Chapter 4:

Understanding the Program of All-Inclusive Care for the Elderly

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Key Points

- The Program of All-Inclusive Care for the Elderly (PACE) is a provider-led, home- and community-based approach to care that provides Medicaid and Medicare coverage to individuals who are age 55 or older and require a nursing facility level of care, but can live safely in the community. Most states offer PACE programs, with enrollment of more than 83,000 individuals in 2025.
- PACE participants generally receive all medical and non-medical services from an interdisciplinary team of providers.
- Most PACE enrollees are dually eligible for Medicaid and Medicare. State Medicaid agencies, federal officials, PACE organizations, and consumer advocates largely agreed that PACE represents the most fully-integrated form of care available to dually eligible individuals.
- PACE is financed through capitated per member per month payments from state Medicaid agencies and Medicare Parts A, B, and D.
- We identified two key areas of complexity in administering PACE: unclear delineation of oversight responsibilities and a lack of data on service utilization. Oversight responsibilities, particularly for states, are unclear in federal statute and regulation.
- PACE organizations, state Medicaid agencies, and federal officials have difficulty capturing service utilization data due to the nature of PACE. Although states can require PACE organizations to report additional data, they face challenges reviewing the data due to issues of data quality and limited staff capacity.

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The Program of All-Inclusive Care for the Elderly (PACE) is a provider-led, home- and community-based approach to care that provides Medicaid and Medicare coverage to individuals who are age 55 or older and require a nursing facility level of care (NFLOC) but can live safely in the community. Most PACE enrollees are dually eligible for Medicaid and Medicare, and PACE provides a fully integrated coverage option for Medicare beneficiaries, in addition to other offerings such as the Medicare Advantage (MA) fully integrated dual eligible special needs plans (FIDE SNPs). Although PACE began as a demonstration program in California, it was made permanent in 1997. It is an optional offering for states under their Medicaid program, and enrollment is voluntary for participants.

The Commission has had a long-standing interest in integrated care for dually eligible individuals because of its potential to address misaligned incentives between Medicaid and Medicare and to improve health outcomes for beneficiaries, including many with complex care needs. PACE features, such as an interdisciplinary care team and a flexible and comprehensive benefit structure, make this care approach unique among integrated care programs and well positioned for the Commission's exploration. This chapter addresses how PACE is designed, administered, and overseen by states and the federal government. This chapter begins with an overview of the PACE model, including the statutory and regulatory framework that governs the program. It then describes our interview findings grouped across several elements of the model: eligibility and enrollment, provider application and procurement, service delivery, grievances and disenrollment, federal and state oversight, and payment. This chapter concludes by looking ahead.

Overview

In 2023, more than 13 million people were dually enrolled in Medicaid and Medicare, with about 70 percent eligible for full Medicaid benefits, referred to as "full-benefit dually eligible beneficiaries," and the remainder eligible for Medicaid assistance with Medicare premiums and in some cases cost sharing, referred to as "partial-benefit dually eligible beneficiaries." Of the full-benefit dually eligible population, approximately 1.3 million received care through the three options that provide fully integrated coverage: MA FIDE SNPs, Medicare-Medicaid Plans, and the PACE (CMS 2024a).[1]

As of April 2025, more than 83,000 individuals were enrolled in PACE across 33 states and the District of Columbia, with many states contracting with multiple PACE organizations (Figure 4-1) (NPA 2025). Participants in PACE generally receive both medical and non-medical services from a single interdisciplinary team (IDT) of providers, both at a PACE center and in their homes. The IDT provides all services covered by Medicaid and Medicare, either directly or through other contracted providers, as well as any additional services determined necessary, without any limitations, cost sharing, or deductibles (42 CFR 460.90).

PACE organizations receive capitated per member per month payments from state Medicaid agencies and Medicare Parts A, B, and D, in addition to any premiums from participants. The small subset of PACE enrollees who are not eligible for Medicaid pay a premium equal to the Medicaid capitated rate plus a premium for Medicare Part D drugs. Medicaid-only and dually eligible PACE enrollees do not pay any premiums (42 CFR 460.186, CMS 2011a). States must develop a Medicaid capitation rate for PACE enrollees based on the cost of Medicaid state plan services for the state's comparable nursing facility-eligible population. Generally, states base the capitation amount for each Medicaid beneficiary enrolling in PACE on a blend of the cost of nursing facility and community-based care for the frail elderly in the area as well as Medicaid managed care data in those states where applicable (CMS 2011a). Combined federal and state Medicaid spending on PACE services totaled $3.9 billion in fiscal year (FY) 2023 (Figure 4-5) (CMS 2023).

PACE originated in San Francisco, California, in 1971 when On Lok Senior Health Services established an adult PACE center as a way to provide culturally competent care to the elders of immigrant families in a community-based alternative to nursing facility care (On Lok 2023). It first was a state pilot program and then operated as a Centers for Medicare & Medicaid Services (CMS, known at the time as the "Health Care Financing Administration") demonstration program throughout the 1980s and 1990s; Congress codified what became known as "PACE" as a permanent Medicare program and Medicaid state plan option (§ 1894 and § 1934 of the Social Security Act) as part of the Balanced Budget Act of 1997 (P.L. 105-33). This legislation established the first form of integrated care in the nation (MACPAC 2020). In the law, Congress outlined five key principles of the PACE model that the Secretary of U.S. Department of Health and Human Services (HHS) may not modify or waive:

- the focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility;
- the delivery of comprehensive, integrated acute and long-term care services;
- the IDT approach to care management and service delivery;
- capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals; and
- the assumption by the provider of full financial risk.

The Balanced Budget Act of 1997 required CMS to develop additional regulations addressing eligibility, administrative requirements, application procedures, services, payment, participant rights, and quality assurance under the PACE model. These regulations were first proposed in CMS rulemaking in 1999, finalized in 2006, and updated in 2019 (CMS 2019, 2006). CMS also includes updates to PACE regulations in annual MA and Part D rules (CMS 2024b).

Research suggests that PACE participants generally have better health outcomes compared to similar groups. Several studies have found that PACE participants experience reduced mortality rates and nursing facility use when compared to non-PACE individuals, including people who are dually eligible, residents of nursing facilities, and people enrolled in home- and community-based services (HCBS) waivers, despite having a higher mortality risk and being more likely to be medically needy (Segelman et al. 2017, Ghosh et al. 2015, JEN Associates 2015, Wieland et al. 2010). Both studies that compare PACE participants to similar populations and follow cohorts of PACE enrollees for extended periods of time have documented PACE's ability to reduce hospitalizations and potentially avoidable hospitalizations (Feng at al. 2021, Meunier et al. 2016, Segelman et al. 2014, Meret-Hanke 2011, Beauchamp et al. 2008).[2] One recent study conducted for HHS found that despite being the oldest, having the greatest number of comorbidities, and having the highest mortality rates on average, PACE enrollees were less likely to be hospitalized, less likely to visit the emergency department, less likely to use institutional care, and no more likely to die compared to enrollees in FIDE SNPs, dual eligible special needs plans (D-SNPs), and non-integrated MA plans (Feng et al. 2021). Although more limited, research also suggests that the PACE model's unique IDT component is better suited to provide behavioral and culturally competent health care, leading to improved mental health outcomes and interactions with providers (Travers et al. 2022, Vouri et al. 2015, Ginsburg and Eng 2009).

Analytic Approach

To better understand the PACE model design, administration of the model, and how states and the federal government oversee it, we contracted with the Center for Health Care Strategies to conduct interviews with PACE subject matter experts. We spoke with key state officials, PACE organizations, consumer advocates, and one state PACE association across five states and the District of Columbia. We also interviewed federal stakeholders from the Center for Medicaid and CHIP Services (CMCS) and the Center for Medicare within CMS, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and the National PACE Association (NPA). We selected five states (California, Louisiana, Massachusetts, Michigan, and Pennsylvania) and the District of Columbia that vary in geography, political leanings, integrated care offerings, and PACE program maturity. This chapter describes PACE as it is operated as of our interviews in 2024, although we

acknowledge that announced reorganization efforts of HHS may introduce changes (HHS 2025).

Key Findings

Our interviews with PACE stakeholders highlighted key findings across six aspects of the model: eligibility and enrollment, provider application and procurement, service delivery, grievances and disenrollment, federal and state oversight, and financing. Interviewees shared details about the experiences of PACE participants and how the PACE model provides community-based care for those with complex care needs. We also heard about the challenges that providers encounter in establishing and operating PACE programs and that federal and state agencies face in overseeing them. Federal officials, state officials, PACE organizations, and consumer advocates all largely agreed that PACE represents the most fully integrated form of care available to dually eligible individuals and identified two key areas of complexity for federal and state regulators: unclear delineation of oversight responsibilities and a lack of data on service utilization. Oversight responsibilities, particularly for states, are unclear in federal statute and regulation. Furthermore, although data exist on service utilization by PACE beneficiaries, PACE organizations, state Medicaid agencies, and federal officials face challenges in capturing that data due to the nature of PACE and a lack of established encounter data codes.

