations involved.

Senior Housing Programs Available in the Market Areas

In Iowa the relationships between housing and prospective PACE programs were examined for two potential service areas:

1. Cedar Rapids – encompassing Linn and Johnson Counties; and
2. Des Moines – encompassing Polk, Warren, and Dallas Counties

The two markets share common characteristics, with both combining urban and rural areas; serving as the location of a major state institution (state capitol and University of Iowa); and, having a relatively low population density in their metropolitan and surrounding rural areas. While local governments in the two areas rely most heavily on rent subsidy vouchers to address affordability, a number of smaller senior housing facilities are present in each area. These facilities have the potential to be a partner in the establishment and operation of a PACE program. Below, each area's housing programs are examined. For a description of federal

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[6] While it is helpful for comparative purposes to have state aggregated information, Iowa State University has prepared profiles of specific housing, living arrangements, and other demographic characteristics of the elderly and other age groups for each of the state's 99 counties. The profiles, "Older Iowans Data for Decision Makers," are available at: http://www.extension.iastate.edu/housing/government/housingClassified.html

housing programs please see **Attachment 4**. The Seniors Housing and Health Care Facilities Commission has developed an excellent report that can serve as a reference for understanding many of these programs and their potential to support seniors' health care needs (see www.seniorscommission.gov). For a list of information resources and website links related to housing in Iowa and federal housing programs see **Attachment 5**.

Housing in Cedar Rapids Market Area

The Cedar Rapids/Linn area has five Section 202 housing facilities with 286 units. Another program, Section 515, provided by Rural Housing Services of the U.S. Department of Agriculture, supports low income housing in rural areas through low interest loans and by subsidizing rent payments. In Linn County and Cedar Rapids there are 16 Section 515/Rural facilities with a total of 222 units. Dallas County has an additional 14 Section 515/Rural programs with 265 units. Many of these facilities also receive financial support through the low income housing tax credit (LIHTC) program.

Beyond the Section 202 and 515 programs which comprise the most significant part of housing in the area, there are housing facilities which receive financial assistance in the form of mortgage insurance provided by the federal government for the purpose of lowering the interest rates charged to these facilities by commercial lenders (Section 221(d)(3) for nonprofit facilities and 221(d)(4) for for-profit facilities).

For a summary of facilities and units by county please see Table 11. **Attachment 6** provides the number of units for each facility in the service area.

Table 11: Housing Facilities and Units, by County, in the Cedar Rapids and Des Moines Service Areas

County/City	**Sum of Fac.s**	**Sec 202 *Fac/ Units***	**Sec 221 (d)(3) *Fac/ Units***	**Sec 221 (d)(4) *Facs/ Units***	***PHA Facs/ Units***	**515/ Rural *Facs/ Units***	**LIHTC *Facs/ Units***	**Sec 8 *Facs/ Units***
Cedar Rapids Service Area								
Johnson/Iowa City	5	1/81		3/185		1/8	1/48*	1/48*
Linn/Cedar Rapids	25	5/286	1/91	3/159		15/222	2/66*	1/183
TOTAL	**31**	**6/367**	**1/91**	**6/344**		**16/230**	**3/114***	**2/231***
Des Moines Service Area								
Dallas	14					14/265	4/94*	
Polk/Des Moines	22	10/972		3/221	4/190	5/118	3/66*	7/459*
Warren	7		1/60	1/81		5/102	6/102*	
TOTAL	**43**	**10/972**	**1/60**	**4/302**	**4/190**	**24/485**	**13/260***	**7/459***

** indicates that the LIHTC or Section 8 related units are part of a mixed financed facility and are identified in the chart for information purposes only. These units are not counted, to avoid duplication. Section 8 rent subsidies are both vouchers and project-based and often linked with senior housing facilities funded under various programs, particularly Rural, LIHTC and FHA insured (221s).*

Housing in Des Moines Market Area

Des Moines has the highest number of section 202 housing developments in the state, with 10 facilities that have a total of 972 units. These facilities range in size from 9 to 169 units. The

surrounding counties of Dallas and Warren have no section 202 housing facilities. Des Moines also has senior public housing located in four buildings with a total of 190 units. Six hundred and ninety-six additional family public housing units and 2,400 Section 8 vouchers are also available throughout the city. In some cases these Section 8 vouchers are used in conjunction with specific housing facilities, often with facilities that also receive a low income housing tax credit (LIHTC).

