MYERS AND STAUFFER LC

South Dakota Feasibility Study on the Statewide Implementation of the Program of All-Inclusive Care for the Elderly

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About Myers and Stauffer:

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

About this Study

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

Executive Summary

On behalf of the South Dakota Department of Human Services (DHS or State), Myers and Stauffer LC (Myers and Stauffer) has conducted a feasibility study to evaluate the potential implementation of the Program of All-Inclusive Care for the Elderly (PACE). If adopted, PACE would represent a new optional State Plan service for the South Dakota Medicaid program.

PACE Background

The purpose of PACE is to delay or prevent institutional care admissions through intensive care coordination and services that allow participants to remain safely in their homes and communities. Eligible participants are 55 years or older, typically have complex medical needs, and meet the state's criteria for nursing facility level of care (LOC). An interdisciplinary team (IDT) of professionals, located at the PACE center, plan and oversee all services required for participants. Any service that is approved by the IDT is provided without regard to the typical benefit limitations associated with Medicare and Medicaid-funded services. The PACE organization (PO) acts as both a payor and a health care provider, receiving a capitated payment for coordinating and providing care. It is a model in which the PO is fully at risk for all costs.

Once a participant is enrolled in PACE, they can no longer access services through traditional Medicaid and Medicare. Instead, the PO becomes the participant's sole provider responsible for planning, providing and paying for all necessary care. The participant is guaranteed access to PACE services, but not to a specific provider. Participants are also guaranteed the right to emergency health care services whenever the need arises without prior authorization by the PACE IDT. Outside of emergency services, participants have the right to choose their health care providers within the PACE organization's network and to receive necessary care in all settings, including placement in a nursing facility when the participant can no longer live safely in the community. Participants, their caregivers, or their designated representatives are encouraged to participate in treatment decisions.[1]

A PACE participant may voluntarily disenroll from PACE at any time for any reason. PACE organizations may disenroll participants only under a very narrow set of circumstances. Per federal regulation, a PACE organization must ensure that its employees and contractors do not engage in any practice that would steer or encourage a participant to disenroll due to a change in health status.[2]

PACE Considerations

PACE has expanded and evolved since its beginning in the 1970s. As of April 2025, there are 185 POs operating in 33 states and the District of Columbia, and serving over 83,500 participants.[3] On average, states who offer PACE have between 2,000 and 2,500 participants enrolled. The National PACE Association (NPA) data indicates that 10 PACE states account for more than 83% of participants. The

[1] National Archives. Code of Federal Regulations 42 CFR 460.121(c) v. June 3, 2019.
[2] National Archives. Code of Federal Regulations 42 CFR 460.162(c) v. June 3, 2019.
[3] National PACE Association (NPA). PACE in the States. April 2025.

average number of participants in the remaining state programs, including the District of Columbia, is approximately 550.[4]

Relative to the number of participants it serves, PACE programs may require a large share of resources from both the State and POs. PACE centers often have high start-up costs and can take years to financially break even, typically requiring significant upfront capital investment. PACE is also challenging to implement in rural areas due to low population density and limited health care infrastructure. However, the benefit to individual participants and their caregivers can be life changing. The individually tailored nature of all-inclusive, 24-hour access to locally based medical care not subject to Medicaid and/or Medicare benefit limits, coupled with access to an IDT and a network of 26 different specialists creates greater opportunity for positive outcomes for PACE participants compared to their non-PACE counterparts including: [5]

- A lower probability of hospitalization and nursing facility admission for participants.
- A higher probability of participants receiving ambulatory care.
- Participants are more likely to be in good health, find life satisfying, and attend social programs at least once per week.
- Despite high care needs, over 90% of PACE participants continue to live in their community with a good quality of life for up to 4 years. [6]
- There is a lower probability of having an unaddressed visual or hearing disability, bowel/bladder incontinence, or other limits on activities of daily living (ADL) for participants.[7]
- Higher rates of consumer, caregiver, and family satisfaction with program services.[8]

South Dakota PACE Feasibility Results

PACE and the South Dakota Long-Term Services and Supports Continuum

PACE fits into the South Dakota continuum of long-term care services and supports (LTSS) as a home and community-based model of care for disabled adults over age 55. South Dakota's home and community-based services (HCBS) continuum for this population consists primarily of:

- The Home & Community Based Options and Person Centered Excellence (HOPE) waiver serving Medicaid and dually eligible Medicare and Medicaid recipients. Services are available statewide and include adult day programs, personal care services, homemaker services, nursing services, adult companion, chore services, assisted living, structured family caregiving, community living homes, home modifications, medical equipment and supplies, assistive devices, emergency

[4] Ibid.
[5] Arku D, Felix M, Warholak T, Axon DR. Program of All-Inclusive Care for the Elderly (PACE) versus Other Programs: A Scoping Review of Health Outcomes. Geriatrics (Basel). 2022 Mar 12;7(2):31. doi: 10.3390/geriatrics7020031. PMID: 35314603; PMCID: PMC8938794.
[6] C Eng, J Pedulla, G P Eleazer, R McCann, N Fox. Program of All-inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing. J Am Ger Soc, 1997 Feb; 45(2):223-32.
[7] Ibid.
[8] NPA and Vital Research. PACE Reduces Burden of Family Caregivers. August 31, 2018.

response system, meals and nutritional supplements, and respite care. As of May 2025, 2,659 participants were enrolled. There is currently no waiting list for this program.[9]

- The Dual Special Needs Plan (D-SNP) is a type of Medicare Advantage managed care plan that aligns Medicare and Medicaid benefits so they are easily accessible to dual eligibles. There are several different types of D-SNPs, which vary based on the degree of alignment, from plan coordination and to full plan integration. The different type of D-SNPs include Coordination-Only (CO), and Fully Integrated (FIDE), and Highly Integrated (HIDE). D-SNPs can be categorized by network type as HMO or PPO. D-SNPs often include extra benefits not covered by Medicare and Medicaid, such as gym memberships, healthy food allowances, transportation assistance, meal delivery, personal care assistance, bathroom safety devices, and in-home support services.[10] PACE is most similar to the integrated D-SNP plans.

  In 2022, South Dakota began offering a CO D-SNP. This type of managed care plan provides access and payment to Medicare services and coordinates with the state Medicaid program to better align Medicaid benefits. There are two plans offering three CO D-SNPs in South Dakota:[11] [12]

  - Aetna offers a statewide CO D-SNP with plan enrollment of 883 as of May 2025.
  - United Healthcare offers two CO D-SNPs serving select counties in South Dakota with a total enrollment of 3,673 as of May 2025.

- Older Americans Act (OAA) funded services are intended to help older adults remain independent in their homes and communities by providing access to nutrition, transportation, in-home support, health promotion, and caregiver support. OAA services are available for those who are not eligible for other services like the HOPE Waiver. The program serves individuals aged 60 and older and their caregivers, regardless of income, assets, or ability to pay. Individuals do not have to meet nursing facility LOC eligibility requirements. Services include case management, adult day programs, home-delivered and congregate meals, nutritional supplements, personal care, homemaker services, nursing services, chore services, respite, transportation services, medical equipment and supplies, assistive devices, caregiver support and health promotion activities.

While PACE has similarities to these three programs, the PACE goals, coordination, and services are most like those offered through the HOPE waiver. Both PACE and HOPE serve older adults and adults with disabilities who are at risk of nursing facility placement by offering services to allow them to live safely in their communities. Both programs offer similar non-medical services such as personal care, adult day health care, assistance with activities of daily living (ADL), home modifications, and caregiver supports. Key differences between PACE and HOPE are:

[9] DSS Statistical Information. https://dss.sd.gov/keyresources/statistics.aspx#medelg. May 2025.
[10] National Council on Aging. What is a D-SNP.
[11] CMS. SNP Comprehensive Report 2025-05.
[12] Codington, Corson, Custer, Davison, Day, Deuel, Dewey, Douglas, Fall River, Haakon, Hamlin, Hanson, Harding, Hughes, Hutchinson, Jackson, Kingsbury, Lake, Lawrence, Lincoln, Marshall, McCook, Meade, Miner, Minnehaha, Moody, Pennington, Perkins, Roberts, Sanborn, Spink, Stanley, Turner, Union, Walworth, Yankton, and Ziebach.

- PACE operates in approved services areas and, in most states, is typically not available statewide. In contrast, HOPE services are available statewide.
- PACE services are comprehensive, highly coordinated, and locally based. Access to care is available 24 hours a day, seven days a week from the PACE center or in the participant's home. HOPE services are not as intensively coordinated.
- PACE services are not limited to the usual Medicaid and Medicare benefit limits. The PO must provide any other service determined necessary by the IDT to improve and maintain the participant's overall health status.[13] HOPE services are subject to Medicaid benefit limits.

Overall, PACE could fit into and complement the South Dakota LTSS continuum as an additional HCBS option. The program's intensive care coordination and accessibility of services could support individuals with higher nursing facility LOC needs, allowing them to remain in their homes and delay more costly nursing facility placement.

Market Viability

Using U.S. Census data and benchmarks for PACE sustainability, the feasibility study assessed PACE viability in all South Dakota zip codes and counties. Due to low population densities and limited health care infrastructure, only two potentially viable service areas were identified: Rapid City and Sioux Falls.[14] These areas appear to have sufficient population density and health care infrastructure to deploy and sustain PACE once fully operational. However, there are three critical factors that could hinder successful implementation:

- The PACE-eligible population densities identified in this study are on the low end of what is required to financially sustain PACE.
- A 60-minute travel time appears necessary to achieve sustainable enrollment due to the low population density of both areas. However, if a PO is strategic in its outreach and enrollment approach, it may achieve higher enrollment rates at 30- and 45-minute travel times and could serve additional participants once fully operational.
- The PO transportation strategy must take into account the time it takes for this frail population to access and disembark from vehicles. This process could quickly prolong travel time beyond 60 minutes.

PACE Financial Impact

The State pays the PO a prospective monthly capitated rate for each enrolled participant. The capitation rates, per federal requirements, are determined on an annual basis as a percentage of the amount that would have otherwise been paid (AWOP) in the absence of PACE.[15] Rates are typically set by dual and non-dual populations but can also be specific to age and geographic location.

[13] National Archives. 42 CFR 460.92 Required services. June 3, 2019.
[14] In most states, PACE is not available as a statewide service. Instead, it is available in the areas determined to be sustainable in terms of population densities and health care infrastructure.
[15] National Archives. Code of Federal Regulations. 42 CFR 460.70 Contracted Services. November 27, 2024.

CBIZ Optumas (Optumas) assisted Myers and Stauffer in this study by developing a draft estimate of the South Dakota Medicaid AWOPs.[16] Optumas used claims and enrollment data to compute the draft AWOPs then compared the results to nine midwestern PACE states. The analysis showed that the South Dakota AWOPs are comparable to those states and would appear sufficient to enlist providers to offer PACE services in Rapid City and Sioux Falls.[17]

Once the AWOPs are calculated, the State must set the capitation rate as a percentage of the AWOP. In theory, paying an amount less than the AWOP generates program savings. Typically, many states establish an initial capitation rate that is close to the AWOP. As a result, cost savings may be marginal in the first years of program operations. One study, while dated, suggests that program savings could be negative in the first few years of operations for Medicaid participants.[18]

As the program matures, there may be opportunities for additional program savings because of greater levels of preventive care and the delay of institutional placement. However, the State only realizes these savings by taking a greater discount on the AWOP when setting the capitation rate. This means that access to timely, accurate, and complete encounter and financial data is essential for the State to set appropriate capitation rates.[19]

For a business entity, becoming a PO requires a significant initial investment of time, capital, and resources. The PO does not receive any payment from Medicare, Medicaid, or private payors until their program has been approved by the Centers for Medicare and Medicaid Services (CMS). PO implementation and approval can take up to three years or more.[20] Once approved, it can take between 2-5 years to ramp up program enrollment to sustainable levels so that the PO can break even financially.

State Agency Administrative Impacts

For the Department of Social Services (DSS), the state Medicaid agency, implementing PACE could have significant impacts including potential upfront costs:

- PACE is a type of managed care program. DSS operates the Medicaid program under a fee-for-service (FFS) model and lacks operational experience and the technical infrastructure needed for managed care delivery models. As a result, PACE implementation could require more initial state agency effort and a shift in resources, time, and focus away from other agency priorities.
- DSS will need to modify the nearly 50-year-old Medicaid Management Information System (MMIS) to reflect new provider types and enrollment categories. The system will be required to make capitation payments while simultaneously preventing FFS claims from being paid for PACE participants. This means the system must include claims edits and audits to prevent duplicative

[16] Optumas is not certifying the AWOPs for use in any future contract period, so the AWOPs are considered draft in compliance with actuarial standards.
[17] AWOPs are based on state specific variables and information. It is not necessarily possible to draw conclusions based on a comparison of AWOPs; other state AWOP data is presented for informational purposes only.
[18] White, Alan J; Abel, Yvonne; Kidder, David. 2000. Evaluation of the Program of All-Inclusive Care for the Elderly: A Comparison of the PACE Capitation Rates to Projected Costs in the First Year of Enrollment. Contract No. 500-01-0027. Abt Associates for the Centers for Medicare and Medicaid Services.
[19] Encounter data consists of data collected when a provider submits a claim to a managed care entity. This data includes detail on patient, diagnosis, procedures, and billing.
[20] Approval time is largely dependent on the PACE organization.

payment as well as create the capacity to collect and store PACE encounter and enrollment data. Given the age of the MMIS, this could potentially be a costly and time-consuming process to develop, test, and roll out necessary system upgrades. The opportunity cost of modifying the MMIS may outweigh the benefits. However, since PACE would be a small program, DSS could consider a work-around strategy instead of modifying the MMIS. Developing this work-around strategy would still require staff and system resources at the beginning of the program implementation, potentially placing an administrative burden on DSS and DHS.

- Additional staff and contract resources are necessary to implement, administer, and oversee PACE. This includes actuarial support to calculate the AWOP and personnel to assist with program implementation, monitoring, and oversight.

Net Fiscal Impact

Although PACE appears viable as a small program in two areas of South Dakota, if implemented, it will have both programmatic and administrative cost impacts. Program cost savings may be realized once the PO has fully ramped up enrollment and is able to break even financially, but this may take several years. Administrative costs will be incurred up front during the implementation process and will continue once the program is operational. The extent of the administrative costs, and ultimately the net fiscal impact, depends upon the State's approach to configuring the MMIS and in managing the program. Overall, the PACE financial impact in South Dakota could be marginal given the small size of the program, but implementation will require upfront state funding to support administrative requirements, particularly MMIS upgrades.

Conclusion

PACE is a promising HCBS model of care that can complement the range of LTSS services already established in South Dakota by serving those with a higher acuity of nursing facility LOC and preventing or delaying institutional care admissions. The feasibility study found that PACE is not a sustainable model for most of South Dakota due to the state's low population density and possible lengthy travel times for participants to receive PACE services. If PACE is implemented in the two potentially viable service areas of Rapid City and Sioux Falls, because the eligible population is relatively small, it will require careful consideration of these challenges, along with strategic planning and resource investment to stand up the program. Working with innovative PACE providers that understand the communities where they would operate is extremely important, as they will need to maximize opportunities for referrals and have a high enrollment penetration rate to achieve long-term financial sustainability.

Introduction

Purpose

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

Background

In 2023, the South Dakota Legislature convened the Study Committee on Sustainable Models for Long-Term Care (LTC) to identify and propose solutions to support the State's continuum of LTC services. The committee's work resulted in several proposals to strengthen the LTC continuum, including the potential expansion of HCBS. One of the Committee's HCBS recommendations called for a feasibility study to identify and evaluate potential benefits, drawbacks, and considerations for implementing a statewide PACE program and to help determine if the program is right for the state of South Dakota.

PACE Feasibility Study Approach

The PACE feasibility study consists of the following data gathering and analytical activities:

- Compilation of stakeholder feedback to identify concerns regarding the South Dakota LTC continuum and the implementation of PACE.
- Assessment of state agency capabilities, capacity, and experience necessary to administer the PACE program.
- Research and analysis of comparable states that have implemented PACE or discontinued PACE.
- PACE market assessment to identify areas of the state that appear to be viable PACE markets based on estimated eligibles, travel times, service gaps, and sufficiency of provider networks.
- Projection of PACE enrollment for service areas identified as viable.
- Development of a capitated rate following Centers for Medicare & Medicaid Services (CMS) requirements.
- Projection of the financial impact in terms of PACE costs and impact on net state revenues.