Eligibility and enrollment

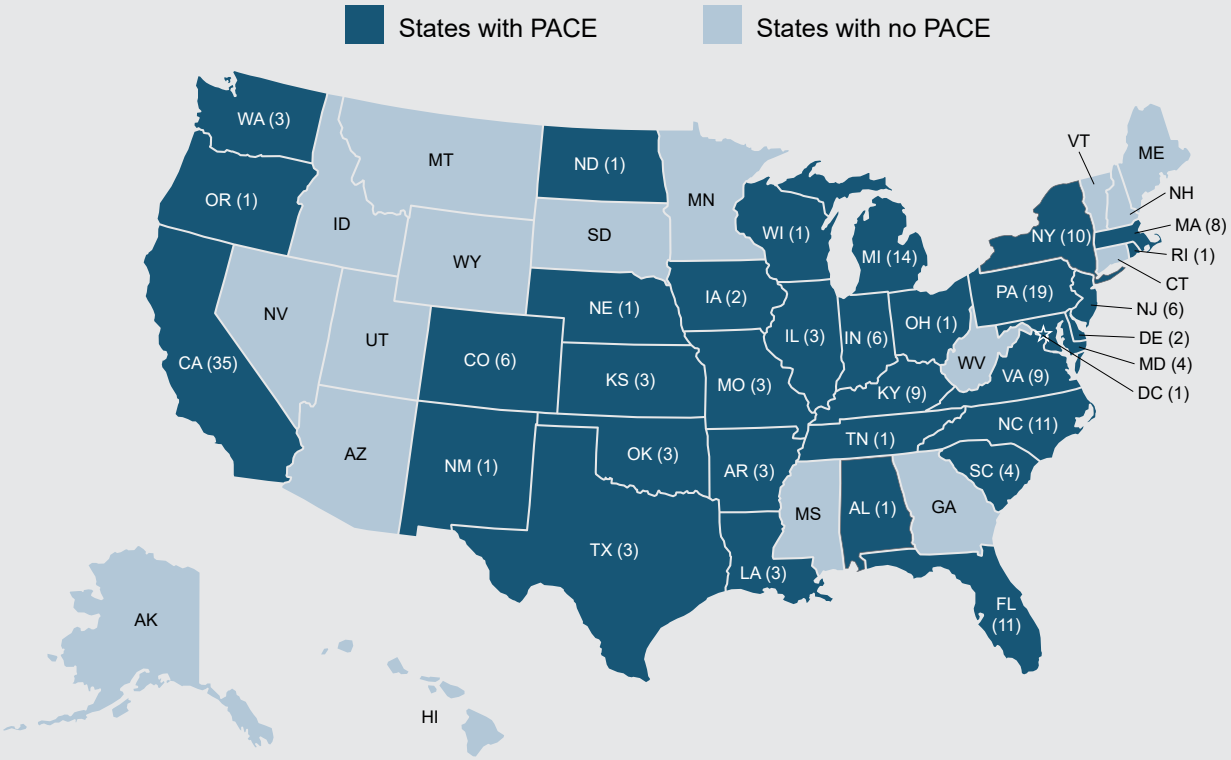
To be eligible for PACE, an individual must be 55 years or older, meet the NFLOC requirement in their respective state, live within the service area of a PACE organization, and be able to live safely in the community at the time of enrollment.[3] States and PACE organizations may include additional eligibility criteria in the three-way PACE program agreements that are signed with CMS that do not modify the basic eligibility criteria specified in regulation, though it is not clear to what extent this is done (§ 1894(a)(5)(D) and § 1934(a)(5)(D) of the Social Security Act). Importantly, eligibility for PACE is not restricted to dually eligible individuals. A PACE enrollee may be eligible for Medicaid, Medicare, both, or neither (42 CFR 460.150(d)). However, most PACE enrollees, 80 percent, are dually eligible for Medicaid and Medicare (CMS 2024c). Once eligibility is determined, enrollment in PACE is effective the first day of the month after the date the PACE organization receives the participant's signed enrollment agreement and continues until the participant's death, regardless of changes in health, unless the participant voluntarily disenrolls or is disenrolled by the PACE organization.

States must evaluate PACE enrollees annually to ensure they continue to meet the state Medicaid NFLOC requirement, with two exceptions. If the state determines that a participant's condition is not likely to improve, they may waive the annual recertification requirement (42 CFR 460.160(b)(1)). Additionally, under "deemed continued eligibility," the state may allow a participant who no longer meets the state Medicaid NFLOC requirement to remain enrolled in PACE upon determining that the participant would likely meet the NFLOC within six months of not being enrolled in the program (42 CFR 460.160(b)(2)).

As of April 2025, 83,533 individuals were enrolled in PACE across 33 states and the District of Columbia (Figure 4-1) (NPA 2025). That same month, 67,851 Medicare beneficiaries were enrolled in 190 PACE organizations (CMS 2025a, 2025b). CMS monthly enrollment data exclude Medicaid-only beneficiaries, who make up 20 percent of enrollees (CMS 2024c). Less than 1 percent of PACE enrollees are Medicare-only beneficiaries (NPA 2023). Many states contract with multiple PACE organizations. Among the five states that shared PACE enrollment data with us, the median PACE organization enrollment was 320 participants in August 2024.

PACE enrollment is lower than enrollment in other integrated care options, but the number of PACE participants has steadily increased in recent years. Enrollment in PACE among dually eligible and Medicaid-only beneficiaries has grown by 62 percent, from 39,653 in 2016 to 64,253 in 2022 (Figure 4-2) (CMS 2024c). Although dually eligible beneficiaries have consistently made up a larger portion of PACE enrollees, Medicaid-only beneficiaries have experienced a higher rate of growth (120 percent compared to 52 percent). By comparison, more than 245,000 individuals were enrolled in Medicare-Medicaid Plans, and more than 367,000 were enrolled in FIDE SNPs in April 2025 (CMS 2025c, ICRC 2025).

FIGURE 4-1. Program of All-Inclusive Care for the Elderly Organizations by State, April 2025



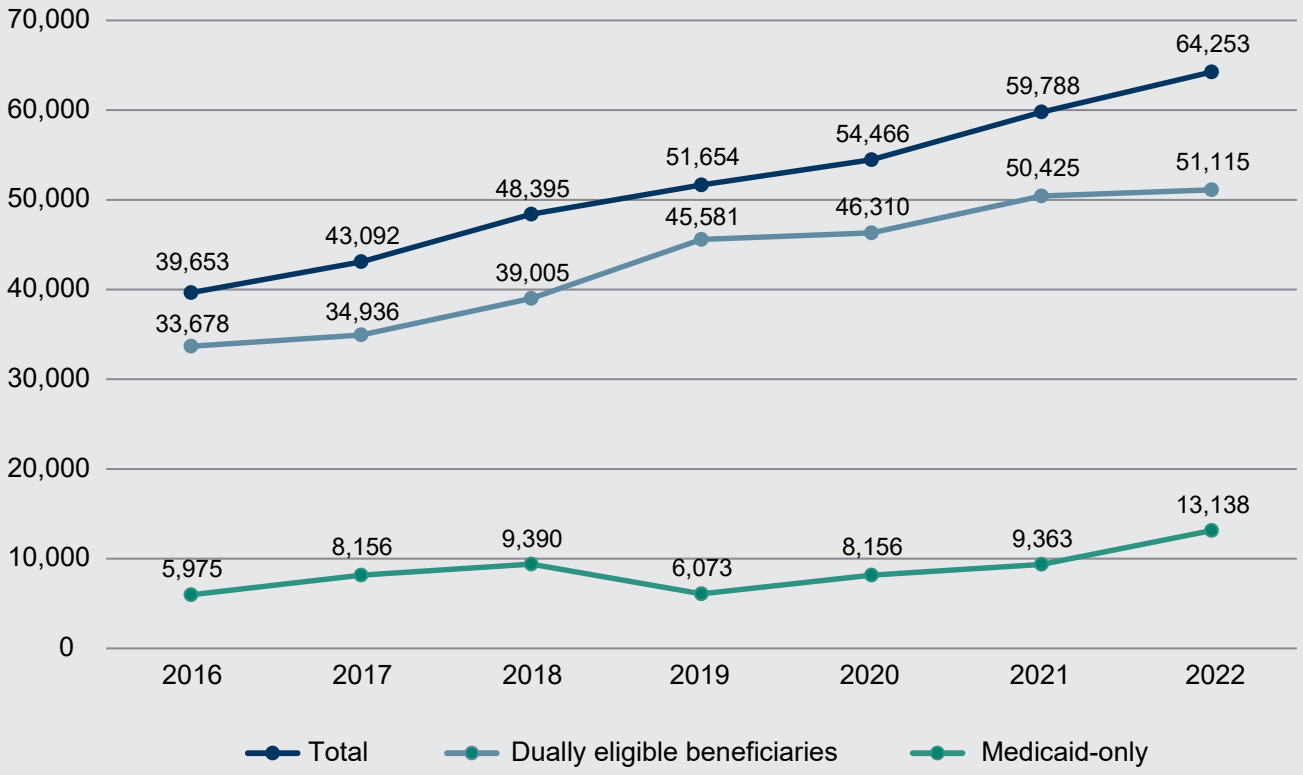
Notes: PACE is Program of All-Inclusive Care for the Elderly. Number in parentheses indicates the number of PACE organizations operating within a state.