In Polk County and Des Moines there are five facilities participating in the Section 515/Rural program with a total of 118 units. Warren County has an additional five facilities with a total of 102 units. Many of these facilities also receive the LIHTC.

Like the Cedar Rapids area, some additional housing facilities receive mortgage insurance through the Section 221(d)(3) and 221(d)(4) programs though this is not significant for the area. Also like the Cedar Rapids area, "soft" demand for housing in the Des Moines area may translate into increased housing provider interest in collaborating with PACE.

For a listing of facilities by county please see Table 11. Attachment 7 provides the number of units for each facility in the service area.

Participation of Senior Housing Residents in PACE/enrollment

In many federally assisted senior housing properties, a substantial portion of senior housing residents may be likely to meet the age, financial and clinical eligibility requirements for enrollment in a PACE program. PACE participants must be over the age of 55 and meet their state's nursing home level of care criteria. Also, though not a requirement for PACE, over 90% of PACE participants qualify for Medicaid coverage. These criteria are similar to some of the most common requirements of senior housing:

- Most senior housing requires the resident to be 62 or older, seven years older than the minimum PACE age.
- Seniors have a disproportionately high number of physical and functional disabilities, indicating a higher likelihood that they would meet the state's clinical and functional criteria for needing a nursing home level of care.
- A typical income limit for senior housing is 50% of the Annual Median Income (AMI), which is comparable to the 300% of the social security income (SSI) limit of $20,000 for the Medicaid program. Fifty percent of AMI in FY2004 for one person is $14,100 in Cedar Rapids and $14,500 in Des Moines.[7]
- Asset tests for low income housing are set by the Department of Housing Development (HUD) nationally while these tests are set by each state for Medicaid eligibility. Both HUD and most states allow for the retention of some assets. In the case of HUD this allowance covers "necessary personal property" while for Medicaid the allowance is for the residence of a spouse or certain other dependents. While some HUD programs do not

[7] HUD's web site provides a listing by state and county of the income limits based on 30% (extremely low income), 50% (very-low income) or 80% (low income) of the area median income. See http://www.huduser.org/datasets/il/il04/index.html.

have an asset test, HUD calculates an imputed annual income based on two percent of assets valued over $5,000.

Since PACE participants must be certified by the State to be nursing home eligible, only a portion of the residents in an "independent" senior housing facility may be eligible for PACE based upon their level of functional impairment. While it will vary from program to program, it is estimated that about 20-30 percent of older persons in federally assisted senior housing have a functional impairment that requires some assistance or services. The proportion of frail elderly needing assistance generally will be higher in older buildings where residents have aged in place rather than in more recent developments where the move-in age is younger.

Given that PACE participants must meet the states level of care criteria for nursing homes (which typically require impairment in multiple activities of daily living), not all those requiring assistance will qualify for PACE. If between 15% and 20% of housing residents would qualify for PACE:

- Of the 1,263 senior housing residents in the Cedar Rapids area (Johnson and Linn counties), a range of **188** to **252** people would be estimated to be functionally eligible for PACE.
- In the Des Moines area (Dallas, Polk and Warren counties) with 2,009 senior housing residents, a range of **301** to **402** would be expected.

While most of these people would be likely to qualify financially for Medicaid, not all would initially choose to enroll in PACE until they become more familiar with the benefits provided.