The results of these activities are synthesized into findings to assist stakeholders in making the decision of whether to implement PACE in South Dakota.

PACE Model Overview

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

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

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

PACE Model of Care

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

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

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

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

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

Eligibility

PACE-eligible individuals must be at least 55 years of age, meet clinical requirements, reside in a PO service area, and be able to live safely in the community upon program enrollment. The average PACE participant has multiple complex medical conditions, cognitive and/or functional impairments, and significant health and LTC needs. Most PACE enrollees qualify as dually eligible Medicare and Medicaid participants meaning they have benefit coverage under both programs. Individuals qualify for Medicare based on being at least 65 years of age or having a disability while Medicaid eligibility also targets low-income individuals. PACE participants can also qualify as Medicaid only, Medicare only, or private pay.

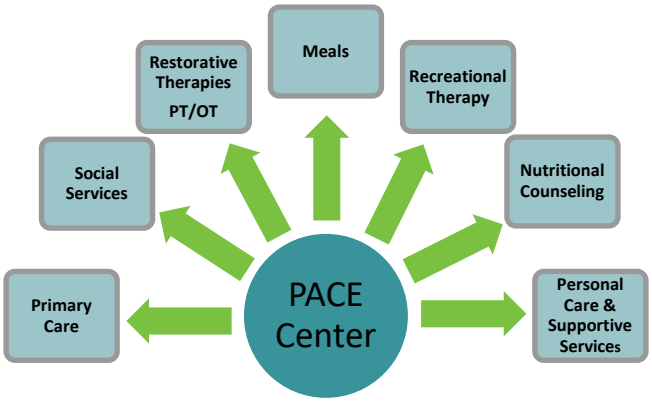
In September 2023, the NPA presented an overview of PACE to the Study Committee on Sustainable Models for Long-Term Care.[21] NPA described PACE participants as:

[21] NPA. Bringing PACE to South Dakota. September 2023.

- 95% live in the community.
- The average age is 77.
- 91% of participants are 65 years or older. 9% are age 55-64.
- For assistance with ADLs, which includes dressing, bathing, transferring, toileting, eating, and walking:
    - 26% of participants need help with 1-2 ADLs.
    - 24% need help with 3-4 ADLs.
    - 33% need help with 5-6 ADLs.
- 46% of participants have dementia.
- The top five participant chronic conditions are: 1) vascular disease; 2) major depressive, bipolar, and paranoid disorders; 3) diabetes with chronic complication; 4) congestive heart failure; and 5) chronic obstructive pulmonary disorder.

What is a PACE Organization?

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



The PO must operate at least one PACE center for its defined service area. The PACE center serves as an adult day health center that also includes a primary care clinic, restorative therapies, and areas for dining, socialization, and therapeutic recreation. The frequency of a participant's PACE center attendance is determined by the IDT based on each participant's needs and preferences.

To become operational, the PO must have an approved program agreement in effect with both the CMS and the state administering agency (SAA). This three-way agreement documents the terms for how the PO will provide comprehensive, coordinated, and community-based health care services to its participants and makes the organization financially responsible for all services required for participants.

The Interdisciplinary Team

The IDT consists of 11 professionals within the organization, including physicians, social workers, and other disciplines that meet daily to manage, monitor, discuss, and document participant care needs. The IDT creates, implements, and monitors participant-specific care plans to ensure identified care needs are met, either by PACE center staff or other network providers. The care planning process begins with an IDT assessment of the participant's needs within 30 days of enrollment and at least semi-annually thereafter. A comprehensive care plan is then designed and updated to meet each participant's needs across all care settings. The IDT is composed of at least the following members:

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

PACE Services

The PO provides comprehensive medical, health, and social services that integrate primary care, acute care, and LTC. It is responsible for providing care that meets the needs of participants across all care settings, 24 hours a day, every day of the year.

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

- Primary care.
- Nursing services.
- Social services.
- Physical therapy (PT).
- Occupational therapy (OT).
- Personal care and supportive services.
- Nutritional counseling.
- Recreation therapy.
- Meals.
- Transportation.
- Nursing Facility.
- Inpatient hospital.
- Home health care.
- Prescription drugs.
- Specialty care.
- Dental services.

As previously noted, services provided to PACE participants are not limited to those covered only by Medicare and/or Medicaid. The IDT determines what services are necessary to ensure the participant is

healthy and safe in the community. For example, in some states, Medicare and/or Medicaid may only provide coverage for one eye exam and a pair of eyeglasses within a 12-month period. However, if the IDT determines that a participant needs eye examinations more frequently or requires multiple pairs of eyeglasses, then those services and supplies will be provided. An additional example of PACE services that may not normally be covered is the installation of an air conditioning unit for a patient with asthma or congestive heart failure. If the IDT determines that an air conditioning unit is needed to improve and maintain the participant's overall health status, then the cost is covered by the PO.

POs, if unable to provide medical specialty services, must ensure access to a provider network that, at a minimum, contracts for the following 26 specialties:[22]

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

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

Community Emphasis

PACE emphasizes community — it seeks to underscore the values, beliefs, and other community customs and standards that influence health care. States should consider these factors in the identification of PACE service areas, and POs should develop their structures, service mechanisms, and staff based on the community they serve. Language barriers, cultural perceptions, stereotypes, family models, religions, and traditions all play a part in a person's access to and decisions regarding health care services. POs build community trust by tailoring their centers and services to fit the culture, beliefs,

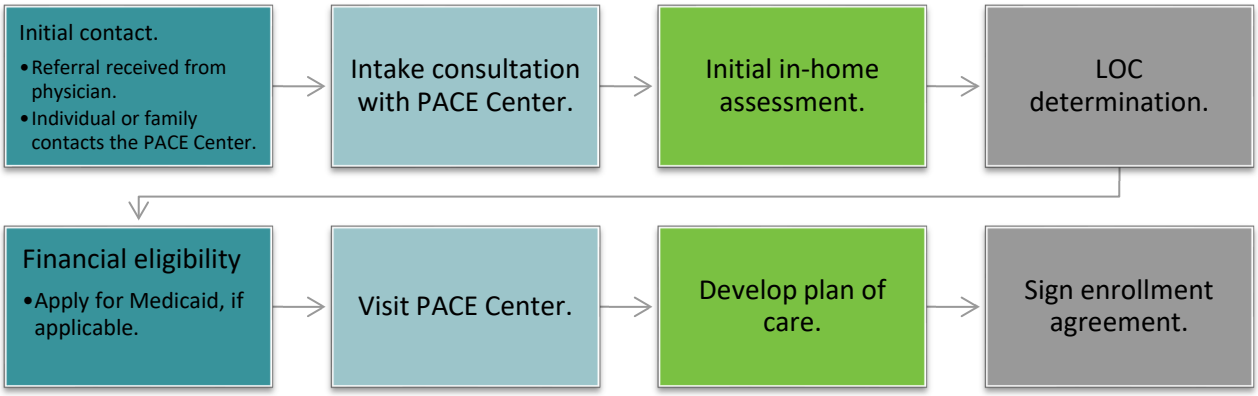
[22] National Archives. Code of Federal Regulations. 42 CFR 460.7. Contracted Services. November 27, 2024.

and values of potential and enrolled participants. In particular, the beliefs of enrollees may influence how they access services, participate in center activities, express their happiness with services, communicate with their health team, and comply with medical plans.

PACE Enrollment Process

PACE is an optional benefit under the Medicaid State Plan and participant enrollment is voluntary. The enrollment process begins with an intake consultation at the PACE center or participant's home, when necessary, followed by an in-home assessment and the nursing facility LOC and Medicaid eligibility determination.[23] If the individual meets eligibility requirements, a care plan is then developed, and an enrollment agreement with the PO is signed. Some aspects of the process may happen simultaneously. From start to finish, the enrollment process generally takes 30-45 days. Once the agreement is signed, the PO becomes the sole source of Medicaid and Medicare benefits for the participant. *Figure 1* presents a generalized PACE enrollment process from initial contact to the signed enrollment agreement. The process may vary by state.

Figure 1. PACE Enrollment Process



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

PACE participants may voluntarily disenroll from the program without cause at any time. POs may not involuntarily disenroll participants without cause. CMS maintains strict parameters around involuntary disenrollment. Participants cannot be disenrolled because of a change in their acuity or health status. Additionally, the PO must ensure its employees or contractors do not engage in any practice that would reasonably be expected to have the effect of steering or encouraging disenrollment of participants due to a change in health status.[24] If it is determined that a participant would be best serviced by transitioning to nursing facility care, the PACE organization continues to oversee and coordinate their care through the IDT while the participant is a resident at the nursing facility. All costs of service, including nursing facility services, are borne by the PACE organization. In this example, the nursing facility would bill the PACE center directly for these services.

[23] If the individual is already Medicaid eligible this step would be to confirm eligibility.
[24] National Archives. Code of Federal Regulations. 42 CFR 460.50 Participant Enrollment and Disenrollment. November 2024.

PACE Rate Setting and Program Funding

PACE is a full-risk health care model, meaning the PO is financially responsible for the total cost of all participant services. The PO is paid with a capitation payment on a per-member, per-month (PMPM) basis. Under the full-risk model concept, the capitated payment is intended to incentivize the PO to manage costs through ongoing intensive care management and the provision of preventative quality health care and social services. The PO must accept the capitated rate amount as payment in full whether it is paid by Medicaid, Medicare, or a private pay participant. The PO may not bill, charge, collect, or receive any other form of payment from the SAA, or from or on behalf of the participant, except payment with respect to any applicable spenddown liability, any amounts due under the post-eligibility treatment of income process, or Medicare payment received from CMS or from other payors.

The SAA sets the amount of the PACE monthly capitation rate based on CMS regulations that require:[25]

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

POs receive two capitation payments per month for dually eligible participants (i.e., those eligible for both Medicaid and Medicare) for their Medicaid eligibility portion and their Medicare eligibility portion, respectively. Payments for dually eligible participants comprise the majority of the PO payment types.

For Medicaid-only participants, a single capitation payment is paid for their coverage. For the remaining smaller percentage of participants that are either Medicare-only or private pay, a single capitation payment is made to the PO from the Medicare Administrative Contractor or through a private insurance premium, as applicable. *Table 1* details the typical PO payor source by census mix.

Table 1. PO Payor Source

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

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

POs combine capitation revenue into a common pool from which all administrative and health care expenses are paid. This capitated financing allows POs to deliver all required participant services rather than be limited to those strictly reimbursable under traditional Medicare and Medicaid benefits.

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

PACE Implementation

State-Level Implementation

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

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

- A feasibility study to determine whether PACE is a viable option for State implementation. This includes service area determination to identify the PACE locations (e.g., by county or zip code) that optimize the provision of program benefits. Once the service areas are confirmed, they would be included in the state's PACE procurement process.
- Development of CMS-compliant State Medicaid PACE rates.
- Procurement or application initiatives to identify and select entities best qualified to provide PACE services.
- Policy, legal, and regulatory development, including but not limited to:
    - Development and submission of a PACE State Plan amendment (SPA), reflecting that the State has elected PACE as part of its Medicaid State Plan and authorizes POs to operate in the state.
    - Potential development of PACE regulations that allow the State to establish requirements, such as provider network access (e.g., time and distance standards), fiscal soundness, licensure and/or certification, reporting, and other state-specific standards. It may be that PACE falls under existing state regulations and that new regulations are not necessary.
    - Development and dissemination of a PACE Provider Manual defining operational policy and procedures (e.g., eligibility, enrollment, disenrollment, quality, encounter data submission, oversight and reporting) for the PACE program.
- Configuration of the MMIS to manage the State's processes for PO provider enrollment, level of care determinations, participant enrollment, and PACE capitation payments. Additional MMIS modifications will be necessary so the MMIS can accept, process, and store PACE encounter data. Edits and audits must be included to confirm compliance for incorrect enrollments, rosters, and claim submissions. The system will also need to be programmed to deny FFS claims submitted when a participant is enrolled in PACE.
- Monitoring and oversight of any providers who may be undergoing the CMS application process and establishing their PACE center.

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

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

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

- **Phase 1 Program Development and Procurement**. PACE implementation typically involves a feasibility study, development of service areas, stakeholder engagement, capitation rate development, Medicaid SPA submission, State policy and procedures development, MMIS configuration, and procurement. This phase can span 12-24 months but may take longer, especially if the MMIS requires significant configuration.[26]
- **Phase 2 PACE Center and Application Procedures.** Once the State has identified an organization to enter into a PACE program agreement. This phase involves an PO application to CMS, provider construction of a PACE center, the SRR, finalization of State policy and procedures, and systems configuration. The duration of this phase is typically 18-36 months or longer[27].

PACE Organization-Level Implementation

The process of becoming a PO entails significant investment of time, capital, and resources, as well as assistance from the State. Typically, the process for PO implementation requires 18-36 months or longer[28]. It begins with the awarding of a service area from the State, construction or renovation of a

[26] Given the age and complexity of the MMIS, if a decision is made to adopt PACE, the State may wish to consider a work-around for the MMIS.
[27] The duration of this phase is largely dependent on the PACE organization.
[28] Ibid.

PACE center, hiring and training of PACE center personnel, developing provider networks, and undergoing an SRR before enrolling participants and delivering services. The capital requirements can be significant, depending on the existing capital infrastructure of the PO and the need for renovation or new construction of a PACE center. Project management and coordination is a significant investment of time for both the PO and the SAA during the implementation process.

Figure 2 details the different steps involved for an organization to become a PO once a service area has been awarded.

Figure 2. Steps Involved in Becoming a PACE Organization

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

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

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

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

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

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

The Impacts of PACE

Research

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

Overall, studies have come to the following conclusions:

- PACE provides quality and cost-effective, community-based care to older adults who could otherwise require a nursing facility or other model of care.[29]
- There has been steady census growth, good consumer satisfaction, reduction in use of institutional care, and controlled utilization of medical services.[30]
- PACE has been associated with the following statistically significant impacts:
    - **Formal support services.** A higher probability of attending a day health center and more day health center days; a lower probability of receiving nurse home visits.
    - **Utilization of medical services.** A lower probability of having a hospital admission and fewer inpatient hospital nights; a lower probability of having a nursing facility admission and fewer nursing facility nights; a higher probability of receiving ambulatory care and more ambulatory visits.
    - **Health status, quality of life, and satisfaction.** A higher probability of being in good or excellent health, finding life to be satisfying, attending social programs at least once per week.
    - **Functional status.** A lower probability of having a visual or hearing disability or weekly bowel/bladder incontinence; a lower level of ADL limitations.[31] Also, despite high care needs, over 90% of PACE participants continue to live in their community with a good quality of life for up to 4 years.
- PACE reduced family caregiver burden and provided support to improve family caregiving: [32, 33]
    - PACE programs report high rates of consumer, caregiver, and family satisfaction, generally greater than 90%.

[29] Arku D, Felix M, Warholak T, Axon DR. Program of All-Inclusive Care for the Elderly (PACE) versus Other Programs: A Scoping Review of Health Outcomes. Geriatrics (Basel). 2022 Mar 12;7(2):31. doi: 10.3390/geriatrics7020031. PMID: 35314603; PMCID: PMC8938794.
[30] Ibid.
[31] C Eng, J Pedulla, G P Eleazer, R McCann, N Fox. Program of All-inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing. J Am Ger Soc, 1997 Feb; 45(2):223-32.
[32] The Impact of PACE on Participant Outcomes, Pinka Chatterji, PhD Nancy R. Burstein, PhD David Kidder, PhD Alan White, PhD, July 1998.
[33] NPA and Vital Research. PACE Reduces Burden of Family Caregivers. August 31, 2018.