Source: CMS 2025b.

PACE organizations that we interviewed shared that most enrollment comes from word-of-mouth referrals, senior housing expositions, and senior center referrals. PACE organizations in multiple states told us state Medicaid agencies were not always including PACE when providing potential beneficiaries with options counseling and case management services. PACE organizations market their services within guidelines set by federal regulations, which include but are not limited to requirements for accurate information, languages offered, and approval from CMS and the state (42 CFR 460.82). New PACE organizations or established PACE organizations expanding their service area cannot advertise until CMS and states grant approval (CMS 2022a). Some organizations also engage in formal marketing through community events, though one PACE organization told us it does not market at all due to approaching an enrollment cap set by the state.

PACE organizations described encountering community providers who were hesitant to refer individuals to PACE for fear of losing their patient, since PACE participants can receive care only from PACE providers, unless the PACE organization contracts with community-based providers to provide services. These stakeholders also noted long eligibility and enrollment timelines, hindering hospitals from referring patients at discharge. Several PACE organizations expressed frustration that individuals may require nursing facility care while their enrollment into PACE is in process, making it less likely the participant would ultimately complete their enrollment in PACE.

FIGURE 4-2. Program of All-Inclusive Care for the Elderly Enrollment, FYs 2016–2022



Notes: FY is fiscal year. This figure excludes Medicare-only beneficiaries.

Source: MACPAC, 2025, analysis of CMS Medicaid Managed Care Enrollment reports for 2016 through 2022.

One state we spoke with that employs independent enrollment brokers for their Medicaid managed care coverage said that the brokers raise awareness about PACE and assist with enrollment. One PACE organization noted that these brokers conduct eligibility determinations for PACE in addition to those conducted by the state and provider. The broker-initiated process includes required steps such as individual counseling that precedes the eligibility determination. By using independent enrollment brokers to document PACE organizations' enrollment denials, this state was better able to observe how some PACE organizations may selectively enroll participants, meaning they avoid enrolling individuals whom they believe may be high cost. Consumer advocates confirmed this practice, noting that PACE organizations sometimes use the eligibility criterion about being able to live safely in the community to exclude high-cost, high-need individuals. States are responsible for establishing the process by which PACE organizations determine who can live safely in the community, but state officials (including those who shared concerns about favorable selection) noted the language is often broad and open to interpretation by PACE organizations (42 CFR 460.152(a)(4)). When asked about these concerns, one federal official emphasized that states are responsible for enforcing enrollment requirements as they see fit.

Provider application and procurement

To become a PACE organization, expand a PACE service area, or add a PACE center, an entity must submit complete applications for both the PACE program and Medicare Part D program to CMS (42 CFR 423.458, 42 CFR 460.12). The applications must include assurances from the state Medicaid agency confirming the entity's qualifications and the state's willingness to enter into the agreement with the PACE organization and CMS (42 CFR 460.12(b)). The applications must also describe the proposed service area, which CMS, in consultation with the state, may alter to avoid overlapping service areas. CMS and the state will approve expansions only after the organization has completed a successful initial trial period audit and, if applicable, addressed any necessary corrective actions (42 CFR 460.12(d)).

States use varied approaches for identifying and selecting PACE organizations, with some issuing requests for proposals (RFPs), others requiring letters of intent, and one directly reaching out to potential providers. Additionally, many states require PACE organizations to meet state licensing requirements, such as obtaining adult day care or PACE-specific licenses. PACE organizations also described the challenges that applicants face navigating the dual state and federal application process, which can take years to complete due to multiple reviews by states and CMS and limited quarterly application submission windows. Although most states expressed interest in expanding PACE statewide, challenges, particularly workforce shortages and concerns about organizations' financial viability, limit expansion in rural areas.

State procurement of PACE organizations. States we interviewed differed in their approaches to procuring new PACE organizations, particularly with the use of RFPs to select PACE organizations to submit applications. Half of the states we spoke with reported using an RFP process to identify potential PACE organizations. Instead of an RFP, two states require potential PACE organizations to submit a letter of intent to begin the state application process. Officials from the final state said that they identify and directly reach out to potential PACE organizations, such as health systems and community organizations, based on service area and areas of unmet need.

In addition to requiring applications to the state as a PACE organization, some states also require that the organization apply to different state licensing boards as a clinical provider. For example, one state we spoke with requires PACE organizations to obtain the state's adult day care license, while another requires that PACE applicants apply to receive the state's separate PACE license. According to an interview with NPA, of the 33 states and the District of Columbia operating PACE programs, 18 require additional licenses beyond the requirements in federal regulation, such as to operate a primary care clinic or for home health.

Application challenges for providers. The federal PACE application process requires applicants to comply with regulations and secure state approval for entering into a three-way program agreement between the PACE organization, the state, and CMS. Federal officials told us that the Division of Medicare Advantage Operations under the Center for Medicare leads the review of PACE applications, with input on specific portions of the application from other CMS divisions, namely the Office of Program Operations & Local Engagement (OPOLE) and CMCS. The Division of Benefit Purchasing and Monitoring under the Center for Medicare also processes the corresponding PACE Medicare Part D Application. Prospective PACE organizations submit their applications through CMS's Health Plan Management System (HPMS).

The calendar year 2025 MA and Part D final rule introduced stricter application requirements, such as submitting the state assurance form, and a review of past performance during the federal application process (CMS 2024a). If the state assurance form is not submitted with the application, the Center for Medicare will consider the application incomplete and will not review the application (42 CFR 460.12(b)(3), 42 CFR 460.20).

Federal officials we spoke with cited incomplete state assurances, inaccurate service area maps, unclear organizational charts, and insufficient descriptions of eligibility determination and disenrollment processes as some common issues with PACE applications.[4] Federal officials explained that delays or incomplete state assurances often occur because PACE organizations frequently submit their applications to CMS while still completing their facilities, obtaining state licensing approvals, and fulfilling state readiness

reviews. The PACE organizations we interviewed emphasized that the state and federal review and approval process can take several years and substantial financial resources. For example, states may require PACE organizations to hire all staff as part of the state readiness review, but since there is no federal deadline for states to conduct the state readiness review, PACE organizations can be fully staffed for extended periods of time without serving any participants (Harootunian 2022). One organization shared that it invested approximately $15 million by the time its PACE center opened.

PACE organizations highlighted the limited quarterly submission window for federal applications as a major barrier, with only one day per quarter available to submit applications for both new organizations and service area expansions (CMS 2025d). They said it complicates the process, especially for larger organizations seeking to expand into multiple areas. The state PACE association we spoke with, however, acknowledged that these submission limits help ensure PACE program quality and sustainable growth. One state noticed an increase in for-profit PACE organizations responding to this single-submission requirement by partnering with subsidiary organizations on applications. Since the lead applicant is the subsidiary organization, the for-profit parent organization is able to submit multiple, separate applications concurrently under different "H-numbers," which is how CMS labels plan contracts. A for-profit PACE organization we spoke with in that state acknowledged using this tactic to expand more rapidly, especially as the organization looks to establish PACE programs in other states. Officials in that state said that this strategy creates administrative challenges and that they are considering whether to tighten requirements on PACE applicant organizations to try to control the growth of for-profit subsidiaries with unique H-numbers entering the market.[5]

State interest in expanding PACE. All but one state we interviewed expressed interest in expanding their PACE programs to additional areas, with many aiming for statewide expansion. One state has doubled the number of zip codes covered by PACE organizations in the past two years, allowing the expansion of PACE organizations' service areas after the COVID-19 public health emergency (PHE) and allowing some PACE organizations to overlap service areas with other PACE organizations' service areas to promote consumer choice.[6] Another state official mentioned that health systems and community organizations often inquired when the state might be expanding the PACE program.

State officials highlighted several challenges with expanding PACE into rural areas. For instance, one state shared that after issuing a request for applications in rural counties, no PACE organizations submitted bids. When the state surveyed PACE organizations about the lack of bids, the organizations cited concerns about finding an adequate workforce and the financial feasibility of operating in rural areas. PACE organizations must make substantial up-front investments to establish a PACE center and expressed concern there would not be enough eligible enrollees in rural areas to make the program financially viable. Additionally, states noted challenges that PACE organizations face in building a sufficient provider network in rural areas, where certain federally required provider types may be scarce or unavailable.