<u>Integrating Housing and PACE Funding for Capital Development and Services</u>

In both the Cedar Rapids and Des Moines area, there are two federal community and economic development programs that may be helpful in supporting the development of PACE in association with housing: HOME and Community Development Block Grants (CDBG). Both programs are formula block grants to state and larger local governments. The programs provide funding that may be used for renovations, acquisitions, additions and other uses for senior housing, community centers, or individual homes. The IDED administers both programs *(see www.community.state.ia.us/community/index.html).*

Apart from a few demonstration programs, housing funds are primarily for "brick and mortar" to develop, acquire or rehabilitate affordable housing and not for funding services. In contrast, federal and state-matching Medicaid funds are primarily for services and not for capital investments, including development of housing or health care centers. The revised Section 202 program (post 1990) permits limited use of operating subsidies (Project Rental Assistance Contracts – PRACs) to pay for up to 15% of the costs of services and staffing of service coordinators associated with housing.

Given the sparse elderly population and location of small housing projects in the Cedar Rapids and Des Moines service areas, it may be necessary to transport individuals over long distances that are attending a PACE center or alternative delivery setting for some PACE enrollees. The co-location of a PACE center (exclusive or as part of a community center with other programs)

in or adjacent to senior housing would minimize the transportation costs for some older participants and serve as a visible presence of the PACE program in the service area catalyst for serving residents in the surrounding area. The center might also enable the co-location of PACE along with other community programs benefiting the elderly, such as a HUD Neighborhood Network program to enable computer use by residents and use of telemedicine or communications to elderly in surrounding areas.

Licensing and Quality Assurance

One of the primary disincentives for housing providers to establish increased level of service programs is the risk of being required to seek a license or certification as a provider of a higher level of care. The triggers for required licensing often involve the provision of 24 hour staff oversight responsibilities and the administering of medicines. Some housing providers prefer to remain identified as "independent" or "supportive housing" (not as licensed assisted living or certified as a personal care facility); and, therefore these providers, may avoid involvement in the provision of services. This in turn may adversely affect the quality of life for some frail residents. Since there are few affordable assisted living facilities in the State, some frail elderly will have limited options but to move prematurely to a facility providing a higher level of care, i.e., a nursing home.

In each of these situations, the establishment of PACE, including the co-location of a PACE health day center with senior housing would offer a mutually beneficial means to assist frail older persons residing in the senior housing facilities and those in the surrounding areas, as well as to streamline, simplify, and make distinctions between the operations of housing and PACE.

Housing and PACE Opportunities

To explore opportunities for housing and PACE collaboration, prospective PACE providers in the Cedar Rapids and Des Moines areas should pursue a dialogue with sponsors of federally assisted senior housing. In addition, an interagency workgroup of key staff from the various State, regional and local housing and community development agencies (e.g. HUD Field Office, Iowa Housing Corporation, Iowa Department of Community & Economic Development, local government officials) would help define how the state's housing and PACE programs could work together.

Of particular interest to housing sponsors may be the impact that PACE may have, not only on service needs of their aging residents, but also on demand for independent senior housing in some market areas. Some of the local markets have vacancy issues, due in part to the availability of newer housing developments that may be better able to attract new residents. Depending upon the location and characteristics of their facility (number of units, design features, age, common space, services available to their residents, financial reserves, mission and capacity of sponsoring organization, etc.), the housing sponsors may seek an active or passive role in collaborating with PACE. Actions could range from educating residents and the community to actively supporting the establishment of a new PACE program. These actions can contribute to PACE enrollment, access to space for PACE services, and financing of PACE capital requirements.

SECTION 8: STATE READINESS

Decision Making

A broad range of state agencies, including the Iowa Department of Human Services, Department of Elder Affairs, Department of Inspections and Appeals, the Iowa Finance Authority (which also acts as Iowa's Housing Authority), and the Department of Public Health, have been included in the decision making process for PACE. Directors from the agencies referenced above each appointed a senior staff person to serve on a workgroup for this project. By devoting staff resources to the project, the directors have sent a clear message as to the importance of the PACE project and their commitment to taking the necessary steps to incorporating PACE into Iowa's long term care system. Representatives from most of these agencies communicate with one another regularly, participate in NPA's State Administrator's List Serve, and participate in monthly calls with NPA staff and their technical assistance advisor from Integrated Care Solutions (ICS). In addition, these agencies are working closely with the state's Senior Living Coordinating Unit (SLCU), which includes members of the governor's cabinet, the general assembly and consumer representatives.