- While nearly half of family members reported a high caregiver burden at the time their loved one enrolled in PACE, more than 58% experienced less burden after enrollment.[34]
- 27% of new PACE participants scored as depressed on an assessment administered before enrollment. Nine months later, 80% of those individuals no longer scored as depressed.[35]

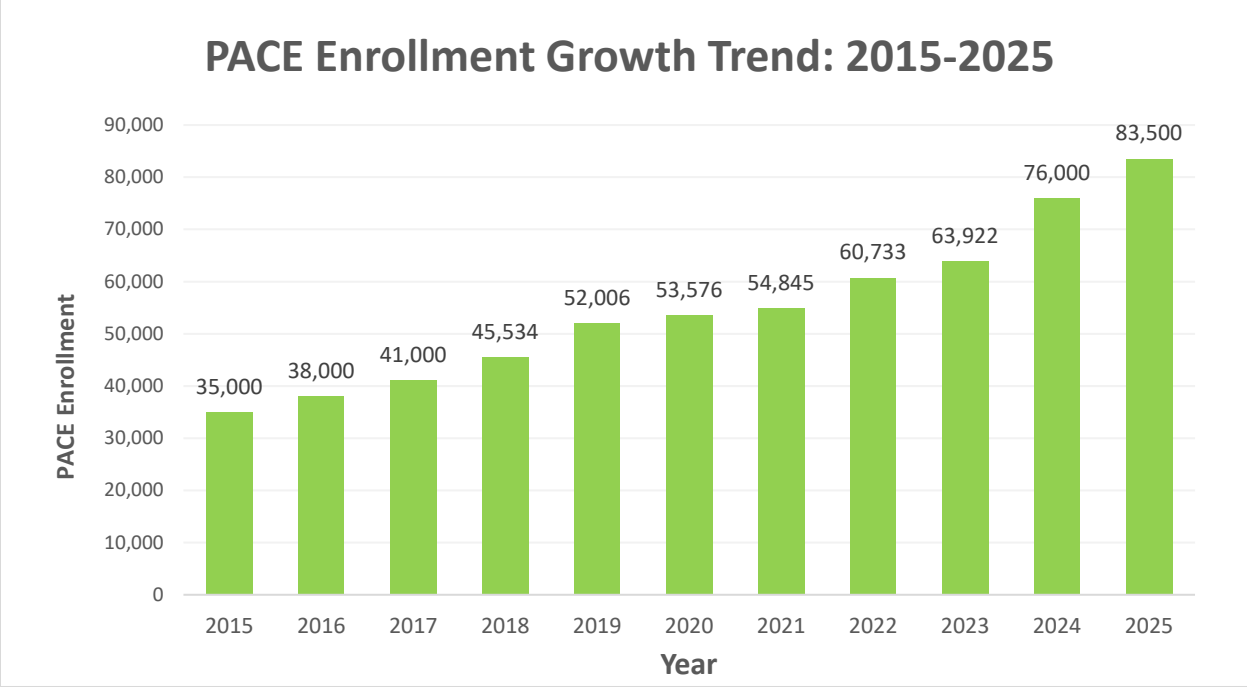
[34] NPA and Vital Research. PACE Reduces Burden of Family Caregivers. August 31, 2018.
[35] Couri, S.M., Crist, S.M., Sutcliffe, S., Austin, S. (2015). Changes in Mood in New Enrollees at a Program of All-Inclusive Care for the Elderly. The Consultant Pharmacist®, 30 (8): 463-71.

PACE Adoption by States

PACE began in the early 1970s and received authorization for federal funding as an optional state Medicaid program in 1997. Over a period of 20 years, PACE progressed to a demonstration project, then a waiver program, and eventually to a permanently recognized provider type under Medicare and Medicaid.

PACE has continued to evolve and expand with more states across the country implementing the program for the first time or expanding an existing program. Since 2015, national PACE enrollment has more than doubled, increasing from approximately 35,000 in 2015 to 83,500 in 2025. One contributing factor to the growth of PACE was the availability of American Rescue Plan Act funding. Some states elected to use this funding to explore implementing or studying the potential to implement a PACE program.[36]

Figure 3. PACE Enrollment Growth Trend: 2015-2025



According to the NPA, as of April 2025, there are 185 POs across the United States operating in 33 states, plus the District of Columbia, accounting for more than 300 PACE centers. [37] The 34 programs are at varying stages of implementation and maturity; therefore, as programs grow with increased enrollment and the addition of new POs, the participant census will continue to evolve across the states.

[36] NPA. NPA reported PACE Enrollment as of April 2025.
[37] Ibid.

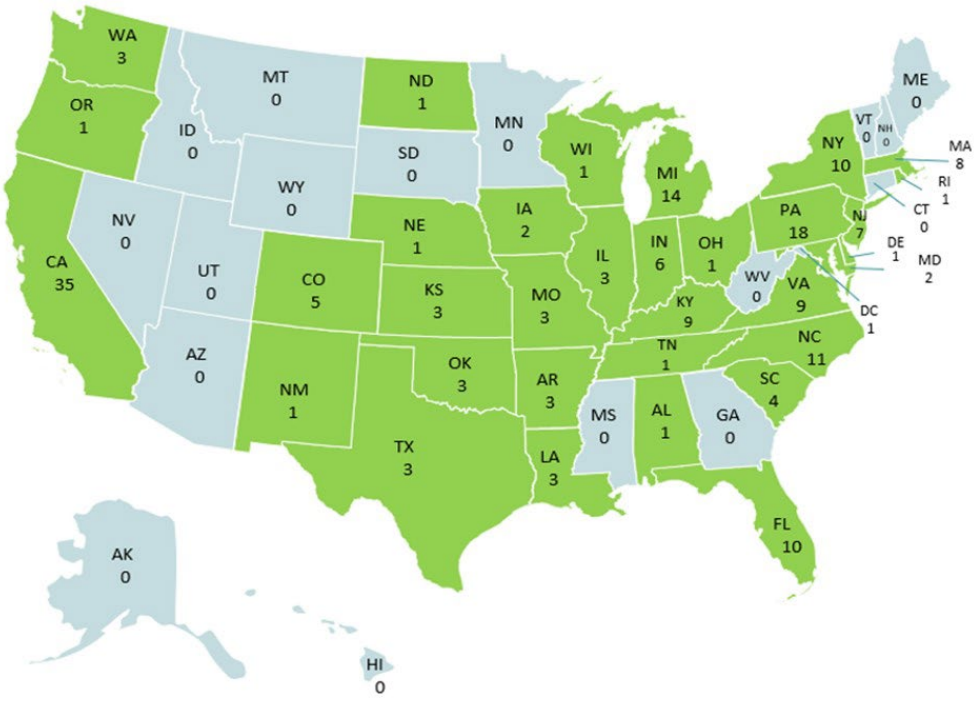
PACE Enrollment by State

PACE is a relatively small program. *Figure 4* displays the number of POs by state, and *Table 2* shows enrollment across the 34 current PACE programs as of April 2025. There are currently 17 states without a PACE program, including Alaska, Arizona, Connecticut, Georgia, Hawaii, Idaho, Maine, Minnesota, Mississippi, Montana, Nevada, New Hampshire, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

- In April 2025, Georgia issued a request for proposals to establish PACE in 13 service areas across the state.
- Wyoming participated in PACE from 2013-2021 with a center located in Cheyenne. The State discontinued PACE in 2021 due to budget restrictions. Please refer to the *State Comparative Analysis* section below for detail on Wyoming's decision to discontinue PACE.

On average, states who offer PACE have between 2,000 and 2,500 participants enrolled. Enrollment reported by NPA as of April 2025 indicates that 10 states with PACE account for more than 83% of participants. The average number of participants in the remaining state programs, including the District of Columbia, is approximately 550.[38]

Figure 4. Number of PACE Organizations by State



[38] NPA. NPA reported PACE Enrollment as of April 2025.

Table 2. PACE Enrollment by State

NPA Reported PACE Enrollment by State as of April 2025			
States and District of Columbia	**PACE Enrollment as of April 2025** ***(Report from NPA)***	**States and District of Columbia**	**PACE Enrollment as of April 2025** ***(Report from NPA)***
Total			**83,533**
California	25,560	Ohio	686
New York	10,010	Arkansas	585
Pennsylvania	8,226	South Carolina	564
Massachusetts	5,822	Kentucky	510
Michigan	5,739	Wisconsin	491
Colorado	4,897	Louisiana	471
Florida	3,351	Rhode Island	460
Virginia	2,188	New Mexico	440
North Carolina	2,115	Delaware	380
Oregon	1,996	Tennessee	271
Washington	1,718	Nebraska	212
New Jersey	1,367	North Dakota	207
Texas	1,126	Alabama	183
Kansas	1,087	Maryland	162
Indiana	871	Missouri	153
Oklahoma	815	Illinois[1]	64
Iowa	748	District of Columbia[2]	58

[1] Illinois PACE start date was June 2024

[2] District of Columbia start date was March 2023.

PACE in Comparable States

Between 2010 and 2022, the U.S. population age 65 and older increased by nearly 43% with growth occurring in every state at different rates. This trend is projected to continue with the national population age 65 and older growing from 58 million in 2022 to 82 million by 2050 (47% increase), and this group's share of the total population is projected to rise from 17% to 23%.[39] In South Dakota, the elderly population is projected to grow by 12% between 2024 and 2029.[40]

The feasibility study identified several PACE states to compare to South Dakota. However, due to similarities in terms of population density, rurality, and relatively small PACE populations, the study focuses on Kansas, North Dakota, and Wyoming. Kansas has had PACE since 2002 and North Dakota since 2008. In contrast, Wyoming administered PACE from 2013-2021. *Table 3* compares data points on population demographics and Medicaid programs.

[39] Population Reference Bureau. Fact Sheet: Aging in the United States. January 9, 2024.
[40] DHS Division of Long-Term Services and Supports. Draft State Plan on Aging 2025-2029: Needs Assessment Key Findings.

Table 3. Medicaid Population Demographics

PACE in Peer States				
	South Dakota	**Kansas**	**North Dakota**	**Wyoming**
Total Population[1]	919,318	2,940,647	783,926	584,057
Age 55 Years+	283,621	864,963	221,607	184,245
Percent 55 Years+	31%	29%	28%	32%
Age 65 Years+	169,586	518,365	133,955	112,097
Percent 65 Years+	18%	18%	17%	19%
Percent 65 Years+ with an Independent Living Disability	9%	11%	10%	9%
Percent of Households: 65 Years+ Living Alone	28%	28%	29%	29%
Counties designated as a HRSA Medically Underserved Areas/Populations and Communities[2]	63 of 66	93 of 105	52 of 53	14 of 23
Urban/Rural/Frontier	Predominantly Rural/Frontier	Rural and Urban	Predominantly Rural/Frontier	Predominantly Rural/Frontier
Medicaid Program				
Medicaid Enrollment[3]	147,234	412,106	108,758	68,773
% Elderly and Disabled	15%	23%	19%	22.6%
HCBS Waivers for Elderly and Disabled	Yes	Yes	Yes	Yes
Elderly Waiver[4] - **Current Enrollment (E)** - **Waiver Capacity (C)**	E: 2,659 C: 3,704	E: 8,138 C:11,716	E: Not Available C: 925	E:1,853 C:4,200
Dual Eligible Special Needs Plans (D-SNPs)[5]	2 plans	4 plans	1 plan	1 plan
PACE[6]	No	Yes	Yes	No
Program Start Date[6]	NA	2002	2008	2013-2021
# of POs[6]	NA	3	1	1
Urban or Rural Location[6]	NA	Urban and Rural	Rural	Urban
PACE Enrollment[6]	NA	1,087	207	NA

Sources
[1]U.S. Census Data. American Community Survey, 2023. Population, Household and Disability Reports.
[2] MUA. HRSA. May 2025 Accessed.
[3]SD DSS. https://dss.sd.gov/keyresources/statistics.aspx; KS KDADS. https://www.kancare.ks.gov/data-policy/spending-enrollment-reports WY; ND HHS. https://www.hhs.nd.gov/medicaid/data; WY DOH https://health.wyo.gov/wp-content/uploads/2025/02/2024-HealthStat-Final-Report.pdf. Waivers: SD Application for HCBS Waiver: SD0189,R07.02, Sept. 9, 2024: KS Application for HCBS Waiver: KS.0303.R06.00, Jan. 1, 2025; Application for HCBS Waiver: ND.0273.R06.04 – Jan 1, 2025: Wyoming 1115 Waiver Application, Nov. 7, 2023.
[4]Medicaid Planning Assistance. American Council on Aging.
[5] CMS. Special Needs Plan Data. https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/special-needs-plan-snp-data . April 2025.
[6] National PACE Association (NPA). PACE in the States. April 2025.

Kansas

Kansas is considered a mostly rural state but is more urbanized than South Dakota. Kansas opened its first PACE center in 2002 serving Sedgewick County, which includes the city of Wichita and is a mostly urban service area. The program expanded to Kansas City in 2008 and has plans to further expand in 2025. In 2015, Kansas added a service area, located in rural central Kansas. This is a large service area with distant travel times. To address this issue, the PO opened an alternative care site where

participants can access health care services, activities, meals, and travel a shorter distance to receive services. As of April 2025, Kansas PACE programs serve 1,087 participants.[41]

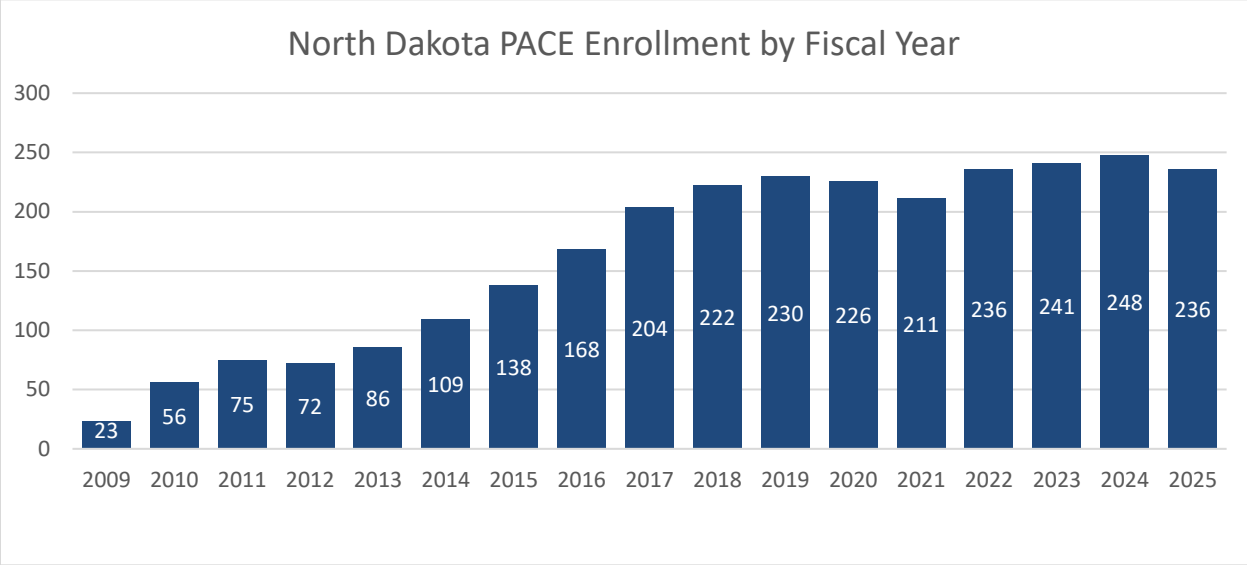
A study by the University of Kansas on behalf of the Kansas Department for Aging and Disability Services found that PACE is a cost-effective, community-based alternative for Kansans at high risk of nursing facility admission. While PACE costs more than the HCBS waiver, on average, Medicaid expenditures were similar when comparing costs for those participants with greater cognitive and ADL needs. PACE Medicaid expenditures were significantly lower than both HCBS waiver and nursing facility costs during the three months period prior to death.[42]

North Dakota

Like South Dakota, the geography of North Dakota is predominantly rural and frontier. The State opened its PACE program, Northland PACE, in 2008, with locations in Bismarck and Dickinson. In 2015, a location was opened in Minot and in Fargo in 2020. Northland PACE serves a total of 236 as of April 2025.

Since the program opened in 2008, enrollment growth has been slow but steady. *Figure 5* was presented by the North Dakota Medicaid agency and shows the slow but steady growth of the program beginning in September 2008. It took the program nearly four years to achieve enrollment of 100 participants, which is a program benchmark for PO sustainability.[43]

Figure 5. North Dakota PACE Enrollment by Fiscal Year



Wyoming

Wyoming has a rural and frontier geography. The Wyoming PACE Program consisted of one PACE service area in Cheyenne from 2013 to 2021. The program was discontinued as part of budget cuts associated with state revenue shortfalls during the COVID-19 pandemic. The program served about 140 participants

[41] NPA. NPA reported PACE Enrollment as of April 2025.
[42] Chapin, Rosemary K., Final Report: PACE Medicaid Cost-Benefit Study. The University of Kansas, School of Social Work. June 2013.
[43] North Dakota Department of Health and Human Services. PACE Enrollment. Access March 2025.

at the time it was cut. DOH made the decision to end the program for two primary reasons: PACE premiums were higher than the cost incurred for the same members outside of PACE, and PACE served only one county, and therefore, did not have a statewide impact.