State program goals. State officials described limited authority to tailor the program's design to meet state goals. Some state officials found certain PACE regulations at odds with expansion of the program, noting that regulatory inflexibility can be a barrier to growing PACE in line with state goals for integrated care. Section 903 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554) allows CMS to waive or modify certain regulatory aspects of the model to give PACE organizations more operational flexibility (CMS 2024d). Five core model elements cannot be waived: a focus on frail older adults requiring NFLOC; the delivery of comprehensive, integrated acute and long-term care services; an IDT approach to care management and service delivery; capitated, integrated financing that allows the provider to pool payments; and the assumption of full financial risk (42 CFR 460.26(c)). Organizations submit waiver requests to the state administering agency, which must forward them to CMS, either indicating agreement with the request or noting concerns (CMS 2005). One state cited the current approval process for PACE organization waivers as a challenge because states may not be able to ensure uniformity of the PACE model within a state so that all eligible beneficiaries can access the same standard PACE model. That state described

one instance in which an official said they submitted waivers seeking increased telehealth flexibilities on behalf of several PACE organizations. The state official said they also asked CMS if waivers approved for one PACE organization could be automatically applied to all PACE programs in the state, but they said CMS declined to do this, instead requiring that individual organizations submit the request themselves.

Service delivery

PACE features an IDT of providers who assess participants' needs, develop care plans, and provide continuous care in the community. PACE organizations must offer a wide range of services, including Medicare- and Medicaid-covered services, without benefit limitations on the amount, duration, or scope of services provided (42 CFR 460.90). Stakeholders noted that PACE's comprehensive and flexible benefit design allows participants to live independently in the community, and many considered it more robust than other integrated care models.

IDT. As a community-based alternative to institutional care, the goal of PACE is to delay, if not prevent, nursing facility and hospital use for as long as possible (CMS 2011b). To achieve this, PACE organizations use an IDT. Each member of the IDT must be employed or contracted by the PACE organization and provide or arrange for care to be provided to participants 24 hours a day, 365 days a year across all care settings. Under the regulations, the IDT must be composed of at least 11 providers: (1) primary care provider, (2) registered nurse, (3) master's level social worker, (4) physical therapist, (5) occupational therapist, (6) recreational therapist or activity coordinator, (7) dietitian, (8) PACE center manager, (9) home care coordinator, (10) personal care attendant, and (11) driver (42 CFR 460.102). The IDT provides or arranges to provide PACE participants with all Medicare- and Medicaid-covered services as well as other services beyond those programs that they deem necessary, regardless of payment source (42 CFR 460.92).

PACE benefit. PACE offers a comprehensive benefit package with flexibilities that other plans serving dually eligible individuals lack. Common benefits offered include a broad range of services such as adult day care, dentistry, laboratory and x-ray services, meals, and transportation. The only services expressly excluded from PACE coverage are cosmetic surgery, experimental procedures, and services furnished outside the country (42 CFR 460.96).[7] Typical Medicaid and Medicare benefit limitations and conditions on the amount, duration, scope of services, deductibles, copayments, coinsurance, and other cost sharing do not apply to PACE (42 CFR 460.90). For example, a Medicaid state plan may limit how often an individual can receive new dentures to every five years. However, in PACE, if a participant requests and is determined to need dentures before that five-year time period is over, the PACE organization would be required to cover them. PACE organizations must also have written contracts with each outside organization, agency, or provider for additional services that are not provided directly by the IDT, including at least 26 medical specialties, such as cardiology and dermatology (42 CFR 460.70).

Interviewees largely agreed that PACE, as designed, provides enrollees with a broad array of comprehensive benefits. Federal officials and consumer advocates highlighted that PACE centers offer socialization opportunities to those at risk of isolation and reduce barriers to accessing care by having nearly all care services provided in one location. Stakeholders also noted that the PACE design helps address social needs such as meals, transportation, and home modifications. Several PACE organizations mentioned being able to provide culturally competent care by hiring multilingual staff, providing social programming, and using alternative care sites.[8] One consumer advocate mentioned that PACE centers offer respite for family caregivers, especially for those caring for individuals with dementia or other high-care needs.

PACE center. Each PACE organization must operate a PACE center, which is a facility in which the IDT coordinates and provides most services, including primary care, therapy, social activities, personal care, and meals (42 CFR 460.98(d)).[9] Although important, center attendance is not mandatory. Instead, the IDT determines how often each participant should attend as part of developing their care plan (42 CFR 460.98(f)). The IDT is required to work with participants and their caregivers to develop and regularly update the care plan to meet all of a participant's medical, physical, emotional, and social needs (42 CFR 460.106).

PACE organizations also have the option to provide services in the participant's home and alternative community settings as needed (42 CFR 460.98(b)(2)). An estimated 95 percent of PACE participants live at home (NPA 2019). If a participant enters institutional care, such as a nursing facility, they remain enrolled in PACE, and the costs are covered by the PACE organization. The broad flexibility PACE organizations have in care delivery allows them to provide a tailored mix of medical and nonmedical services across the full spectrum of care settings by the IDT or contracted providers that can help older adults remain in the community.[10]

Consumer advocates identified a few challenges with PACE from the enrollee perspective, particularly regarding the amount of home-based care provided. In some states, PACE offers fewer home services compared to other Medicaid-managed long-term services and supports or HCBS programs. Although PACE must provide all Medicaid-covered services in a state's approved plan (42 CFR 460.92(a)(2)), there are no federal requirements for the quantity of home-based care, since the IDT determines participant care plans (42 CFR 460.90(a)). Consumer advocates said that few states require standardized home care needs assessments for PACE, allowing organizations to instead choose their own instrument and method to determine hours of home care, which can result in participants at different PACE organizations in a state receiving varying levels of support despite having similar needs.[11] Additionally, consumer advocates shared that some PACE organizations may struggle to balance fidelity to integrated care provided in the PACE center with participant preferences to receive services in the home, particularly after the PHE. In one state, the lack of access to local hospitals and specialists led a PACE organization to serve more homebound enrollees, prompting both the state and the organization to adjust service delivery and clinical policies. Advocates also noted that PACE organizations may struggle to support enrollees at home without a substantial unpaid support system, usually provided by family caregivers. Federal officials said that PACE organizations are responsible for providing care 24 hours a day, 7 days a week, and although reliance on family caregiving is permitted, the needs of PACE participants often exceed the level of care unpaid caregivers can safely provide.

All of the PACE organizations we interviewed use participant and caregiver satisfaction surveys to gather enrollee feedback, as PACE organizations are required to develop, implement, and maintain quality-improvement programs that measure participant and caregiver satisfaction (42 CFR 460.134). Survey results are used by the PACE organization only to improve services and are not shared with CMS, though CMS may review quality-improvement measures during audits. PACE organizations must also establish a participant advisory committee (PAC) to discuss enrollees' concerns, with the majority of the committee's membership made up of participants and their representatives (42 CFR 460.62(b)). All PACE organization interviewees shared that they use PACs to identify issues and make continuous improvements to their organizations, such as updating the layout of a PACE center for better functionality.

Grievances and disenrollment

If a PACE participant is not satisfied with their care, they may take several actions, such as submitting a grievance, requesting a service and appealing any denials, or disenrolling from the program entirely. PACE organizations must have formal grievance, service determination request (SDR), and appeals processes in place to address participant disagreements with decisions regarding their care. States monitor PACE program disenrollment through various methods, including requiring providers to report disenrollments to Medicaid agencies and providing financial rewards to organizations with low voluntary disenrollment rates. Common reasons for disenrollment include participant death and relocation.

Grievances and appeals. A grievance is a verbal or written complaint that a PACE participant may use to express dissatisfaction with the quality of care provided or the services delivered, regardless of whether the participant requests any corrective action (42 CFR 460.120(b)). A PACE participant or their representative may make an SDR for the IDT to provide, modify, or continue a service (42 CFR 460.121(b)). If the SDR is denied by the IDT, a participant may appeal the decision (42 CFR 460.122).

PACE organizations must have a formal written grievance process to address and resolve medical and nonmedical complaints from participants, family members, designated representatives, and caregivers within 30 days (42 CFR 460.120(g)). Additionally, PACE organizations must notify participants of their rights to submit grievances, provide continuous care during the grievance process, document and track grievances, and analyze the information for quality improvement (42 CFR 460.120). PACE organizations must have a similar formal written appeals process, the first step of which is making an SDR, to address noncoverage or nonpayment of services (42 CFR 460.122). They are also required to notify participants in writing of additional appeal rights under Medicare, Medicaid, or both; help the participant decide which option to pursue if both apply; and send the appeal to the correct external entity (42 CFR 460.124).

States we spoke with use different processes for monitoring grievances and appeals from PACE enrollees. One state has a specific ombudsman program for PACE, while others rely on general long-term care or health care ombudsman programs to monitor for grievances. In some states, grievances are submitted to the state PACE office or the licensing department, while one state we spoke with offers a hotline for PACE grievances. Enrollees with Medicaid can also use the general Medicaid state fair hearing appeals process, which varies by state and takes 30 to 60 days (42 CFR 460.124).

Consumer advocates highlighted that PACE denial notifications are often vague and lack clear explanations, making it difficult for enrollees to understand the reasons for service denials and to file appeals. For example, one consumer advocate noted that the reason for denial is often listed as a reference to the federal PACE statute or regulations (42 CFR 460) or because the IDT determined a service was not medically necessary. One element of PACE that can make it difficult for enrollees to appeal denials is that the PACE organization acts as both the health care provider and plan (42 CFR 455.410). One consumer advocate mentioned this can be particularly challenging when participants need to gather additional medical opinions and submit evidence to appeal a service denial, since all the providers work for the PACE organization. Recent federal regulations (42 CFR 460.120) now require PACE organizations to have formal grievance processes and resolve complaints within 30 days. Consumer advocacy organizations we interviewed told us they had not heard of many PACE enrollees filing appeals or submitting grievances, which may be due to the small size of the PACE program.