The Department of Inspections and Appeals will need to be included in the decision making process with respect to certifying the PACE program. Currently, the state recommends that they apply the adult day certification to PACE in the event that the PACE provider chooses to directly provide adult day services. Should the prospective PACE provider choose to contract with an outside entity for adult day services, then the provider would not be required to hold an adult day certificate but would be required to contract with an entity that did hold this certificate.

Administering PACE

The SLCU designated Iowa DEA as the lead state agency for the CMS PACE Project. The Iowa DEA is also the designated State Unit on Aging under the Older Americans Act. The Iowa DHS is the state Medicaid agency and lead state agency for Olmstead related activity. State officials have not yet determined which agency is best suited to serve as the state administering agency for PACE.

During the past four years, the state has been working toward rebalancing its long term care system, placing greater emphasis on the development and expansion of home and community-based services (HCBS). If done in collaboration with the DEA, the DHS could provide a good administrative fit for PACE given its experience with the state's HCBS program and two Medicaid managed care programs. If a provider application were submitted today, DHS likely would be the state administering agency for PACE. However, there does appear to be some discussion surrounding the rebalancing of long term care programs in the next legislative section, which would be important to consider when determining the agency best suited to administer PACE.

As has been demonstrated in Kansas and Arkansas, the Iowa DEA would also provide a good administrative fit for PACE given its role as the designated State Unit on Aging, the relationship that it has developed with the aging and disability communities through the Area Agencies on Aging, its relationship with the provider community and advocacy groups in Iowa, and its

understanding of what is currently working and what needs improving in the state's long term care system.

Regardless of which agency becomes the administering agency for PACE, there likely will be a need for an interagency agreement to help define the role and responsibilities of each agency and coordinate their activities for PACE.

State Staffing

Representatives from a broad range of state agencies attended the state capacity building meeting on May 4, 2004. These representatives were from the Iowa Department of Human Services, Department of Elder Affairs, Department of Inspections and Appeals, the Iowa Finance Authority (also acts as Iowa's Housing Authority), and the Department of Public Health. In addition, some state staff have toured PACE sites and attended training seminars pertaining to PACE.

Currently, state staff are energized about working on PACE. Interest and involvement in PACE development span across multiple state agencies. Staff have indicated that it is likely they will need to seek legislative approval for funding, staffing and a variety of issues pertaining to PACE. Should this prove to be the case, staff may face difficulty maintaining their energy and momentum toward PACE development given the challenges and delays inherent in acquiring legislative support.

State staff may be a bit uncertain about their respective roles with respect to developing PACE, given that they have not yet determined which state agency will serve as the state administering agency for PACE. There does appear to be strong leadership for PACE among state staff in Iowa. State staff contributing to the CMS PACE project, are clearly champions for PACE. They are very familiar with the PACE model of care. They have toured the On Lok program in San Francisco as well as the PACE sites in Wisconsin and Colorado. They have worked for the past two years to educate a variety of state staff and the SLCU about PACE and are working collaboratively with staff from the state legislature and governor's office in addition to a variety of state agencies, professional trade organizations and prospective providers toward PACE development. In addition, there are opportunities to foster leadership and partnerships across a wide range of executive branch agencies given the level of collaboration and coordination that exists among these agencies with respect to existing long term care programs. Leadership from DHS will be especially important to PACE given the likely role the agency will play with respect to rate setting and MMIS issues.

Rate Setting and Data Collection

In 1998, the Iowa DHS worked with an actuarial consultant to calculate a proposed Medicaid capitation rate. In 1999, the two prospective PACE providers, with whom the state had been collaborating, decided not to move forward in developing a PACE program after determining that it was not financially viable given the draft rate and start-up expenses. Since that time, state staff have not revisited their methodology for setting a current PACE rate. As a result, they are not in a position to offer a rate estimate for planning purposes. State staffs have indicated that they will need to acquire funding in order to pull the necessary data from their MMIS system, which is managed by an outside contractor. Funding for this activity may require legislative

approval. Consequently, State staff likely will experience difficulty and delays in accessing the Medicaid data they need to establish a UPL and rate for PACE.