In 2023, the Wyoming Legislature authorized a study to review the possibility of reinstating PACE. DOH conducted the study and found that while the program had high consumer satisfaction and successfully executed high-quality integrated and coordinated care, the program was difficult to implement and administer in rural and frontier states. The study proposed three alternative options to PACE, including (1) rate increases for adult day health programs and non-emergency transportation, (2) creating a non-risk-based bundled PACE-like program that would be paid a flat fee per day, and (3) implementation of a D-SNP.[44]

[44] Wyoming DOH. Aging in Wyoming Part III: Reviewing the Program of All-Inclusive Care for the Elderly and Alternatives. October 17, 2023.

PACE and the Continuum of Long-Term Services and Supports

LTSS refers to the continuum of HCBS and institutional services provided to individuals who need assistance with self care activities due to a physical, cognitive, or mental disability or condition.[45] These self-care activities are refered to as ADL and cover essential activities, such as eating, bathing, and dressing. LTSS also covers instrumental ADLs, which are activities that support independence, such as shopping, meal preparation, housework, and transportation.[46]

Both Medicare and Medicaid pay for LTSS but there are differences in the duration, scope, and allowable services. Medicaid funds the majority of LTSS, paying for services on behalf of individuals with limited resources and specifc medical needs.

CMS has specifc Medicaid requirements for eligiblilty, benefits, and coverage. States are allowed to operate "waiver" programs to provide services or care for individuals not normally permitted under Medicaid requirements. HCBS are covered as waiver programs and are designed to help individuals who are older or have a disability safely reside and receive care in the least restrictive and most integrated setting — meaning their home or community instead of an institutional setting. HCBS includes assisted living, personal care services, in-home services, home-delivered meals, and transportation. HCBS can also be accessed through non-Medicaid programs funded through the federal Older Americans Act and administered by the states.

Institutional care is an LTSS service that is authorized under a state's Medicaid plan in compliance with Medicaid program regulations and covers long-term stays in larger, formal settings with a focus on medical care. Institutional services include nursing care, 24-hour supervision, three meals per day, assistance with ADLs, and rehabiliation services, such as occupational, physical, and speech language therapies. Institutional care is delivered in nursing facilities and intermediate care facilities.

Medicare is a federal health insurance program for individuals who are 65 years or older and younger persons with disabilities or certain diseases. Medicare offers limited LTSS. For example, in-home support services are not covered by Medicare, while home health care may be covered on a limited basis and institutional care may be covered for up to 100 days. LTSS may also be accessed through a D-SNP, which is a managed care plan for individuals eligible for both Medicaid and Medicare. A D-SNP combines and coordinates Medicare and Medicaid benefits to make them more easily accessible to dual eligibles. There are multiple types of D-SNPs and the extent and type of LTSS available varies by plan.

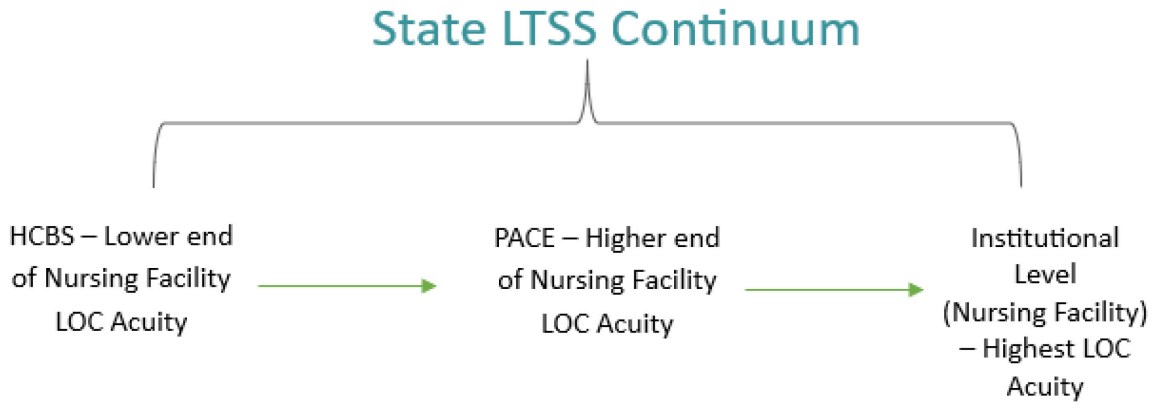
PACE fits into the LTSS continuum as a state plan HCBS by providing integrated and comprehensive health and social services, including LTC, through a PACE center serving a specific geographic area. The

[45] Congressional Research Services. Medicaid Coverage of Long-Term Services and Supports. R43328. Colello, Kirsten J. September 15, 2022.
[46] Manett. Center for Health Care Strategies, Inc. Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment: A Toolkit for States. December 2017.

IDT closely manages participant care and is accessible 24 hours a day. PACE is also not constrained by the Medicaid and Medicare coverage limits, providing it with the flexibility to provide services and support to help the participant remain safe and healthy in the community.

Figure *6* presents a general snapshot of the LTSS continuum. In most states, PACE fits into the LTSS continuum by serving participants who are nursing facility LOC but have a higher acuity than other individuals being served in HCBS waivers. PACE is positioned as an additonal option to delay more expensive nursing facility placements for eligible individuals with higher LOC needs.

Figure 6. LTSS Continuum



Current South Dakota Long-Term Care Services and Supports

South Dakota HCBS Continuum of Care for the Elderly and Physically Disabled Adults

South Dakota offers a variety of HCBS waiver and non-waiver programs for the elderly and physically disabled. Administration of HCBS programs primarily involves two state agencies — DHS and DSS. DHS, through the Division of Long Term Services and Supports, oversees and administers a Medicaid waiver and Older Americans Act funding. DSS administers the Medicaid program, including reimbursement of provider medical claims, program oversight, and Medicaid enrollment. The following section provides a summary of available HCBS programs serving older adults and adults with disabilities. *Appendix C* includes a table comparing PACE to the different South Dakota HCBS programs.

Home and Community-Based Options and Person-Centered Excellence[47]

The Home and Community-Based Options and Person-Centered Excellence (HOPE) Medicaid waiver provides medical, social, and personal care services to seniors and adults with disabilities who are at risk of nursing facility placement. The waiver offers a variety of benefits to support and promote participant health, independence, and quality of life. HOPE waiver services and supports include adult day programs, personal care services, homemaker services, and respite care. Many states with similar waiver programs have waiting lists for services; however, the HOPE waiver does not currently have a waiting list.

To qualify for the Medicaid HOPE waiver, the applicant must:

- Be age 65 or older or have a qualifying disability (ages 22-64).
- Meet nursing facility LOC.
- Meet Medicaid LTC financial eligibility.
- Have a plan of care that can justify waiver services and ensure health and welfare of applicant.

An individualized care plan determines which services a HOPE waiver participant will receive. HOPE waiver services include:

- In-home (homemaker, personal care, nursing, adult companion, chore).
- Respite/residential respite care.
- Adult day services.
- Assisted living.

[47] South Dakota DHS, Division of Long-Term Services and Supports. HOPE Waiver. Accessed April 2025.

- Structured family caregiving.
- Community living home; allows up to four individuals to live and receive care in a home-like setting.
- Community transition support.
- Environmental accessibility adaptions.
- Home-delivered meals/nutritional supplements.
- Medical equipment, supplies and assistive devices.
- Emergency Response System.

Home Again – Money Follows the Person[48]

In South Dakota, the Money Follows the Person (MFP) Demonstration is referred to as Home Again. This program is administered by DSS and assists eligible seniors with transitioning from specific facilities or institutions to home and community-based settings. Additionally, MFP provides coordination and support during the first year following a participant's transition, ensuring that individuals have the necessary resources to maintain their independence within their communities.

South Dakota Dual Eligibles Special Needs Plans

A dual-eligible special needs plan (D-SNP) is a Medicare Advantage managed care plan that coordinates Medicare and Medicaid benefits so they are easily accessible to dual eligibles. D-SNPs often include extra benefits not covered by Medicare and Medicaid, such as gym memberships, healthy food allowances, transportation assistance, meal delivery, personal care assistance, bathroom safety devices, and in-home support services.[49] There are several different types of D-SNPs, including Fully Integrated (FIDE), Highly Integrated (HIDE), and Coordination-Only (CO). D-SNPs can be categorized by network type as HMO or PPO

In 2022, South Dakota began offering a "Coordination-Only" D-SNP or CO D-SNP. This type of managed care plan does not integrate Medicare and Medicaid services but manages Medicare services and coordinates with the state Medicaid program to better align Medicaid benefits. There are three CO D-SNPs offered by two health plans in South Dakota:[50]

- Aetna offers a statewide CO D-SNP with plan enrollment of 883 as of May 2025.
- United Healthcare offers two CO D-SNPs serving select counties in South Dakota with a total enrollment of 3,673 as of May 2025.

[48] DSS. HomeAgainSD.
[49] National Council on Aging. What is a D-SNP.
[50] CMS. SNP Comprehensive Report 2025-05.

Older Americans Act Programs (Non-Medicaid)[51]

- Older Americans Act (OAA) funded services are intended to help older adults remain independent in their homes and communities by providing access to nutrition, transportation, in-home support, health promotion, and caregiver support. OAA services are available for those who are not eligible for other services like the HOPE Waiver. The program serves individuals aged 60 and older and their caregivers, regardless of income, assets, or ability to pay. Individuals do not have to meet nursing facility LOC eligibility requirements. Services include case management, adult day programs, home-delivered and congregate meals, nutritional supplements, personal care, homemaker services, nursing services, chore services, respite, transportation services, medical equipment and supplies, assistive devices, caregiver support and health promotion activities.

OAA also provides direct funding to Native American tribes to help support tribal elders living in the nine Indian reservations located across the state. Services include home-delivered and congregate meals, transportation, homemaker services, and caregiver supports.

[51] DHS Division of Long-Term Services and Supports. Draft State Plan on Aging 2025-2029: Needs Assessment Key Findings.

Potential PACE Eligibility in South Dakota

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

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

The market analysis identifies potential PACE service areas using U.S. Census data to estimate the number of PACE-eligible participants residing in each South Dakota ZIP code. An "eligible" is an individual who meets the PACE eligibility criteria but who is not enrolled in a PO. The estimate of potential eligibles is mapped to illustrate how their concentration varies by location across the state and to identify potential PACE service areas.

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

Estimate of PACE-Eligibles

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

- Individuals must be age 55 and older.
- Individuals must meet the South Dakota Medicaid clinical eligibility requirements for nursing facility LOC.
- Meet the South Dakota Medicaid financial eligibility thresholds.

These factors were applied to U.S. Census American Community Survey (ACS) data related to age, income, and disability. According to the 2022 U.S. ACS data:[52]

- South Dakota has a total population of 935,102. Of those, 285,627 or 30% are 55 years or older.

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

- Within this group, the ACS estimates that approximately 19,720 individuals, or 6.9%, have an independent living difficulty.
- When combined with economic census data and the Medicaid eligibility criteria, an estimated 4,443 South Dakotans may be eligible and likely to enroll in PACE.
- These PACE eligibles are distributed across the state but are most heavily concentrated in the Sioux Falls and Rapid City metropolitan areas. *Table 4* shows the top 10 counties with estimated PACE-eligibles.

Table 4. Top 10 Counties for Estimated PACE-Eligibles

Top 10 Counties for Estimated PACE-Eligibles	
Counties	**Estimated PACE-Eligible Persons**
Pennington	681
Minnehaha	675
Oglala Lakota	287
Brown	135
Yankton	135
Lawrence	133
Meade	133
Davison	99
Codington	93
Corson	83
All Other Counties	1,989
Total	**4,443**

The choropleth map in *Figure 7* presents the PACE-eligible individuals and ZIP codes in which they reside. The dark blue shading is used to identify ZIP codes with the highest concentration of potential PACE eligibility. The lighter green shading indicates areas with low concentrations of eligible individuals. *Table 5* presents the potential PACE eligibles by top 10 ZIP codes. The map and tables suggest that there are five areas to assess as potential PACE service areas: Aberdeen, Rapid City, Sioux Falls, Watertown, and Yankton.

Figure 7. PACE-Eligible Individuals

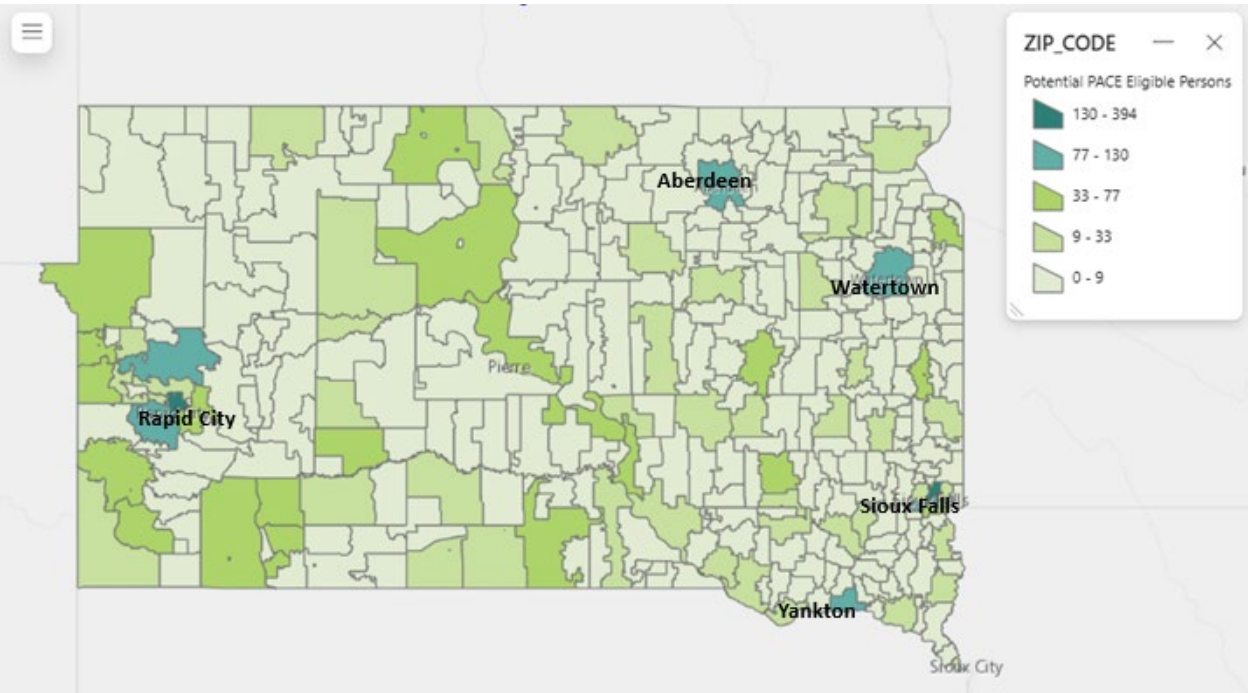


Table 5. Top 10 ZIP Codes for Estimated PACE-Eligibles

Top 10 ZIP Codes for Estimated PACE-Eligibles		
ZIP Codes	**City**	**Estimated PACE-Eligible**
57701	Rapid City	394
57104	Sioux Falls	266
57078	Yankton	130
57702	Rapid City	126
57401	Aberdeen	120
57103	Sioux Falls	114
57106	Sioux Falls	104
57201	Watertown	90
57785	Rapid City	89
57703	Rapid City	77
Subtotal Top 10 Zip Codes		**1,510 (34% of total)**
All Other ZIP Codes		**2,933 (66% of total)**
Total Estimated PACE Eligibles		**4,443**

Determining Feasible Service Areas – Market Density

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

- The Sioux Falls area includes ZIP codes that average 9-15 estimated eligible residents per square mile.
- The Rapid City area includes ZIP codes that average 5-9 estimated eligible residents per square mile.
- In contrast, most of the state, which is predominantly rural and frontier, averages less than one estimated eligible resident per square mile.