Disenrollment. A PACE participant may voluntarily disenroll from the program at any time, with disenrollment taking effect on the first day of the subsequent month (42 CFR 460.162(a)). Since PACE participants must receive all their Medicaid and Medicare services from PACE or contracted providers, enrolling in an MA plan, Original Medicare Part D, Medicaid prepayment plans, or optional benefits such as a Section 1915(c) HCBS waiver or Medicare hospice benefit would count as a voluntary disenrollment (42 CFR 460.154(i)). Involuntary disenrollment can occur for a number of reasons, including failing to pay premiums, engaging in disruptive or threatening behavior, moving outside the PACE program service area, or no longer meeting the state Medicaid NFLOC requirement and not being deemed eligible to continue in the program (42 CFR 460.164).

All states interviewed actively monitor their PACE programs for voluntary and involuntary participant disenrollment through a variety of methods. One state requires PACE organizations to submit a form that codes the reasons for a participant's disenrollment, as well as any areas of dissatisfaction and the participant's contact information, to the state Medicaid agency. This state noted that it has had limited success reaching participants that disenroll from PACE. Another awards PACE organizations with low voluntary disenrollment rates an annual bonus to encourage participant continuity. States and PACE organizations also stressed that participant disenrollment of either kind is not common, given the small census of programs and generally high satisfaction of participants. Consumer advocates we interviewed, including an organization that serves as the state's ombudsman program, shared that they had not heard of many PACE disenrollments.

When disenrollments do occur, PACE organizations must make referrals and share medical records with

new providers as well as collaborate with CMS and the state administering agency to ensure participants enroll seamlessly in other applicable programs (42 CFR 460.168). Consumer advocates expressed concern that federal transition of care regulations for PACE do not adequately hold PACE organizations accountable and are not as comprehensive as transition of care requirements for Medicaid managed care plans (specifically at 42 CFR 438.62).

Stakeholders listed several reasons why PACE participants may disenroll. State officials and PACE organizations listed participant death and relocation out of a program's service area as the most common reasons for disenrollment.[12] They also cited the intensity of the PACE program's care model as a reason for voluntary disenrollment. One PACE organization described their program as high touch, requiring enrollees to frequently meet with providers and attend the PACE center, which they said could be overwhelming for some individuals.[13] These stakeholders also noted seeing a rise in voluntary disenrollments as more MA plans offer plan debit card benefits as supplemental offerings. Plan debit cards are particularly attractive to older adults with fixed or limited incomes, such as PACE participants who may not understand that they are disenrolling from PACE by enrolling in another health plan. Consumer advocates also highlighted PACE's closed network model, mentioning that some individuals choose to disenroll because they find that the PACE organization, or their preferred primary care or specialist providers, will not contract with each other. However, PACE organizations we spoke with frequently sign single-case contracts with participants' preferred providers.

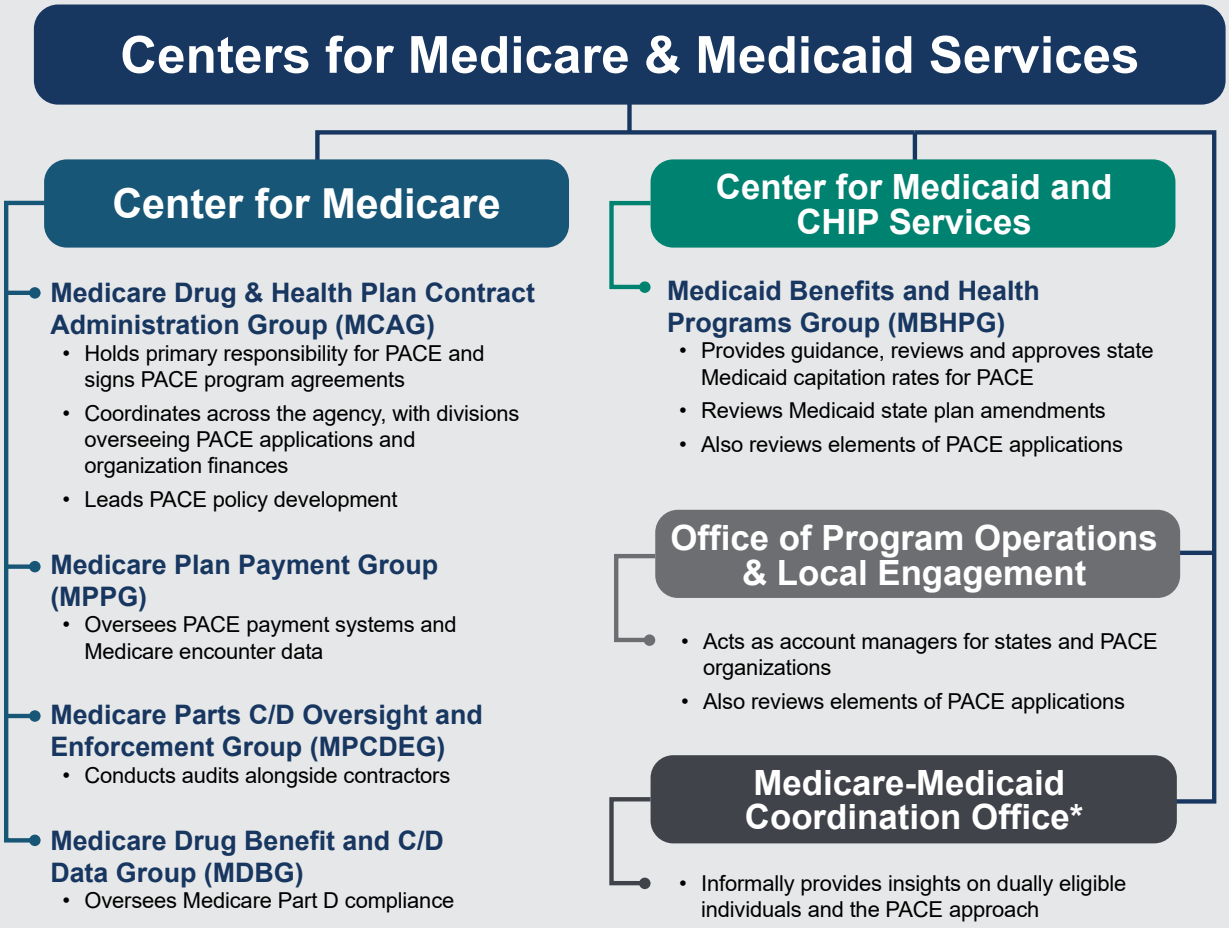
Officials in two states noted that some PACE organizations have limited nursing facility options in their provider network, leading to disenrollment when enrollees are unwilling to move to available facilities. Federal officials confirmed in interviews that there are no nursing facility network adequacy requirements for PACE organizations. States and providers also mentioned tension between families that may wish to move an enrollee into a nursing facility and IDTs that determine the enrollee is still best served in the community. Federal officials at CMS and ASPE acknowledged that voluntary disenrollments often occur when enrollees transition to nursing facilities. Officials from ASPE suggested examining provider networks, payment issues, or the rise of MA institutional special needs plans as potential causes. They emphasized that these disenrollments appear to reflect enrollee preferences rather than PACE organizations trying to avoid paying for nursing facility care, though they recommended states increase their monitoring.

Federal and state oversight

Federal statute and regulation outline shared oversight of PACE with federal and state officials responsible for overseeing different PACE processes. However, an oversight structure that some stakeholders described as overly complex and without clear ownership can create confusion, and the state's expected role in oversight is not always explicit. Structural challenges in reporting utilization and quality data also complicate efforts to oversee PACE organizations. Stakeholders said that current data reporting required of PACE organizations is minimal, and although some PACE organizations said that they share more extensive data with their PACE associations and with their ownership, other PACE organizations may consider reporting requirements burdensome. Nearly all stakeholders, including federal and state officials, PACE organizations, and consumer advocates, also expressed interest in the development of a standardized national PACE quality measure set that would allow for comparisons within and across states. Yet, these measures have proven challenging to develop because of the diversity of PACE programs and their small population size.

Complex oversight structure. As a Medicaid and Medicare program, PACE oversight activities span a number of divisions and offices within CMS (Figure 4-3). Although PACE is not an MA product, federal oversight of PACE relies on the same oversight infrastructure that supports MA. Officials said the Center for Medicare holds the primary responsibility for PACE oversight at CMS, coordinating the oversight and monitoring of PACE with all other CMS groups.[14]

FIGURE 4-3. Program of All-Inclusive Care for the Elderly Oversight Apparatus within the Centers for Medicare & Medicaid Services



Notes: PACE is Program of All-Inclusive Care for the Elderly. * The Medicare-Medicaid Coordination Office is officially known as the "Federal Coordinated Health Care Office."