Because Federal Medicare rates, which impact Medicaid rates, are low in Iowa, the low Medicare rates may compromise the ability of the state to set an adequate capitated Medicaid rate. The fact that HCBS rates have increased by less than two percent in Iowa over the last decade also has the potential to compromise the state's ability to set an adequate Medicaid rate. In addition, the Medicaid rate could also be adversely affected by the fact that ongoing case management is not paid for by Medicaid in Iowa in the event that this cost is not factored into the upper payment limit and rate.

Capacity

A number of developments reflect Iowa's strong capacity for PACE. The state already has elected PACE in its SPA, which was approved in 1999. The state has experience with two Medicaid managed care programs (MediPASS and Iowa Plan). In addition, the state has actively sought to identify a PACE provider and enter into a valid program agreement since 1997. When it became apparent that start-up costs were deterring interested providers from starting PACE programs, the DHS established administrative rules in September 2000 establishing grants through the Senior Living Trust Fund for the development of long term care alternatives. Funding was made available through the grant program for applicants to apply for up to $1 million for PACE program development. This funding may be used for capital or one-time expenditures to develop needed services, including (but not limited to): start-up expenses, training expenses and operating losses for the first year of operation. Some questions remain about how accessible this money is and whether it has been used in whole or in part to meet other government spending needs. In addition, legislative action is required to access these funds.

In addition, state staff within the Iowa DEA, DHS, DPH, and Iowa Finance Authority have been consistently responsive to requests for information and assistance related to the completion of this report. They already are working with key state legislators, including the appropriation chairs, to educate them about PACE and build support for funding. They are actively involved in monthly phone conferences and have consulted with NPA staff and the state administrators' list serve on a number of issues. Staff from a number of state agencies participated in the state capacity building in May, collaboratively exploring strategies for developing PACE and building next steps. State staffs, particularly those within the DEA, have a strong understanding of PACE development issues and the potential challenges they will face, including the need to acquire legislative support, licensing and certification, rate setting, oversight, and monitoring.

SECTION 9: NEXT STEPS FOR THE STATE

During the Iowa PACE Summit, participants explored potential challenges, strategies for overcoming those challenges, opportunities, and next steps for PACE in Iowa. (See, **Attachment 8 – Iowa PACE/Housing Summit**) Most of the identified challenges related to financing concerns and the need to obtain legislative action. The strategies identified for overcoming these challenges involved a broad range of education and outreach activities geared

toward state officials, legislators, providers, consumers, and advocacy organizations. Participants at the summit also identified a number of reasons why they believe PACE will work well in Iowa. These reasons included: an improved quality and preferred option for receiving care for consumers; a better way of delivering care and improving collaboration among providers; and greater predictability in expenditures, cost containment, and reduced risk for the state.

Given the findings from the Summit and within this report, there are a number of next steps which the state will need to consider in order to incorporate PACE into their long term care system. These steps include:

- Determine which state agency will serve as the administering agency for PACE;
- Identify all issues requiring legislative action and develop strategies and a timeline for obtaining the necessary legislative support for PACE;
- Secure funding, authorization, and support from state legislature to move forward with PACE;
- Update the UPL and rate setting methodology by defining comparable population in FFS, pulling data, and establishing a draft (or estimated) rate to share with prospective providers;
- Determine availability of grant funds from the Senior Living Trust Fund for PACE development;
- Finalize licensing and/or certification requirements for PACE; and
- Secure commitment from prospective providers to complete a provider application.

The state has already built a strong foundation for PACE in Iowa. Given this foundation, the state environment, state readiness, provider interest, and state demographics there is clearly an opportunity to incorporate PACE into Iowa's long term care system. The challenges which have been identified have been overcome in other states developing PACE. In addition, the State of Iowa has already begun implementing state-specific strategies for overcoming these challenges. These steps will advance the work that has already been done and will help make PACE a reality for frail elders in Iowa.