Each ZIP code in Figure *8* is shaded based on the calculated market densities. Dark blue shading represents ZIP codes with the highest density, whereas light green shading represents the lowest density. The map indicates that Rapid City and Sioux Falls have the highest population density for PACE-eligibles per square mile. However, as the map in Figure *8* clearly shows, these two areas are relatively low density per

Market Density

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

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

square mile which means longer drive times may be necessary to achieve PACE service area viability.

Figure 8. Population Density – Statewide

Estimating Enrollment

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

Geographic Considerations

The market analysis applies travel time standards of a 30-minute drive from an urban PACE center location and within 45-60 minutes of suburban and rural PACE center locations. The analysis uses the central population areas with reasonable access to hospitals and health care providers as the focus ZIP code of the proposed service areas. This focus ZIP code could be a likely location for a PACE center. For distance measurement purposes, travel time is calculated from the center of the focus ZIP code to the center of each outlying ZIP code. Travel times in urban areas can vary greatly based on the time of day. For the purposes of this analysis, travel time estimates are based on 4:00 p.m. local time. This is the time when most PACE participants are transported from the PACE center to their homes.

Results

The Rapid City and Sioux Falls metropolitan areas could each potentially support one PO each. The study considered other areas of the state but determined they were not feasible due to low PACE-eligible population density. In order to amass a number of participants to sustain PACE services in these other areas, travel times would exceed 60 minutes.

Table 6 presents estimates of the potential PACE-eligibles and participants in Rapid City and Sioux Falls. The analysis determined that, to meet the minimum requirement of a PACE service area having at least 1,000 potentially eligible individuals, a 60-minute travel time is necessary. Because there are numerous influences on enrollment decisions, the analysis looked at 30-minute and 45-minute travel times and stair-stepped participant penetration rates based on the PACE eligibility estimates. *Table 6* includes data for market penetration of 10%, 15%, and 20%. For service area development purposes, we have used the 10% benchmark for market penetration to analyze service area feasibility.

Table 6. Summary of Potentially Viable PACE Service Areas

Summary of Potentially Viable PACE Service Areas: Estimated Eligibles and Program Enrollment								
General			Population Data		Eligibility Estimates	Market Potential – Participants		
Potential Service Area	Travel Time from PACE Center	Central ZIP Code	Total Population (2022)	Age 55+ Population (2022)	Based on Clinical and Financial Analysis	Projected Enrollment @ 10%	Projected Enrollment @ 15%	Projected Enrollment @ 20%
Rapid City	30 minutes	57701	164,456	54,688	481	48	72	96
Sioux Falls	30 minutes	57104	371,802	98,510	735	74	110	147
Rapid City	45 minutes	57701	164,456	54,688	795	80	119	159
Sioux Falls	45 minutes	57104	371,802	98,510	792	79	119	158
Rapid City	60 minutes	57701	164,456	54,688	902	90	135	180
Sioux Falls	60 minutes	57104	371,802	98,510	1,027	103	154	205

The market analysis also examined other possible service areas that appear to be less feasible PACE markets due to the low number of potential eligibles and enrollment. *Table 7* displays the results. None of the five potential service areas examined approached the benchmark of having at least 1,000 potentially eligible individuals within a 60-minute drive time.

Table 7. Summary of Less Viable PACE Service Areas

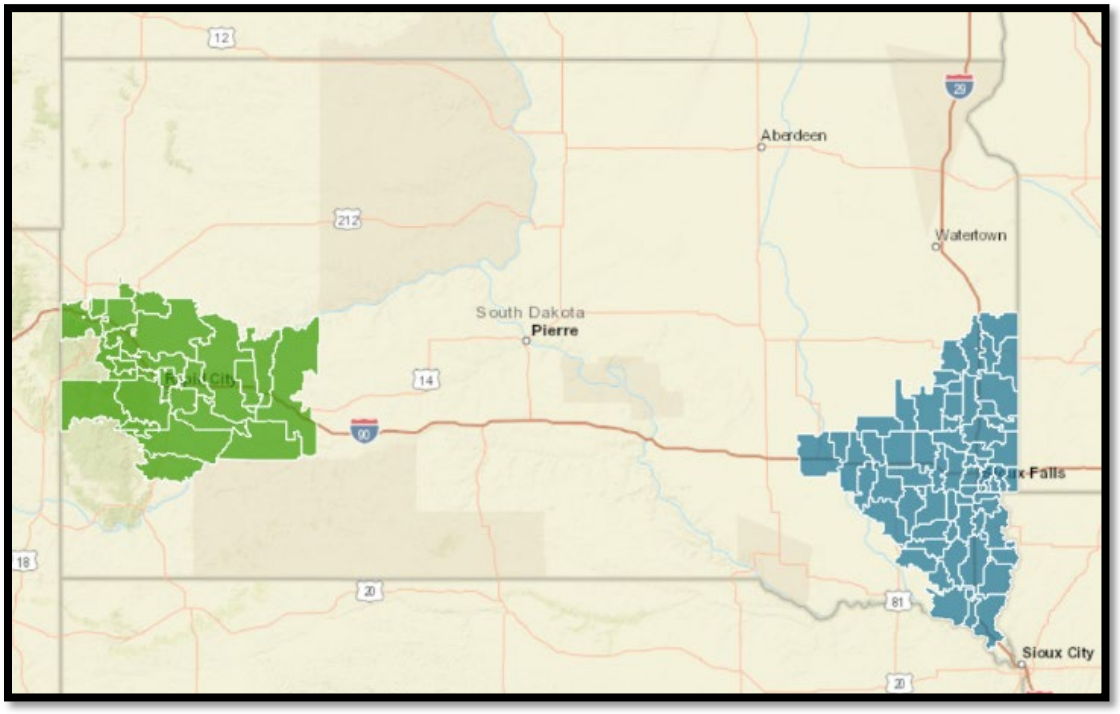
Summary of Less Viable PACE Service Areas: Estimated Eligibles and Program Enrollment								
General			Population Data		Eligibility Estimates	Market Potential		
Potential Service Area	Travel Time from PACE Center	Central ZIP Code	Total Population (2022)	Age 55+ Population (2022)	Based on Clinical and Financial Analysis	Projected Enrollment @ 10%	Projected Enrollment @ 15%	Projected Enrollment @ 20%
Aberdeen	30 minutes	57401	49,357	15,693	128	13	19	26
Watertown	30 minutes	57201	66,772	22,346	99	10	15	20
Yankton*	30 minutes	57078	38,956	13,128	141	14	21	28
Aberdeen	45 minutes	57401	49,357	15,693	138	14	21	28
Watertown	45 minutes	57201	66,772	22,346	172	17	26	24

Summary of Less Viable PACE Service Areas: Estimated Eligibles and Program Enrollment								
General			Population Data		Eligibility Estimates	Market Potential		
Potential Service Area	Travel Time from PACE Center	Central ZIP Code	Total Population (2022)	Age 55+ Population (2022)	Based on Clinical and Financial Analysis	Projected Enrollment @ 10%	Projected Enrollment @ 15%	Projected Enrollment @ 20%
Yankton*	45 minutes	57078	38,956	13,128	223	22	33	45
Aberdeen	60 minutes	57401	49,357	15,693	163	16	24	33
Watertown	60 minutes	57201	66,772	22,346	278	28	42	56
Yankton*	60 minutes	57078	38,956	13,128	283	28	42	57

**Some Yankton ZIP codes overlap with Sioux Falls.*

Based on the market analysis that considers potential eligibility, access to care, and distance assuming a 60-minute travel time, the State may wish to consider Rapid City and Sioux Falls as the most viable options for establishing PACE in South Dakota. *Figure 9* displays the ZIP code coverage of each service area based on a 60-minute drive time.

Figure 9. Potentially Viable PACE Service Areas by ZIP Code



It is important to note that the projected enrollment for Rapid City and Sioux Falls is, overall, at the low end of the spectrum of what is necessary for a PO to be financially sustainable. This means that any PO who is operating in these service areas will have to strategically assess the market to determine the most appropriate PACE center location and must exercise an innovative and targeted outreach plan to

generate sufficient enrollment to be financially sustainable. In addition, the PO will need to carefully consider and manage their transportation strategy. PACE participant transportation must take into account the time it takes for this frail population to access and disembark from vehicles. This process could quickly prolong travel time beyond 60 minutes.

Health Care Workforce in Potential PACE Service Areas

The identification of viable PACE service areas should account not only for the eligible population size and travel time but also the health care workforce availability, including specialists and direct care workers. This section of the market analysis drills down to examine the availability of health care resources in the two proposed service areas.

Rapid City PACE Service Area

The Rapid City service area is in western South Dakota and covers five counties, two of which are classified as urban:

- Butte (rural).
- Custer (rural).
- Lawrence (urban).
- Meade (rural).
- Pennington (urban).

The Health Resources and Services Administration (HRSA) has classified these counties' experience as medically underserved for certain low-income populations and in specific geographic areas related to shortages primary care, dental care, and mental health professional. The highest primary care workforce shortage is in Meade County.[53] *Appendix D* details the health professional shortage areas (HPSAs) by Rapid City service area county.

Highlights:

- There are 902 potentially PACE-eligible individuals in this service area.
- The area's highest workforce shortages are in Meade and Pennington counties.
- There are six hospitals in the area with nursing facilities, ambulance services, and dialysis facilities clustered around major roads and highways. There are also four FQHCs located throughout the service area.

Sioux Falls PACE Service Area

The Sioux Falls service area is in eastern South Dakota and covers 13 counties, two of which are classified as urban:

[53] HRSA. HPSA Find. Accessed May 2025.

- Brooking (rural).
- Clay (rural).
- Davison (rural).
- Hanson (rural).
- Hutchinson (rural).
- Moody (rural).
- Turner (rural).
- Lake (rural).
- Lincoln (urban).
- McCook (rural).
- Miner (rural).
- Minnehaha (urban).
- Union (rural).

HRSA data shows that these counties are medically underserved for low-income populations and in specific geographic areas. The highest primary care workforce shortage is in Brookings County.[54] *Appendix D* details the health professional shortage areas by Sioux Falls service area county.

Highlights:

- There are 1,027 potentially PACE-eligible persons in this service area.
- The area's highest workforce shortages are in Brookings County.
- There are 11 hospitals in the area with nursing facilities, ambulance services, and dialysis facilities clustered around major roads and highways. There are also 10 FQHCs located throughout the service area.

Network Adequacy in Potential PACE Service Areas

In July 2024, the South Dakota Department of Health (DOH) published a strategic analysis of the South Dakota rural healthcare network.[55] This report included an analysis of urban and rural area provider availability for primary care, medical specialists, and surgical specialists. Specifically, the report looked at CMS-proposed federal marketplace network adequacy standards by specialties presented in *Table 8*. The goal of the federal network adequacy standards is to ensure health insurance plans in a specific market have sufficient access to different health care provider types within reasonable travel times and without appointment delays.

The DOH study found that urban areas, especially around Sioux Falls, had an excess supply of providers in 2023. These areas are projected to maintain this excess five years into the future with the exception

[54] HRSA. HPSA Find. Accessed May 2025.
[55] South Dakota Department of Health and Guidehouse. Data Analysis Summary: Strategic Analysis of South Dakota's Rural Healthcare Programs. July 26, 2024.

of allergy and immunology specialties. The excess supply of providers is attributed to urban areas having more resources, higher population density, and a greater demand, which sustains provider practices and promotes provider competency. *Table 8* shows the types of primary care, medical specialists, and surgical specialists reviewed in the DOH study. Most of these specialties are required to be provided by the PACE center or through a PO contract with a provider and appear to be adequate in Rapid City and Sioux Falls.

The DOH study noted that, while 57% of the state's population lives in rural areas, urban areas have the most health care sites per 10,000 square miles for every type of care type except rural health care centers and Indian Health Service hospitals.

Table 8. South Dakota Health Care Network Required Providers

South Dakota Healthcare Network –Access to Providers Required by PACE Highlighted primary care and specialty types must be covered either by the PO or through PO contract		
Primary Care	**Medical Specialties**	**Surgical Specialties**
Family Practitioners	Allergy and Immunology	Cardiothoracic Surgery
Internists	Cardiology	Otorhinolaryngology
Pediatricians	Dermatology	General Surgery
	Endocrinology	Neurosurgery
	Gastroenterology	Gynecology
	Hematology/Oncology	Ophthalmology
	Neonatology	Orthopedic Surgery
	Nephrology	Plastic Surgery
	Pulmonary Medicine	Urology
	Radiation Therapy	Vascular Surgery
	Rheumatology	
	Physical Medicine/Rehabilitation	
	Podiatry	
	Psychiatry	
	Radiology – Interventional	

Highlighted primary care and specialty types must be covered either by the PO or through PO contract.

Trends in the Direct Care Workforce

Direct care workforce (DCW) plays an essential role in preserving the quality of life for older adults by promoting their independence and aiding them to live safely in their homes and communities. DCW includes certified nursing assistants, home health aides, and personal care aides. They provide services in private homes, group homes, residential care facilities, assisted living facilities, continuing care retirement communities, as well as nursing facilities and hospitals.[56]

As South Dakota's population ages, there will be a huge increase in the demand for DCW to assist with daily activities like bathing, dressing, cooking, and medication management. According to the Paraprofessional Healthcare Institute (PHI), by 2032, South Dakota will have over 17,300 DCW job openings.[57] This is an important consideration for PACE, as DCWs play a crucial role in helping participants remain safely at home,

[56] PHI. Understanding the Direct Care Workforce. (n.d.). March 17, 2022.
[57] PHI. South Dakota – Key State Characteristics.

especially when their care needs surpass the capacity participant or their family caregivers.[58] If the State decides to add PACE as an option, a potential PO's plans to recruit and maintain DCW should be closely examined.

Health Care Workforce and Network Adequacy Conclusions

HRSA has identified health professional shortage areas in Rapid City and Sioux Falls for some low-income populations and certain geographic areas. However, the DOH study indicates that there is adequate access to primary care and medical specialties in these two service areas to support a PACE center. While the demand for DCW will grow as the South Dakota population ages, these service areas are best positioned to access workers.

[58] Springer Nature Link. Community-Based Integrated Care for Older Adults – The Role of Direct Care Providers in PACE. Holmes, April; Newmuis, Renee. August 17, 2022. In: McNabney, M.K. (eds).

South Dakota PACE Capitated Rate

To receive federal funding, CMS requires states to set monthly PACE capitation rates that are less than the AWOP in the absence of PACE.[59] The AWOP represents the costs associated with the following PACE eligibility requirements:

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

Optumas developed draft AWOPs for the PACE feasibility study. Because Optumas is not certifying these AWOPs for use in any future contract period, the AWOPs are considered draft in compliance with actuarial standards. The Optumas AWOP report is available in *Appendix D: AWOP Actuarial Report*.

Approach

Optumas developed the South Dakota AWOPs using base period Medicaid claims and enrollment data for State Fiscal Year (SFY) 2024. This data reflects the experience for Medicaid individuals who meet PACE eligibility requirements and either reside in a nursing facility or are enrolled in either South Dakota's HOPE or ADLS HCBS waivers. Claims for these two waivers are included, as they reflect the nursing facility institutional equivalent used for PACE. Individuals on other waivers were not included. The data includes all State Plan services for the identified individuals meeting PACE eligibility requirements. Analysis was also performed to identify the service area-specific AWOPs for Rapid City and Sioux Falls; these were further broken down into dual eligible (i.e., those eligible for Medicaid and Medicare) and nondual eligible (i.e., Medicaid only) AWOPs.

Once the base data was compiled and analyzed, Optumas applied a series of high-level adjustments to arrive at the projected AWOPs. Adjustments were made for an estimate of incurred but not reported claims, nursing facility and HCBS policy changes in SFY 2025 and SFY 2026, pharmacy rebates, trended from the SFY 2024 base data period to the SFY 2026 rating period, and costs for Medicaid administration were applied. The draft AWOP estimates were developed on a blended basis which reflects combining the nursing facility and HCBS waiver population PMPM costs.

The resulting draft SFY 2026 AWOPs are presented in *Table 9*. To establish a PACE capitated payment rate, the State would apply a discount to the AWOP. *Table 9* shows a 95% AWOP for informational purposes only.

[59] National Archives. Code of Federal Regulations. 42 CFR § 460.182. October 1, 2002.