Source: MACPAC interviews, 2024.

Federal oversight consists of PACE organization audits and review of quality data reporting. PACE organizations are required to undergo annual audits with on-site elements during their initial three contract years of operation (§ 1894(e)(4)(A)(i) and § 1934(e)(4)(A)(i) of the Act). After the trial period, CMS audits move to a remote basis, and the frequency of audits is determined based on risk factors that CMS identifies.[15] Federal officials said that audits focus primarily on areas impacting participant access to services (Figure 4-4). Federal officials described audits as resource intensive for CMS, but they said that the audit results are useful for identifying specific challenges with PACE organization performance as well as for informing policymaking.[16] PACE organizations are also required to submit quality data to HPMS. PACE organizations are required to submit data on 23 medical and non-medical elements on a quarterly cadence, comprising basic safety and utilization information such as reported falls, medication administration errors, and emergency room visits (CMS 2024e). In addition to audits, account managers from OPOLE review each

PACE organization's data to determine if there are any concerning utilization patterns or quality outcomes, such as disenrollments and adverse events, and then meet with organizations quarterly to discuss the data reports. Federal officials said these meetings act as opportunities for CMS to potentially identify any upcoming areas of non-compliance and learn more about how PACE organizations are using their data for process improvement. OPOLE works with MCAG to issue compliance actions for failures that have had considerable negative participant impact.

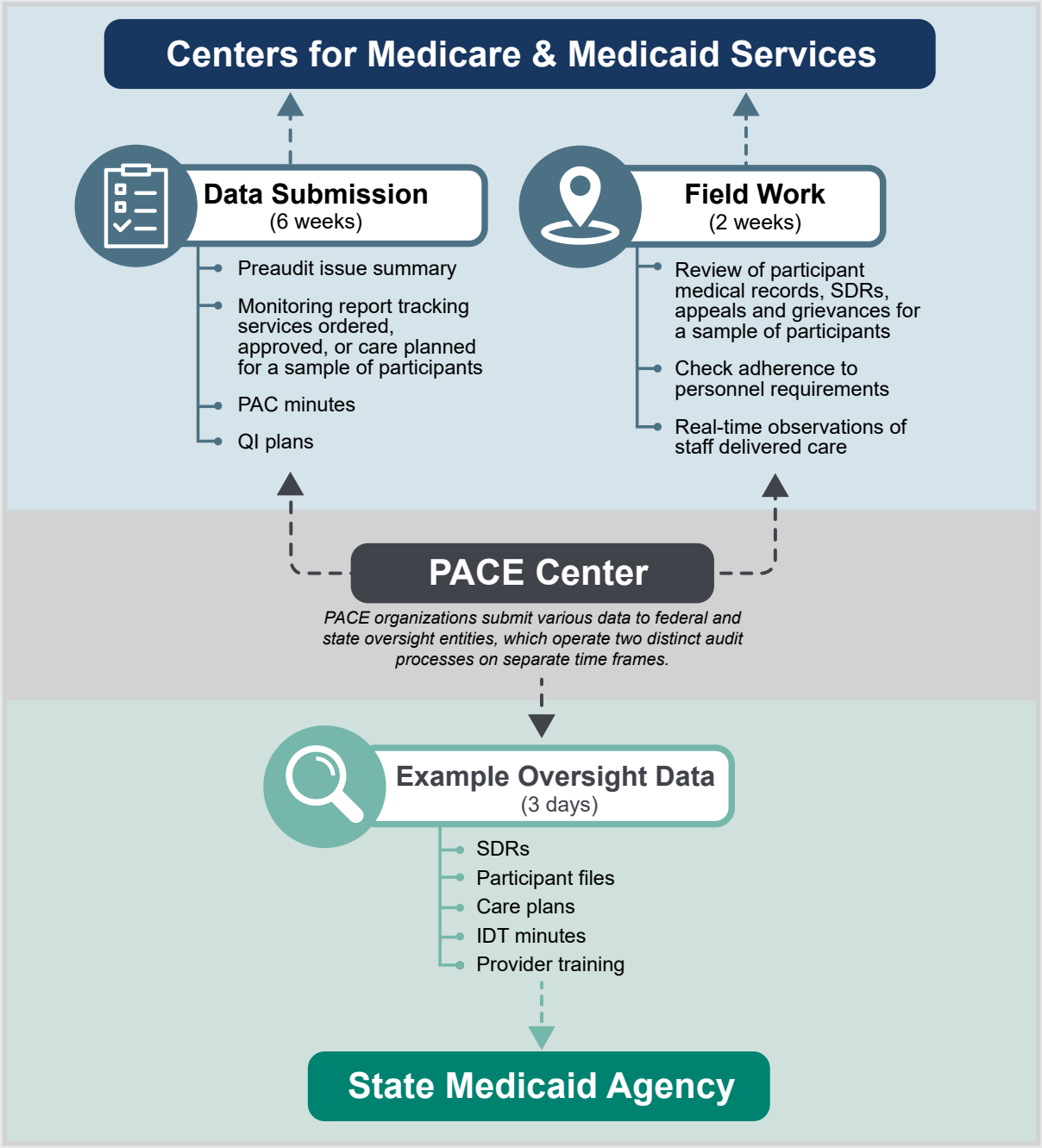
Several stakeholders raised concerns with the structure of PACE oversight, describing a fragmented system that they said makes it difficult to determine where responsibility for oversight of PACE enrollee experiences and outcomes lies. One state official criticized how CMS oversees PACE at length, describing the program as "homeless" within the agency because of how oversight is split among many separate divisions. This organizational confusion results in PACE organizations and states receiving conflicting information. For example, the state official said they were told by CMS that PACE organizations could offer participants plan debit cards, similar to those offered by MA plans that many stakeholders said draw dually eligible beneficiaries away from the PACE program; yet, a PACE provider in another state said in an interview that CMS informed them that cash cards would count as income for the participant and could affect their financial eligibility for Medicaid.[17] Even though federal responsibility for PACE is divided, the state official said that CMS is "too involved" in day-to-day management of PACE sites, taking on a larger role than the agency does with D-SNPs because PACE organizations also act as providers.

Others underscored the difficulty of understanding how oversight activities connected to PACE organization performance. Audit results are public, but several stakeholders said these reports are often difficult to parse and focus more on corrective actions issued than general performance, which federal officials attributed to the sensitive nature of audits. Federal officials said the agency is transparent with the audited organizations about identified issues.[18] Consumer advocates also said PACE regulations lack specific beneficiary protections to be overseen, such as network adequacy standards or defined limits on wait times for accessing services like HCBS, that are available to other Medicaid HCBS users.[19]

State role. States' oversight approaches varied. Regulations describing federal and state monitoring under 42 CFR 460 subpart K do not clearly differentiate roles for CMS and states, only stating that CMS monitoring is "in cooperation with the state administering agency." Our interviews found that audits are the primary tool used by states for oversight, with the cadence and level of audit review varying depending on the number of PACE organizations in the state (Figure 4-4). State officials said they typically check for PACE provider compliance with federal regulations without duplicating what is done by CMS. One state official said that they conduct routine audits triannually for the state's mature PACE organizations but annual audits, similar to CMS, during an organization's first three years of operations. For three states, officials said that they visit PACE centers and manually pull information from electronic medical records, patient files, and SDRs to validate whether participants were receiving all the services they were authorized to receive. Officials in one of those states described their audit process as a three-day site visit. Those state officials said their audits consist of checking whether level of care determinations are being completed appropriately, if care plans include the necessary medical and social components, and whether personnel have received required training. Another state focuses its oversight activities on assisting PACE organizations in improving processes. For example, the state official said they randomly sample minutes from the IDT meetings to see what was discussed, examine patient files to see if those issues were addressed, and—eventually, though the official said this is not currently in practice—speak with participants about how the issue was resolved.

Although not always part of the audit process, state officials mentioned that their oversight also relies on minutes from PACE organizations' PACs to identify potential issues.[20] An official in one state noted that state engagement with PACE organizations occurs regularly outside of audits as well, such as in biweekly site visits and calls.

FIGURE 4-4. Federal and State Medicaid Agency Audit Reporting Requirements for Program of All-Inclusive Care for the Elderly



Notes: PAC is participant advisory committee. QI is quality improvement. PACE is Program of All-Inclusive Care for the Elderly. SDR is service determination request. IDT is interdisciplinary team. Centers for Medicare & Medicaid Services audits of PACE centers include an initial data submission period followed by field work, which requires an on-site visit for PACE centers in their trial period. Listed data elements required for state audits represent examples provided through interviews with state officials, but requirements vary by state. The estimated duration for each audit step is included in parentheses.

Sources: MACPAC interviews with state officials and review of CMS audit protocol, CMS 2022b.

Our interviews confirmed that there are few domains for which state Medicaid agencies have primary oversight responsibility. For example, states must review and approve that involuntary disenrollments are in line with regulation (42 CFR 460.164(f)) and process external appeals through the state fair hearing process (42 CFR 460.124(b)). States are also tacitly responsible—as the entities that set the criteria by which PACE organizations evaluate whether a participant can be considered capable of living safely in the community at the time of enrollment (42 CFR 460.150(c)(2))—for overseeing whether PACE organizations abuse the assessment process to select participants who may be healthier or lower cost. However, states may also form two-way agreements with PACE organizations to include additional requirements to those explicitly required by federal regulation or the three-way program agreement. In an interview with MACPAC, NPA estimated that about half of states may use two-way agreements with PACE organizations. Four states in our study included additional requirements in their two-way agreements, but officials said that those agreements tend to be relatively pro forma, either emphasizing that the state also has an interest in ensuring PACE organization compliance with federal regulations or specifying how data should be reported for state systems. However, one state requires PACE organizations to submit additional financial reports and to comply with other guidance documents the state may release, while another state official said their state was in the process of revising its two-way agreement for the first time since 2015 to include additional reporting requirements and detail the state auditing process.[21]

State officials made clear in interviews that they do not wish to duplicate what one state official described as an extremely burdensome federal audit for PACE organizations, leaving it to CMS to ensure compliance with federal regulations.[22] One federal official agreed that compliance with federal regulations is CMS's purview, emphasizing that there should not be any overlap between the CMS and state audits. CMS invites states to attend quarterly calls between OPOLE and PACE organizations that occur outside of the audit process. Although states do not have direct access to the CMS data reports discussed on these calls, federal officials said that states tend to actively participate in these meetings, although they noted that engagement varies by state. Meanwhile, federal officials said that they rely on their state partners to raise issues that they have identified with enrollment or through grievances made to the state Medicaid agency, as CMS lacks line of sight on those processes. Additionally, many states require PACE organizations to conduct and report satisfaction surveys with participants. Federal officials said they view these surveys as tools PACE organizations can use to improve internal processes, and although CMS does not review the results, officials noted they may inform quality improvement plans that PACE organizations do discuss with CMS.

Limited utilization data reporting. Stakeholders described minimal data reporting required by federal and state entities for oversight, and in nearly all cases, reporting requirements focused on process measures rather than quality outcomes. Interviewees noted challenges with reporting PACE data that ranged from technical difficulties in defining and reporting Medicaid encounters to a lack of staff capacity to process data to inform oversight, which make comparisons across PACE organizations impractical and hamper state Medicaid agency efforts to provide their legislatures with evidence to support the continued growth of PACE.

In addition to submitting limited utilization data to HPMS for quality oversight, PACE organizations must submit data on certain Medicare encounters to CMS. Federal officials said that PACE Medicare encounter data are based primarily on claims for services provided outside the PACE center, which differs from MA plans that must report encounters for all covered services.[23] Among states interviewed, only one state currently requires PACE organizations to submit Medicaid encounters, while two other states are working with organizations to develop such requirements.[24] Yet another state once required PACE organizations to submit Medicaid encounters, but the state official said they dropped the requirement due to challenges those organizations faced in reporting accurate data. Identifying encounters in a PACE center is challenging because, unlike with traditional providers, a participant may encounter various members of their IDT while at the center, each potentially offering a mix of what could be Medicare-covered or Medicaid-covered services. Interviewees said that the high-touch nature of PACE would likely generate a huge volume of claims data that could overwhelm small PACE organizations, regardless of what approach they took to defining encounters.

Several PACE organizations voiced concerns with encounter data reporting requirements, particularly for purposes of oversight and reimbursement. Although some states have figured out how to work with organizations to report accurate data, NPA officials said they are concerned that some states simply apply existing managed care reporting systems to their PACE program without adapting them to properly capture actual services and expenses. A state PACE association concurred with that assessment, and officials said that encounter codes for managed care plans do not adequately document the services provided to PACE enrollees. The state association shared that it is working with its counterparts in the state Medicaid agency to improve data collection to better capture services and supports for non-medical social needs. A number of PACE organizations and NPA said that there is a lack of consistency in how PACE organizations within a state report on the same data due to the broadness of federal and state reporting instructions, which can make comparison difficult. That said, we also heard from several PACE organizations that they can report encounter data and currently do so for their associations, but the states may not be requesting it.[25]

Given the spectrum of ownership in PACE, from large organizations with sites in several states to small local community-based organizations, interviewees said PACE organizations vary in their level of sophistication with regard to reporting data. At least one PACE organization official voiced frustration with the administrative burden of meeting various complex reporting requests. The PACE official said as their organization has grown, it was forced to start acting more like a health plan rather than as a provider delivering patient care, likening the experience to running two companies at once. Some PACE organizations we interviewed described challenges with their providers meeting all CMS reporting requirements and guidelines, with one organization saying the process—with strict timelines and the need for extensive documentation—is "arduous" for PACE organization providers who do not experience similar requirements in other delivery systems.[26] The PACE organization representative added that they hire local providers, who require constant training on reporting requirements and PACE and continue to struggle to report as expected.

Consumer advocates said that federal and state agencies could require a greater range of data to be collected and publicly shared to improve oversight. Advocates recommended a number of potential data elements, including but not limited to authorized services versus services used; percentage of requested services approved by the IDT; enrollee experiences during transitions in care; and stratification of data by race, sex, insurance type, and PACE organization ownership type.[27]

Measuring quality. Stakeholders said that quality is difficult to measure in PACE given the limited reported data available. Even where some measures exist, the lack of standardization means that PACE organizations are largely measured against the yardstick of their prior performance. PACE organizations must establish quality improvement programs and meet or exceed minimum levels of performance established by CMS and states (42 CFR 460.134(c)). Federal officials said that CMS audits include four elements, one of which is compliance and quality improvement. As part of the audit, CMS conducts an interview to review a PACE organization's quality data to ensure all required data are collected and analyzed and that measures are taken to improve performance when necessary. However, CMS collects quality data only if it finds evidence of non-compliance. The officials emphasized that CMS audits and reporting requirements do allow the agency to spot issues and see improvement in quality over time for individual PACE organizations. However, one federal official indicated that the data elements produced by existing reporting requirements have limited utility, remarking that some within CMS do not find the HPMS quality data helpful in understanding PACE performance.

Most states do not require substantial reporting on quality, although regulation grants them authority to require a range of data reporting, including on quality (42 CFR 460.130(d)). Some officials said they are attempting to familiarize PACE organizations with reporting this type of data, while others said they lack the capacity to review the quality data they currently require. An official in one state said it focuses on five components of quality but noted that these components are essentially used to check whether a provider is correctly completing a required process. Another state requires PACE organizations

to submit a quarterly quality report, but officials in that state said the reports are not yet complete enough to use, and state staff capacity to oversee them is limited. An official in another state said the state has a PACE site with ongoing quality issues and requires some quality measures in its two-way agreement, but the state does not have the capacity to review the data. And yet another state meets with PACE organizations about their quality plans, but it does not request data on quality.[28] Instead, most states require participant and caregiver experience surveys, such as the Integrated Satisfaction Measurement for PACE survey or Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Survey (Box 4-1). Several states and consumer advocates said they rely on those surveys as a proxy for quality, and one federal expert voiced appreciation for the surveys while noting that the PACE program's small size makes it difficult to measure participant experience in broader surveys of dually integrated beneficiary satisfaction.

Nearly every interviewee supported or recommended the creation of national quality measures for PACE, and several stakeholders described past and ongoing efforts aimed at developing them. Officials said CMS previously undertook a project to develop quality standards, but the agency was stymied by questions of whether measures would be comparable across PACE organizations nationally. Measures would need to be applicable for PACE programs of various sizes and with different patient mixes, and officials said the utility of publishing such measures was less clear for participants as few have a choice of PACE organizations in their community. However, another federal expert said they are interested in standardized quality measures to compare PACE program performance by ownership type in light of the rapid growth of for-profit PACE organizations. Officials in one state, which had previously told MACPAC about its efforts to develop standardized quality measures for PACE, echoed that national quality measures are needed to understand the level of care PACE organizations are providing.[29] New York, which was not included in this study, has also investigated the development of PACE-specific quality measures (New York DOH 2022). PACE organizations also expressed a desire to have more uniformity in quality measures—and regulations—across states, which they said would allow organizations to expand across state borders more easily, potentially covering otherwise difficult-to-service rural areas. NPA noted that it is developing a PACE provider recognition program, which would include a standard quality measure set that it would use to evaluate providers (APIQ 2023).

BOX 4-1. Measuring Participant Satisfaction in the Program of All-Inclusive Care for the Elderly

States rely on a number of survey tools to evaluate Program of All-Inclusive Care for the Elderly (PACE) performance, often using participant satisfaction as a proxy. A commonly used instrument directly designed for the PACE population is the Integrated Satisfaction Measurement for PACE survey. This instrument, developed in 2009 in collaboration with the California PACE Association, is used across 32 states covering nearly 75 percent of PACE centers. PACE participants provide responses on their satisfaction with key PACE domains, including activities, meals, transportation, and care teams; states may also survey participant caregivers or PACE center staff (Vital Research 2023). Another method through which states may capture PACE quality is the Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Survey, which includes questions related to unmet need, satisfaction, and caregiver supports (AHRQ 2024). A third survey instrument, the National Core Indicators—Aging and Disabilities, may also include PACE participants and breaks out responses on questions relating to access and satisfaction by home- and community-based service program type. Currently, only two states include PACE participants in this survey (NCI-AD 2024).