Table 9. SFY 2026 Draft PACE AWOPs

SFY 2026 DRAFT PACE AWOPs			
Service Area	**Dual Status***	**AWOP**	**Capitation Rate at 95% of AWOP**
Rapid City	Dual	$5,373	$5,104
Rapid City	Non-Dual	$9,123	$8,667
Sioux Falls	Dual	$5,374	$5,105
Sioux Falls	Non-Dual	$7,981	$7,582

**The dual amount shown represents the Medicaid share of the dual-eligible AWOP. It does not include the Medicare amount that would be paid to the PO. Non-dual eligible reflects the AWOP for Medicaid-only participants.*

PACE State AWOP Comparison

Optumas compared a blended South Dakota PACE AWOP for dual-eligibles in the Sioux Falls and Rapid City potential service areas to the dual-eligible AWOPs for nine PACE states in the midwestern United States. The dual eligible AWOPs were selected for comparison since this cohort consists of approximately 85% of participants. Across the nine states, the AWOPs ranged from $5,000 to $8,800. The South Dakota dual AWOP is $5,400 and appears adequate to enlist providers to offer PACE services. *Figure 10* charts the different dual-eligible AWOP amounts for the nine states and South Dakota. *Table 10* details the state-specific dual AWOP amounts.

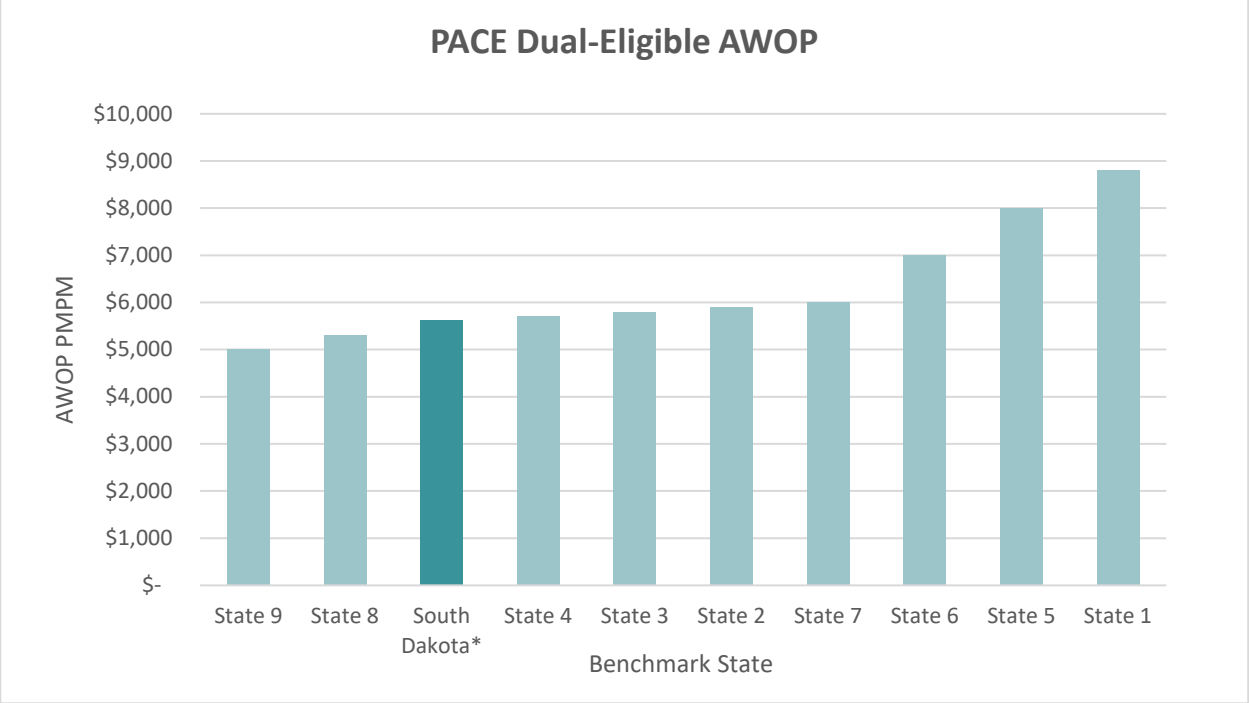
Table 10. State-Specific AWOP Amounts[60]

Benchmark State	Dual AWOP*
State 9	$5,000
State 8	$5,300
South Dakota**	$5,400
State 4	$5,700
State 3	$5,800
State 2	$5,900
State 7	$6,000
State 6	$7,000
State 5	$8,000
State 1	$8,800

**AWOPs are rounded to the nearest hundred.*
***South Dakota AWOP reflects the average Dual AWOP for the potential PACE service areas of Sioux Falls and Rapid City.*

[60] AWOPs are based on state specific variables and information. It is not necessarily possible to draw conclusions based on a comparison of AWOPs; other state AWOP data is presented for informational purposes only.

Figure 10. Dual-Eligible AWOP PMPM Amounts



The draft AWOPs identified for the Sioux Falls and Rapid City potential PACE service areas are in alignment with other state AWOPs and appears to be adequate to support the program.[61]

[61] AWOPs are based on state specific variables and information. It is not necessarily possible to draw conclusions based on a comparison of AWOPs; other state AWOP data is presented for informational purposes only.

PACE Cost Analysis

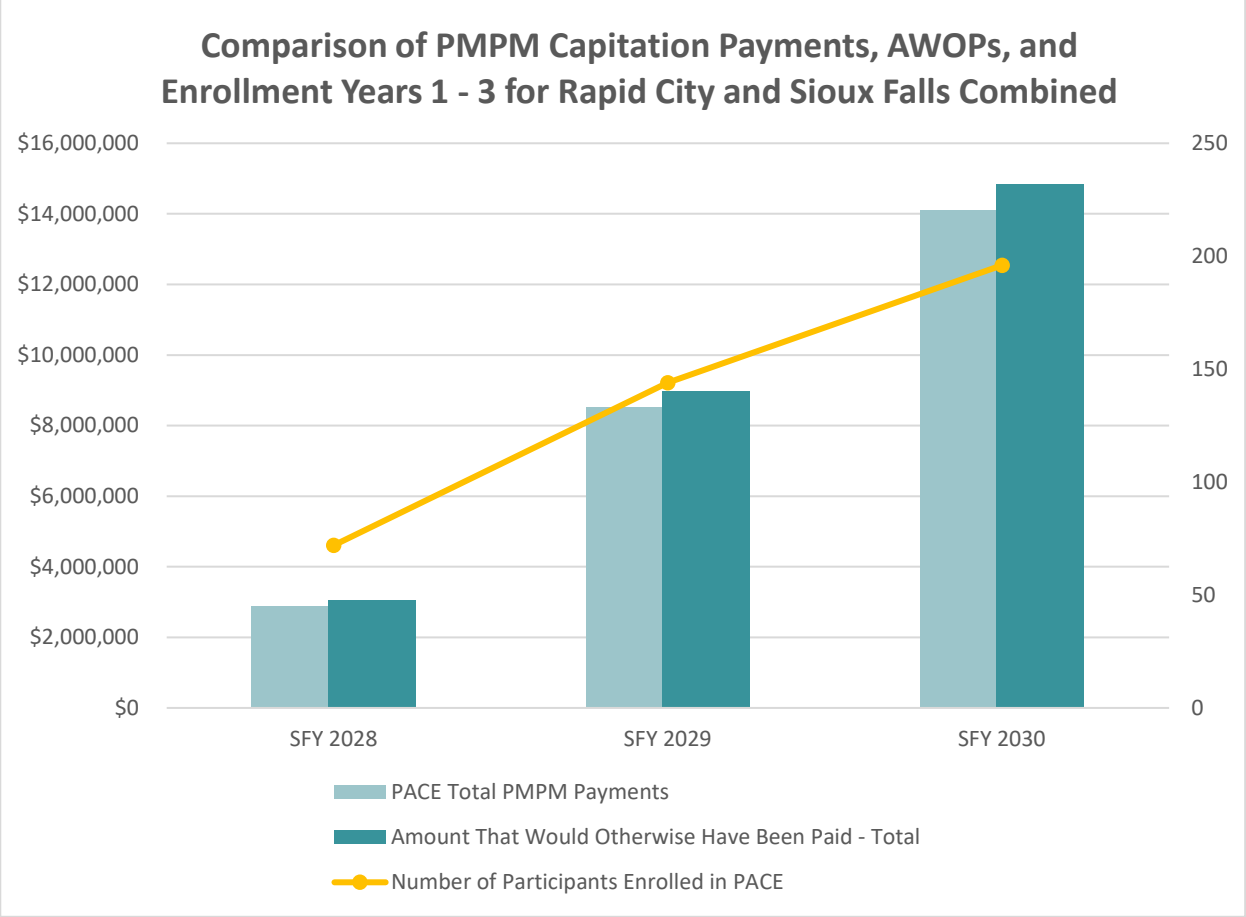
PACE implementation and operation has both programmatic and administrative cost impacts. The program cost impact may be realized once the PO has fully ramped up enrollment and is able to break even financially. Administrative cost will be incurred up front during the implementation process and will continue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

Program Costs

For program costs, the federal AWOP requirement means that the capitation rates paid by Medicaid may result in cost savings relative to the expenditures that would otherwise be paid for a comparable population not enrolled in PACE.

There are numerous factors that influence the extent and timing of program savings. These factors include the length of time the PACE program has been active, the availability of PACE data to inform rate setting, the number of participants enrolled in PACE, and the participants' resource needs, among others. For example, if South Dakota were to open two PACE centers, each with an approved census of 100 individuals, it could take 3-5 years, or longer, for the PO to reach full enrollment and break even financially. POs typically enroll 2-6 participants each month. *Figure 11* charts this example showing the initial PO enrollment over three years and displaying the federal and state fund expenses during the three-year ramp-up period. This chart indicates that, because of the small size of the centers and the three-year ramp-up period, state fund impacts are likely to be minimal during the first few years of program operation.

Figure 11. Comparison of PMPM Payments, AWOPs, and Enrollment - Years 1 through 3



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

- A higher probability of the PACE participant being in good health and delaying nursing facility placement.[62]
- A higher probability of fewer emergency department visits, hospital admissions, and shorter inpatient hospital stays.[63]
- A higher probability of fewer nursing facility admissions and shorter nursing facility stays.[64]
- A higher probability of fewer health care costs during the last three months of life compared to non-PACE participants.[65]

[62] C Eng, J Pedulla, G P Eleazer, R McCann, N Fox. Program of All-inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing. J Am Ger Soc, 1997 Feb; 45(2):223-32.
[63] Ibid.
[64] The Impact of PACE on Participant Outcomes, Pinka Chatterji, PhD Nancy R. Burstein, PhD David Kidder, PhD Alan White, PhD, July 1998.
[65] University of Kansas, School of Social Welfare. Program of All-inclusive Care for the Elderly Medicaid Cost-Benefit Study. Chapin, Rosemary K.; Wendel, Carrie; Lee, Robert; Landry, Sarah; Zimmerman, Mary K.; Oslund, Pat; Bruns, Kim; Leedahl, Skye; Hill, Jacqueline; Rachlin, Roxanne; Sergeant, Julie. June 2013.

The State can realize these potential savings by applying a greater percentage discount off AWOP when setting the capitation rate. This means that access to timely, accurate, and complete encounter and financial data is essential for the State to measure potential savings when establishing the appropriate PACE capitation rate.[66]

State Administering Agency Costs

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

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

For the SAA, implementing PACE will likely have significant impacts including potential upfront costs associated with staffing needs, additional contracting, and MMIS configuration. Also of concern is the fact that PACE is a type of managed care program; South Dakota Medicaid operates an FFS system and appears to have limited experience with managed care. The learning curve for the agency could put pressure on personnel by requiring more staff time and effort and potentially shifting staff and funding away from other agency priorities.

The PACE service areas identified in this feasibility study have a small number of eligibles, and at most, would support two PACE centers. Typically, one additional State staff position is recommended for every two to three new PACE centers. Additional personnel with project management, clinical, or financial backgrounds may be required during implementation and for any State-defined assessment reviews once the program is operational. The State could hire or contract for this support. DSS would also need to contract for actuarial services to calculate the AWOP amounts on an annual basis.

The most significant potential cost associated with PACE implementation is the configuration of the nearly 50-year-old MMIS. The system will need to be modified to reflect new provider types and eligibility categories to make capitated payments, including necessary edits and audits to prevent duplicative billing and to create the capacity to collect and store PACE encounter data. In addition, the timing involved with locating expertise to update, test and roll out necessary change orders could prolong the PACE

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

implementation process. When a participant is enrolled in PACE they may not be enrolled in any other program. The MMIS must be programmed to prevent this situation and the potential of payment of FFS claims received during a participant's PACE enrollment. Given the age and complexity of the MMIS, this could potentially be a costly and time-consuming process to develop, test, and implement necessary system upgrades. The opportunity cost for this configuration may be too high relative to the benefit. If the State elects to adopt PACE, DSS may wish to consider a work-around strategy in lieu of MMIS modification until a longer-term solution could be developed.

Estimated Cumulative Net Cost Impact

Table 11 displays a hypothetical scenario in which South Dakota implements a PACE center in Rapid City and in Sioux Falls. The table projects costs beginning in SFY 2026 through SFY 2031 and assumes that the POs are paid a capitated rate that is 95% of the AWOP. When compared to the AWOP, this results in program savings accumulating as enrollment ramps up.

Next, the table estimates the state agency costs to administer the program. When factoring in state agency costs, the net program savings from PACE will not be immediately realized and could result in increased costs. This is dependent on the State's approach to program administration and rate setting. Based on the cost of a South Dakota administrator position, the estimated cost of the new position, including fringe benefits, is $132,000. Additional personnel with project management, clinical, or financial backgrounds may be required during implementation and for any State-defined assessment reviews once the program is operational. The SAA will also need to contract for actuarial services to calculate the AWOPs on an annual basis. This analysis assumes a cost of $325,000 per year during implementation for contracted staffing and actuarial support and that this cost decreases to $150,000 once the POs are operational.

According to DSS and based on prior MMIS upgrades, the MMIS updates necessary to support PACE could cost as much as $10 million total funds. If the State decides to move forward with PACE there are two options available to address this high cost:

- The State could delay PACE implementation until a modern MMIS technology is introduced.
- The State could consider a less expensive work-around solution pending MMIS modernization. This option may be feasible given the small size of the program and the slow enrollment ramp up process.

Because work around options may be available, the table on the hypothetical scenario does not include the MMIS PACE update costs.

In the hypothetical scenario, costs are shown during a 2-year implementation period, a 3-year PO enrollment ramp-up period, and a final year with the PO at full enrollment. The net impact over this 6-year period is a $47,066 decrease in total fund cost but with a $9,325 increase is state funds due to initial administrative costs. If the full MMIS update, estimated to cost $10 million, were included in the

hypothetical scenario, then the net impact over this 6-year period is a $9.9 million increase in total fund cost of which $1 million is state funds.[67]

Table 11. Hypothetical PACE Implementation Scenario

PACE Implementation Hypothetical Scenario for 10% Penetration Rate and 60 Minute Drive Time: Net Impact to State Revenues SFY 2026 – SFY 2031						
Program Detail	**SFY 2026 Cost**	**SFY 2027 Cost**	**SFY 2028 Cost**	**SFY 2029 Cost**	**SFY 2030 Cost**	**SFY 2031 Cost**
No PACE – 100% AWOP						
Rapid City	-	-	$1,485,321	$4,377,052	$7,042,890	$7,380,896
Sioux Falls	-	-	$1,558,610	$4,593,027	$7,790,271	$8,864,415
Total	**-**	**-**	**$3,043,931**	**$8,970,079**	**$14,833,161**	**$16,245,311**
State Share	**-**	**-**	**$1,475,546**	**$4,348,246**	**$7,190,375**	**$7,874,915**
PACE Program Costs – 95% AWOP						
Rapid City	-	-	$1,411,055	$4,158,199	$6,690,745	$7,011,851
Sioux Falls	-	-	$1,480,680	$4,363,246	$7,400,758	$8,421,194
Total	**-**	**-**	**$2,891,735**	**$8,521,445**	**$14,091,503**	**$15,433,046**
State Share	**-**	**-**	**$1,401,768**	**$4,131,197**	**$6,830,856**	**$7,481,169**
Difference Total			**($152,197)**	**($448,634)**	**($741,658)**	**($812,266)**
State Share			**($73,778)**	**($217,049)**	**($359,519)**	**($393,746)**
State Administrative Costs						
PACE Administrator	$131,912	$136,133	$140,490	$144,985	$149,625	$154,413
MMIS Update	Cost depends upon the update approach. A full MMIS update could cost as much as $10 million. MMIS work around approaches may be a less expensive alternative option but the cost would depend upon the approach. Therefore, no cost is shown for the MMIS update.					
Additional Staff or Vendor Support	$325,000	$325,000	$150,000	$150,000	$150,000	$150,000
Total	**$456,912**	**$461,133**	**$290,490**	**$294,985**	**$299,625**	**$304,413**
State Share	**$228,456**	**$230,567**	**$145,245**	**$147,493**	**$149,812**	**$152,206**
Total Program and Administrative Cost Impact of PACE						
Total Funds Impact	**$456,912**	**$461,133**	**$138,293**	**($153,649)**	**$442,033)**	**($507,853)**
Net State Funds Impact	**$228,456**	**$230,567**	**$71,467**	**($69,556)**	**($209,707)**	**($241,540)**

**Assumes the PACE rate is 95% of AWOP for SFY 2028 through SFY 2031. State fund savings will increase if the rate is reduced to a lower percent of AWOP or if there are more PACE participants.*
***Applies annual trend of 3.5% to the SFY 2028-SFY 2031 AWOPs.*
****Calculates a weighted FMAP of 51.52% for SFY2026 using the FFY 2025 and FFY 2026 FMAPs. Uses this FMAP for SFY2027-2031.*

[67] Assumes 90% federal financial participation for design and development of the PACE MMIS update. Refer to https://www.medicaid.gov/medicaid/data-systems/medicaid-management-information-system.

Findings

The table below summarizes the general benefits, challenges, and drawbacks of PACE identified in this study.

Table 12. PACE Benefits, Challenges, and Drawbacks

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

Sources:

[1] Arku, Daniel et al. "Program of All-Inclusive Care for the Elderly (PACE) versus Other Programs: A Scoping Review of Health

[2] Outcomes. "Geriatrics (Basel, Switzerland)vol. 7,2 31. 12 Mar. 2022, doi:10.3390/geriatrics7020031

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

PACE Implementation in South Dakota

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

South Dakota Market Analysis Results

- Using U.S. Census data and benchmarks for PACE sustainability, the feasibility study identified Rapid City and Sioux Falls as potentially viable PACE service areas in terms of population density and accessible health care infrastructure.
    - Other areas of South Dakota were examined, but low population densities and limited health care infrastructure would make PACE challenging to implement and sustain.
- The feasibility study estimates the number of potential PACE-eligibles or individuals who meet the PACE eligibility criteria but are not enrolled in a PO. In this analysis, the study applies a standard of 1,000 eligibles in a service area as the minimum benchmark for program sustainability.

  The feasibility study identified 902 potential PACE-eligibles in Rapid City and 1,072 potential PACE-eligibles in Sioux Falls based on a 60-minute travel time.
    - Given this low number of potential PACE-eligibles, a PO would need to maximize opportunities for referrals and achieve a high penetration rate for participant enrollment to ensure long-term financial sustainability.
    - While this study showed a 60-minute travel time was necessary to achieve sustainable enrollment given the low population density of both areas, if a PO is strategic in its outreach and enrollment approach, it may achieve higher enrollment rates at 30- and 45-minute travel times. This could allow for the potential to serve a higher number of participants once fully operational.
    - When examining travel times, a PO must consider how it will manage its transportation services given that travel times may be longer due to multiple stops and the timing associated with this frail population accessing and disembarking the PACE vehicle.

PACE Capitation Rates

- States pay a prospective monthly capitated rate on behalf of each PACE-enrolled Medicaid participant. The capitation rates, per federal requirements, are determined on an annual basis as a percentage of the AWOP in the absence of PACE.[68] AWOPs are typically set by dual and non-dual populations.
- Optumas performed actuarial analysis to calculate the AWOPs for the Rapid City and Sioux Falls service areas by using Medicaid claims and enrollment data for the PACE equivalent population

[68] National Archives. Code of Federal Regulations. 42 CFR 460.70 Contracted Services. November 27, 2024.

residing in nursing homes or receiving services through the HOPE and ADLS waivers. They compared the draft AWOPs to nine midwestern PACE states. The analysis showed that the South Dakota AWOPs are in alignment with the nine states and would appear adequate to interest providers and support PACE in Rapid City and Sioux Falls.[69] *Table 13* presents the draft AWOPs.

Table 13. SFY 2026 Draft PACE AWOPs

SFY 2026 DRAFT PACE AWOPs			
Service Area	**Dual Status***	**AWOP**	**Capitation Rate at 95% of AWOP**
Rapid City	Dual	$5,373	$5,104
Rapid City	Non-Dual	$9,123	$8,667
Sioux Falls	Dual	$5,374	$5,105
Sioux Falls	Non-Dual	$7,981	$7,582

**The amount shown represents the Medicaid share of the dual-eligible AWOP. It does not include the Medicare amount that would be paid to the PO. Non-dual-eligible reflects the AWOP for Medicaid-only participants.*

State Agency Administrative Concerns and Impacts

- PACE is a type of managed care program. The State lacks experience and the technical infrastructure necessary for administering managed care. The learning curve could put pressure on personnel by requiring more time and effort and by potentially shifting staff and funding away from other agency priorities.
- At least one additional State full-time position is recommended for every 2-3 new PACE centers. The State will also need to contract for actuarial assisting in setting AWOPs. Additional staff and contract resources may be necessary to implement, administer, and oversee PACE. This includes actuarial support to set the AWOP and clinical support to assist with program implementation, monitoring, and oversight.
- The most significant concern for state agency capacity and resource impacts is the configuration of the nearly 50-year-old MMIS. The system will need to be modified to reflect new provider types and eligibility categories to make capitated payments, including necessary edits and audits to prevent duplicative billing and to create the capacity to collect and store PACE encounter and enrollment data. In addition, the timing involved with locating expertise to update, test, and roll out necessary change orders could prolong the PACE implementation process. Based on prior review of MMIS upgrades, DSS estimates the PACE MMIS configuration could cost as much as $10 million.

[69] AWOPs are based on state specific variables and information. It is not necessarily possible to draw conclusions based on a comparison of AWOPs; other state AWOP data is presented for informational purposes only.

PACE Financial Impact

- PACE has both programmatic and administrative cost impacts.
    - A full picture of the program cost impact will be realized once the POs have fully ramped up enrollment and is able to break even financially.
    - Administrative cost will be incurred up front during the implementation process and will continue once the program is operational. The extent of the administrative costs, and ultimately net fiscal impact, depends upon the State's approach to managing the program.
- Once the AWOPs are calculated, the State sets the capitation rate as a percentage of the AWOP. Typically, many states establish an initial capitation rate that is close to the AWOP. This means that PACE cost savings may be marginal in the first few years of program operations.
- When the program is finally operating at full enrollment, there may be additional program savings because of greater levels of preventative care and the delay of institutional placement. The State can only realize these savings by taking a higher discount off the AWOP when setting the capitation rate. This means that access to timely, accurate, and complete encounter and financial data is essential for the State to set appropriate capitation rates.[70]
- Depending on the State's administrative approach, any program savings may be offset by the cost of new staff, MMIS updates, and contracting for actuarial and other support services. The bulk of these costs will be during implementation, driven by the MMIS configuration to support the program.
- Overall, the PACE financial impact in South Dakota will be marginal given the small size of the program but will require upfront state funding to support administrative requirements.

Other PACE Challenges and Concerns

- **PO Financial Burden.** POs carry the entire financial burden of operations until the PACE center opens and has reached the break-even point of enrollment. The PO financial burden includes a significant initial investment of time, capital, and resources. The PO does not receive any payment from Medicare, Medicaid, or private payors until their program has been approved by CMS. PO implementation and approval can take up to two years. Once approved, it can take 2-4 years to ramp up program enrollment to sustainable levels so the PO can break even financially.
- **Limited Service Areas.** PACE would not be available to address the needs of older adults living outside the Rapid City and Sioux Falls areas and could pull state agency resources away from developing needed services and supports in these areas.

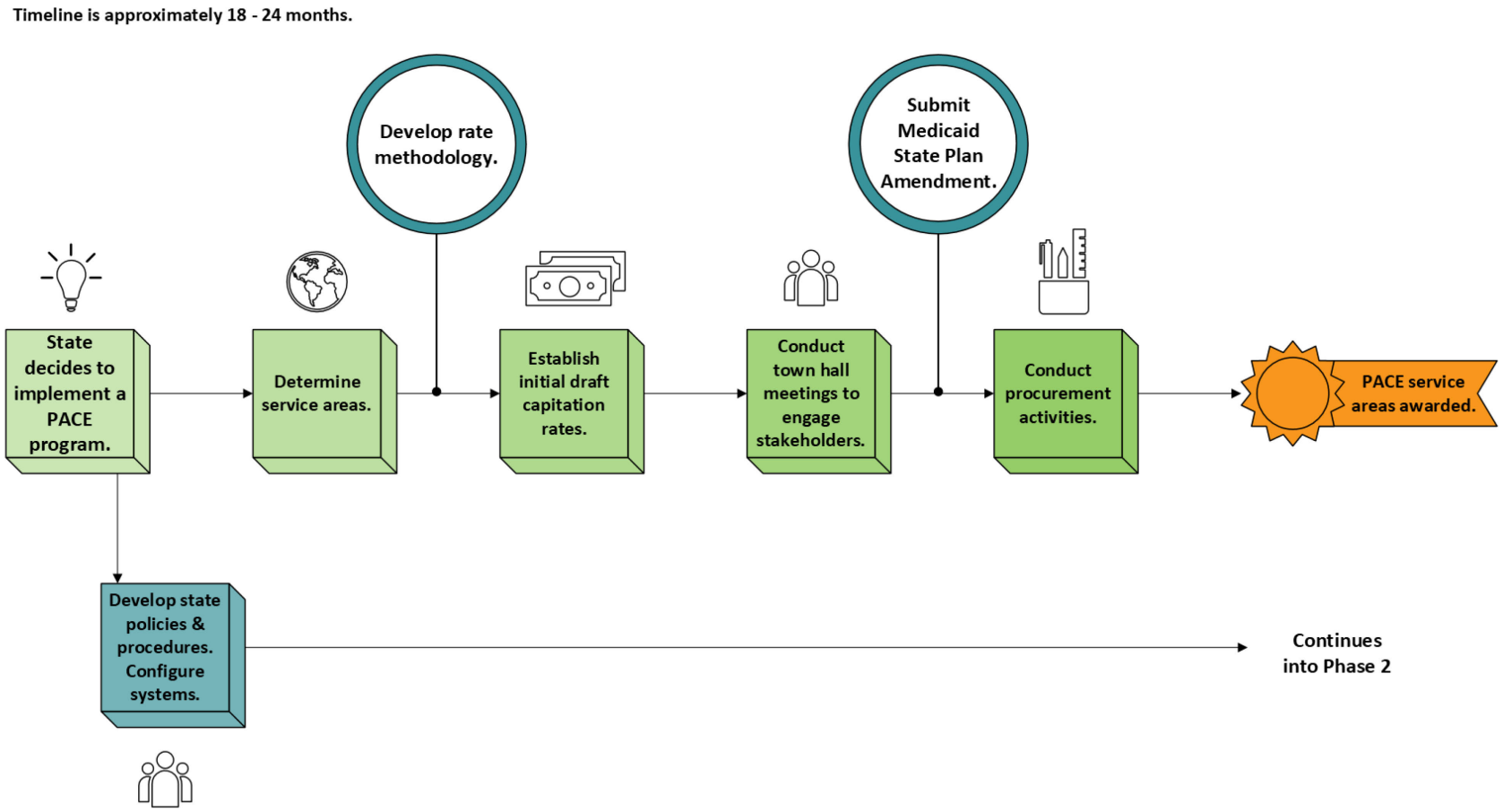
[70] Encounter data consists of data collected when a provider submits a claim to a managed care entity This data includes detail on patient, diagnosis, procedures, and billing.

Appendix A: List of Acronyms

ABI	Acquired Brain Injury
ACS	American Community Survey
ADL	Activities of Daily Living
ARPA	American Rescue Plan Act
ASO	Administrative Service Organizations
AWOP	Amount that Would Otherwise have been Paid
CMS	Centers for Medicare & Medicaid Services
DCW	Direct Care Workforce
DHS	South Dakota Department of Human Services
D-SNP	Dual Special Needs Plan
DSS	South Dakota Department of Social Services
FQHC	Federally Qualified Health Centers
FTE	Full-Time Equivalent
HCBS	Home and Community-Based Services
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
ICF	Intermediate Care Facilities
IDT	Interdisciplinary Team
LOC	Level of Care
LTC	Long Term Care
LTSS	Long Term Services and Supports
MFP	Money Follows the Person
MMIS	Medicaid Management Information System
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NF	Nursing Facility
NPA	National PACE Association
PACE	Program of All-Inclusive Care for the Elderly
PETI	Post-Eligibility Treatment of Income
PMPM	Per Member, Per Month
PO	PACE Organization
RAI	Requests for Additional Information
SAA	State Administering Agency
SNF	Skilled Nursing Facilities
SPA	State Plan Amendment
SRR	State Readiness Review

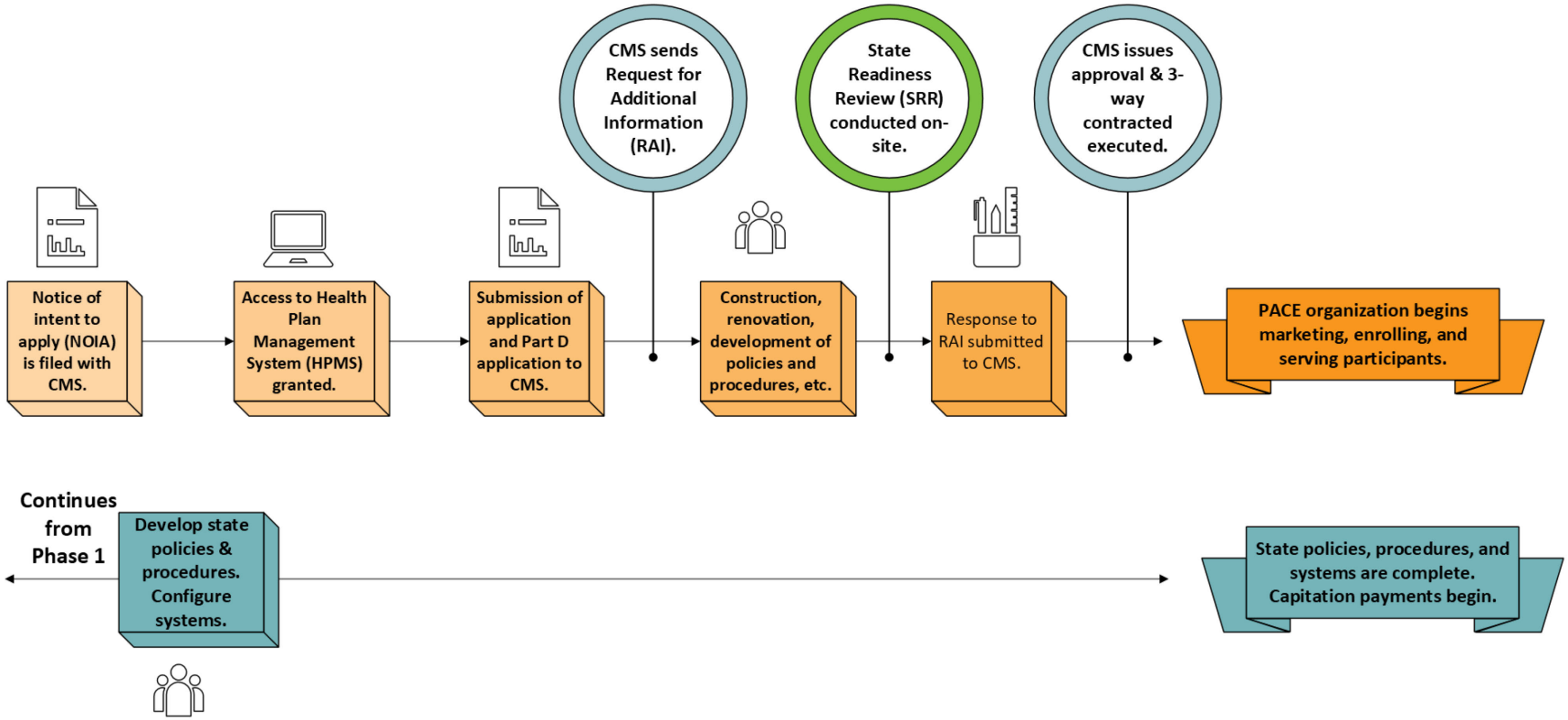
Appendix B: Implementation Charts

Implementation Overview: Phase 1



Implementation Overview: Phase 2

Timeline is approximately 18 - 24 months.



Appendix C: PACE Compared to South Dakota HCBS

PACE Model Compared to South Dakota Home and Community Based Services for Older Individuals				
Program Component	**PACE**	**HOPE Waiver**	**Coordination Only D-SNP***	**Older Americans Act Funded Programs**
Age	55+	65+ or Qualifying Disability (ages 22 - 65)	18+	60+
Service Area	Designated Service Areas	Statewide	Aetna Plan: statewide United Healthcare Plan: select counties	Statewide
Eligibility - Nursing Facility Level of Care Requirement	Yes	Yes	No	No
Must have both Medicare and Medicaid to Qualify	No	No	Yes	No
Combines Medicare and Medicaid benefits	Yes	No	No	No
Expanded Financial Eligibility Rules	Yes - income limit equivalent to 300% of SSI or $2,901	Yes - income limit equivalent to 300% of SSI or $2,901	No	No
Covers Acute, Chronic, and Long-Term Care Needs	Yes - services are provided at the PACE center, at home or through a contracted provider. PACE coordinates, provides and pays for all services determined necessary by an interdisciplinary team of professionals	No - HOPE covers long-term services and supports. Participants are eligible for acute and chronic care medical benefits through the South Dakota Medicaid fee-for-service program.	No. D-SNPs cover acute and chronic care benefits. Long-term services and supports are accessed through the HOPE Waiver. Access to institutional services is available through the South Dakota Medicaid fee-for-service program.**	No - only covers long-term care services and supports.
Where are services provided?	PACE Center, Participant's home, other community-based settings, hospitals, and nursing facilities.	Participant's home and community-based settings.	Via the D-SNP network of providers incudes hospitals and clinics.	Participant's home and community-based settings.
Administering Agency	NA	DHS	DSS	DHS

PACE Model Compared to South Dakota Home and Community Based Services for Older Individuals				
Services Available	Medicare and Medicaid-covered services including but not limited to: • Adult Day Services • Dental Services • Durable Medical Equipment • Emergency Services • End of Life Care • Home Care Services • Hospital Care • Laboratory/ X-Ray • Nursing Facility • Meals • Mental Health Services • Nursing Services • Nutritional Counseling • Physical & Occupational Therapy • Personal Care • Prescription Drugs • Preventive Care • Primary Care • Recreational Therapy • Respite Services • Social Services • Social Work Counseling • Specialists (Cardiology, Optometry, Podiatry, etc.) • Transportation • Other services determined necessary by the IDT	• In-home (homemaker, personal care, nursing, adult companion, chore) • Respite/residential respite care • Adult Day Services • Assisted living • Structured family caregiving. • Community living home services allows up to four individuals to live and receive care in a home-like setting • Community transition support • Environmental accessibility adaptions • Home-delivered meals/Nutritional supplements • Medical equipment, supplies, and assistive devices • Emergency Response System	Functions as a specialized managed care plan, but also coordinates Medicaid benefits. D-SNPs are required to offer Medicare Part A (hospital/inpatient), B (outpatient), and D (prescription drug) benefits. D-SNPs may offer additional benefits not covered by Medicare such as vision, dental, hearing, transportation, and gym memberships.	• Case management • Adult day programs • In-home services • Respite and caregiver services • Health promotion programs • Congregate and Home delivered meals • Emergency response systems • Transportation.

* The Dual Special Needs Plan (D-SNP) is a type of Medicare Advantage managed care plan that aligns Medicare and Medicaid benefits so they are easily accessible to dual eligibles. There are several different types of D-SNPs, which vary based on the degree of alignment, from plan coordination and to full plan integration. The different type of D-SNPs include Coordination-Only (CO), and Fully Integrated (FIDE), and Highly Integrated (HIDE). D-SNPs can be categorized by network type as HMO or PPO. D-SNPs often include extra benefits not covered by Medicare and Medicaid, such as gym memberships, healthy food allowances, transportation assistance, meal delivery, personal care assistance, bathroom safety devices, and in-home support services.

PACE Model Compared to South Dakota Home and Community Based Services for Older Individuals
**United Healthcare D-SNP county coverage: Aurora, Beadle, Bon Homme, Brookings, Brown, Butte, Campbell, Charles Mix, Clark, Clay, Codington, Corson, Custer, Davison, Day, Deuel, Dewey, Douglas, Fall River, Haakon, Hamlin, Hanson, Harding, Hughes, Hutchinson, Jackson, Kingsbury, Lake, Lawrence, Lincoln, Marshall, McCook, Meade, Miner, Minnehaha, Moody, Pennington, Perkins, Roberts, Sanborn, Spink, Stanley, Turner, Union, Walworth, Yankton, and Ziebach.

Sources:
Format and input adopted from:
Colorado HCBS Adult Waivers and PACE Comparison Chart. https://www.allforkidshealth.com/wp-content/uploads/Transition-to-Adult-Adult-Waiver-Comparison-Chart.pdf
Michigan Comparison of Home and Community Based Long Term Care Programs https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder1/Folder16/Comparison_of_Home_and_Community_Based_Long_Term_Care_Programs-2019.pdf?rev=e09d390888b745628d04f3a2cbe7a2ed

Appendix D: AWOP Actuarial Report

CBIZ OPTUMAS
CONSULTANTS | ACTUARIES | ECONOMISTS

May 16, 2025

Subject: South Dakota PACE – SFY26 DRAFT AWOPs – Methodology Report

South Dakota PACE – SFY26 DRAFT AWOPs – Methodology Report

Overview

CBIZ Optumas (Optumas) was contracted to develop an estimate of the Amount that Would Otherwise be Paid (AWOP) as part of the current feasibility study being performed by Myers and Stauffer. The AWOP serves as the basis for developing a potential payment rate to prospective PACE organizations (POs). The payment rate must be below the AWOP in order to be compliant with CMS guidelines for approval of federal funding. This AWOP estimate is only applicable for the feasibility study, and Optumas is not currently certifying these rates for use for any future contract period. As such, these are currently labeled as DRAFT to comply with actuarial communication standards.

Background

The AWOP development is reflective of a benchmark for what potential PACE enrollee level of expenditures would be in the absence of PACE. CMS requires that the AWOP development reflects the same PACE eligibility requirements, which include:

- Member must meet the state's criteria for nursing home level of care;
- Member must be at least 55 years of age;
- Member must be comparable frailty of those that would likely enroll in PACE;
- Member must live in an area that offers PACE; and
- Member must have the ability to live safely in the community.

The AWOP is developed using experience from South Dakota's long term care Medicaid population which is administered through fee-for-service (FFS). The AWOP has been developed in compliance with the general CMS guidelines above. This includes developing region specific AWOPs for the Sioux Falls and Rapid City areas, in addition to statewide AWOP for information purposes. Table 1 below outlines the counties that were provided for those regions. Additionally, the AWOPs have been developed for both dual and non-dual (Medicaid only) populations.

Table 1: PACE Regions and Service Counties

PACE Region	Service Counties
Sioux Falls	Brookings County Clay County Davison County Hanson County Hutchinson County Lake County Lincoln County McCook County Miner County Minnehaha County Moody County Turner County Union County
Rapid City	Butte County Custer County Lawrence County Meade County Pennington County

Summary of PACE AWOP Development

Base Data

The FFS data used to develop the AWOP estimate included the experience for Medicaid members that meet the state's criteria for nursing home level of care. This was identified using level of care information provided by the state and reflects members that either reside in a nursing facility participating in South Dakota's Medicaid program, or those members enrolled in either of South Dakota's HOPE or ADLS Home and Community Based (HCBS) waivers as those reflect the nursing home institutional equivalent. Members on other waivers, such as CHOICES, were not included as they would be under a different institutional equivalent. The data was further limited to those members that were age 55 or older, meet a minimum level of nursing home or waiver service utilization, and includes all state plan services for these members.

The period of the base data used was claims data incurred July 1, 2023 - June 30, 2024 (SFY24) with paid dates through February 28, 2025, and enrollment data for the same period.

The AWOPs were developed using the Paid amounts within the FFS data. All patient liability amounts are excluded in the development of the AWOPs. *Table 2* displays the SFY24 base data member months and PMPMs for each rate cell.

Table 2: SFY24 Base Data Member Months and PMPMs

		SFY24 Statewide Base Data	
Level of Care	**Dual Status**	**MMs**	**PMPM**
Nursing Facility	Dual	28,413	$6,936
Nursing Facility	Non-Dual	1,065	$12,062
HCBS Waiver	Dual	17,230	$2,510
HCBS Waiver	Non-Dual	1,198	$6,125

Base Data Adjustments

Once the base data was compiled, Optumas applied a series of high-level adjustments to arrive at the projected AWOP. *Table 3* details the adjustments made to the base data to arrive at the projected AWOP.

Table 3.A: SFY24 Base Data Adjustments

Base Data Adjustment	Adjustment Description
IBNR Adjustment	Estimate for Incurred but Not Reported Claims
SFY25 Policy Adjustment	Reimbursement Update for HCBS and SNF
SFY26 Policy Adjustment	Reimbursement Update for HCBS and SNF
Pharmacy Rebates	Removal of Pharmacy Rebates Collected Outside of Detailed Claims Data
Trend to SFY26	Trend SFY24 Adjusted Base to SFY26 Contract Period
State Administration	Application of Costs for Administration of Medicaid*

**Administrative costs do not reflect administrative costs for PACE Organizations.*

The impact of IBNR and policy adjustments were based on the actual South Dakota FFS data. Note however, that only policy changes related to HCBS and SNF services were included within this adjustment, as these are expected to have the most material impact to this population, and therefore any other policy changes that effect other services are not reflected within this estimate. The adjustments for pharmacy rebates, trend, and state administration listed above were applied at a high level based on benchmarks from other State PACE programs. This approach was used for the feasibility study, and per CMS guidance the certification of the AWOP would require a more detailed and rigorous analysis of adjustments to achieve compliance and actuarial soundness.

Table 3.B: SFY24 Base Data Adjustment Factors

Base Data Adjustment	Aggregate Adjustment Factor
IBNR Adjustment	0.999
SFY25 Policy Adjustment	4.6%
SFY26 Policy Adjustment	1.1%
Pharmacy Rebates	-0.6%
Annualized Trend	1.8%
State Administration	4.0%

Regional Adjustment

Optumas performed a regional analysis to develop region specific AWOPs for the Rapid City and Sioux Falls areas. Regional factors were developed by comparing the SFY24 base data PMPMs for the Rapid City and Sioux Falls regions to the Statewide PMPM. *Table 4* details the regional factors applied to the Statewide AWOP to arrive at the region-specific PMPMs.

Table 4: Regional Factors by Rate Cell

		Regional Factors	
Level of Care	**Dual Status**	Rapid City	Sioux Falls
Nursing Facility	Dual	0.99	0.98
Nursing Facility	Non-Dual	1.00	1.01
HCBS Waiver	Dual	0.98	1.03
HCBS Waiver	Non-Dual	1.02	0.98

Nursing Facility/Waiver Blend

The draft AWOP estimate is developed on a blended basis, which reflects combining both the Nursing Facility (NF) and HCBS waiver population PMPMs. Optumas utilized the SFY24 FFS member months by region (Rapid City and Sioux Falls) and population to establish the enrollment proportion to apply to the nursing facility and HCBS Waiver AWOPs. *Table 5* below details the Nursing Facility and Waiver proportions used to blend the PMPMs for region. The proportions for the combined NF and HCBS for each region and dual/non-dual status will add up to 100%. Please note that these percentages are specific to the PACE comparable population and eligibility criteria outlined above, which reflect a subset of the nursing home and HCBS population and does not include other HCBS populations such as the CHOICES waiver.

Table 5: Nursing Facility and Waiver Blend by Rate Cell and Region

	Rapid City		Sioux Falls		Statewide	
Dual Status	NF	HCBS	NF	HCBS	NF	HCBS
Dual	50.5%	49.5%	57.6%	42.4%	62.3%	37.7%
Non-Dual	39.0%	61.0%	41.1%	58.9%	47.1%	52.9%

SFY26 Blended AWOPs

The SFY26 DRAFT AWOPs for each region are shown in *Table* 6 below. A DRAFT payment rate can be selected at any rate below the AWOP. Myers and Stauffer have performed scenario analysis for payment rate selection as part of other areas of the feasibility study.

Table 6: Final SFY26 Blended AWOPs

Region	Dual Status	SFY26 DRAFT AWOP PMPM
Rapid City	Dual	$5,399
Rapid City	Non-Dual	$8,928
Sioux Falls	Dual	$5,732
Sioux Falls	Non-Dual	$8,989

Appendix E: Health Professional Shortage Areas

Rapid City Service Area Health Professional Shortage Areas, by County										
County Name and Designation		Primary Care			Dental Care			Mental Health		
County Name	MUA[71]/[72] Designation	HPSA Type	FTE Shortage[73]	Priority for Designation of Resources	HPSA Type	FTE Shortage[74]	Priority for Designation of Resources	HPSA Type	FTE Shortage[75]	Priority for Designation of Resources
Butte	MUA	Geographic	2.01	Medium	Low-Income Population	0.85	Medium	High Needs Geographic	8.96	Medium
Custer					Geographic	0.76	Medium	High Needs Geographic	8.96	Medium
Lawrence	MUA	Low-Income Population	2.47	Medium	Low-Income Population	1.03	Medium	High Needs Geographic	8.96	Medium
Meade	MUA	Geographic	6.13	Medium				High Needs Geographic	8.96	Medium
Pennington	MUA	Low-Income Population	4.49	Medium	Low-Income Population	2.00	Medium	High Needs Geographic	8.96	Medium

MUA = Medically underserved area; P = Population; FTE = full-time equivalent

[71] HRSA. HPSA Find. Accessed May 2025.

[72] Ibid.

[73] This indicates the number of additional practitioners needed to achieve the population to practitioner target ratio.

[74] Ibid.

[75] Ibid.

Sioux Falls Service Area Health Professional Shortage Areas, by County										
County Name and Designation		**Primary Care**			**Dental Care**			**Mental Health**		
County Name	**MUA[76]/P[77] Designation**	**HPSA Type**	**FTE Shortage[78]**	**Priority for Designation of Resources**	**HPSA Type**	**FTE Shortage[79]**	**Priority for Designation of Resources**	**HPSA Type**	**FTE Shortage[80]**	**Priority for Designation of Resources**
Brookings	MUA	Low-Income Population	2.57	Medium	Low-Income Population	1.91	Medium	Geographic	1.57	Medium
Clay	MUA	Low-Income Population	0.85	Medium	Low-Income Population	0.86	Highest	Geographic	3.02	Highest
Davison	MUA	Low-Income Population	1.23	Medium	Low-Income Population	1.04	Medium	Geographic	1.62	Highest
Hanson	MUA							Geographic	1.62	Highest
Hutchinson	MUA							Geographic	3.02	Highest
Lake	MUA							High Needs Geographic	2.44	Highest
Lincoln	MUA							Low-Income Population	3.08	Medium
McCook	MUA	Geographic	1.44	Medium				Low-Income Population	3.08	Medium
Miner	MUA	Geographic	0.62	Medium				High Needs Geographic	2.44	Highest
Minnehaha	MUA	Correctional Facility	0.47	Lowest	Low-Income Population	4.66	Medium	Low-Income Population	3.08	Medium
Moody	MUA	Native American Population	0.26	Lowest				High Needs Geographic	2.44	Highest
Turner	MUA							Low-Income Population	3.08	Medium
Union	MUA							Geographic	3.02	Highest

[76] HRSA. HPSA Find. Accessed May 2025.
[77] Ibid.
[78] This indicates the number of additional practitioners needed to achieve the population to practitioner target ratio.
[79] Ibid.
[80] Ibid.