Financing

As an integrated care approach, PACE organizations receive capitated payments from Medicaid and Medicare. These capitation payments do not fluctuate with changes in a participant's health status but must account for the frailty of PACE enrollees compared to the general Medicaid or Medicare populations.[30] PACE organizations must accept these payments as full reimbursement for both Medicaid and Medicare participants, meaning providers cannot charge participants deductibles, copayments, or coinsurance (42 CFR 460.182(c), 42 CFR 460.90). Unlike other integrated models, PACE organizations fully braid these financing streams into a single fund to provide all necessary services to PACE participants. This means the PACE organization does not have to delineate which services are covered by Medicare or Medicaid and bill for their respective services provided by the IDT; rather, PACE providers do not bill at all for services provided through the PACE program, and the PACE organization operates with full financial risk.

Due to a lack of high-quality data, published studies have largely been unable to estimate the effects of integrated care, including PACE, on Medicaid spending (Barrie Smith et al. 2021). Research on PACE's impact on Medicaid spending is mixed. Some studies reported an increase in Medicaid spending under PACE, while others identified savings to Medicaid from enrolling frail adults in PACE who would have otherwise received more expensive care in institutional settings (Ghosh et al. 2015, Wieland et al. 2013, Foster et al. 2007).

BOX 4-2. Other Sources of Program of All-Inclusive Care for the Elderly Financing

Program of All-Inclusive Care for the Elderly (PACE) organizations receive a blend of monthly capitated payments from Medicare Parts A, B, and D and any premiums from participants, in addition to capitated payments by state Medicaid agencies.

Medicare Parts A and B. The Centers for Medicare & Medicaid Services (CMS) pays PACE organizations using county-level benchmarks (Skopec 2024). Unlike Medicare Advantage plans, PACE organizations do not submit bids but rather receive the benchmark amount for the counties served. Medicare payments to PACE organizations are risk adjusted, and organizations also receive a frailty adjustment (CMS 2011a).

Medicare Part D. PACE organizations must submit bids as Medicare Part D plan sponsors with separate plan benefit packages for dually eligible participants, for whom PACE organizations receive additional amounts to cover where Medicare Part D low-income subsidies do not fully cover participant costs, and for Medicare-only participants (CMS 2011a). CMS pays PACE organizations monthly with payments comprising Medicare Part D premiums paid on behalf of participants, reinsurance subsidies, and low-income subsidies (CMS 2024f).

Premiums. PACE organizations may not collect premiums from dually eligible or Medicaid-only participants, who comprise the majority of program participants. PACE organizations may collect Medicare Part D premiums and a premium to cover the Medicaid capitation payment from Medicare-only participants and any participants who pay privately (42 CFR 460.186).

Post-eligibility treatment of income. PACE organizations may collect payment from Medicaid-covered participants related to their liability in spending down income to meet Medicaid financial eligibility or as part of post-eligibility treatment of income (CMS 2011a). Some states do use this option for PACE.

The methodologies for Medicaid and Medicare capitation payments to PACE organizations differ.[31] Generally, states base the capitation rate for each Medicaid participant on a blend of the cost of nursing home and community-based care for the elderly in the area as well as Medicaid managed care data in those states where applicable to account for the frailty of the PACE population (CMS 2011a). Medicaid rates must be less than the amount that would otherwise have been paid (AWOP) for a comparable population age 55 or older meeting NFLOC criteria not enrolled in PACE (42 CFR 460.182). Although each state uses different methods to determine their Medicaid AWOPs and capitation rates for PACE, approximately half of states set the capitation rates as a fixed percentage of the AWOP (e.g., 95 percent of the AWOP). States can create multiple rate cells based on participant age, sex, geographic region, eligibility category, or Medicare status to more accurately project the AWOP (CMS 2025e). However, states cannot use separate institutional and community rate cells, as they can in some Medicaid payments to D-SNPs (MACPAC 2013). Separate Medicaid rates are determined for dually eligible and Medicaid-only PACE participants. Among our case study states, Medicaid capitation payments for full-benefit dually eligible individuals ranged from approximately $2,800 per member per month to $7,700 per member per month; this range reflects the various factors that the rate comprises, such as local cost of living and health care costs, as well as local policies, budgetary constraints, and negotiated agreements between state Medicaid agencies and PACE organizations (Skopec 2024). Rates for Medicaid-only participants are normally higher than rates for dually eligible beneficiaries to account for services that are usually covered by the Medicare capitation payment (Stitt and Higgins 2021). For example, in one state we spoke with, the highest capitation payment made for Medicaid-only participants was about $2,800 per member per month more than the highest capitation payment made for full-benefit dually eligible participants in 2022.

Combined federal and state Medicaid spending on PACE services totaled $3.9 billion in FY 2023. Fifty-six percent ($2.2 billion) of that spending came from the federal share of Medicaid costs, while another 5 percent ($183 million) came from the federal share of relief associated with the COVID-19 PHE. The remaining 40 percent, or $1.5 billion, came from the 32 states and the District of Columbia with PACE programs last year (CMS 2023). Aggregate Medicare spending data on PACE are not available. For more information on other sources of PACE financing, see Box 4-2.

Medicaid spending on PACE has increased substantially in recent years as the federal government and states have moved to increase the use of HCBS relative to institutional care. Over the past two decades, spending on PACE has grown from $0.9 billion in 2011 to $3.9 billion in 2023 (Figure 4-5).

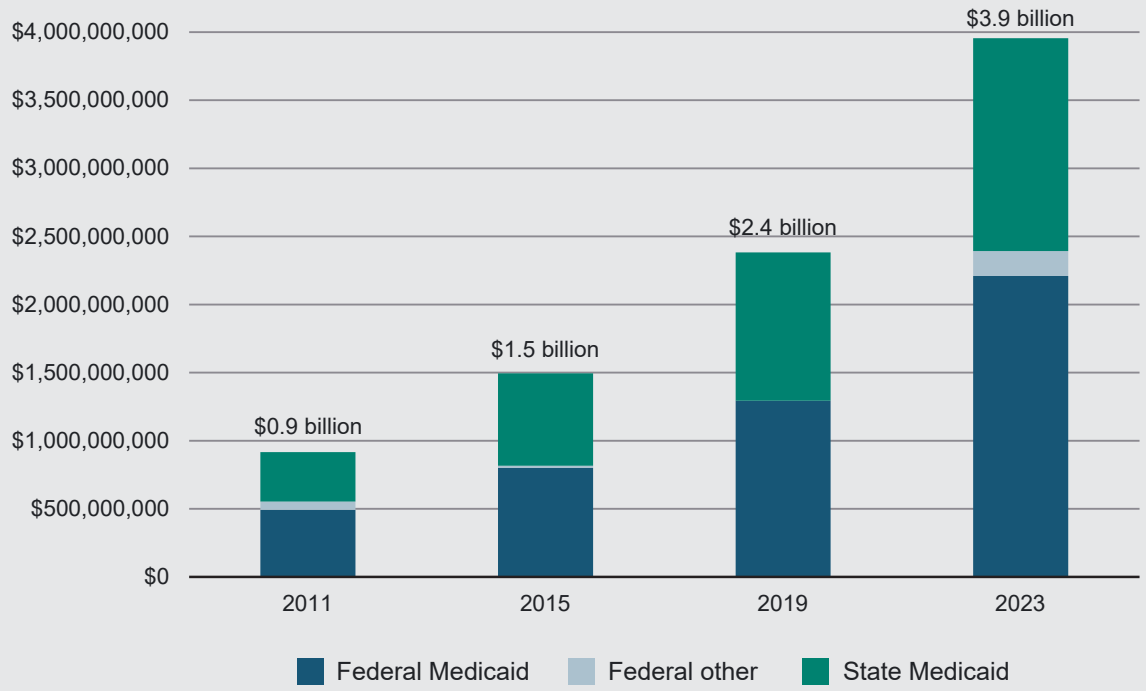
Interviews with federal and state officials revealed few specifics about how states approach developing their PACE capitation rates, although several states said they rely on the same third-party actuaries that develop rates for their Medicaid managed care programs. States attempt to develop their capitation rates using comparable populations, but the PACE population's unique needs paired with the lack of reliable data on PACE organizations' utilization and costs raises concerns about how well Medicaid capitation rates match the services provided. One federal official shared that substantial variation in the quality of encounter and claims data at the state level makes it difficult to assess the adequacy of PACE payments relative to PACE expenses and that differing state rate-setting methodologies and comparison populations can result in either lower or higher Medicaid spending on PACE compared to alternative care settings as well as between PACE organizations. California is unique among the states we interviewed in developing its PACE capitation rates using utilization and experience data (CMS 2018). However, states varied in how often they update PACE capitation rates as state budgets constrain the availability of funds from the legislature for both service expansions and capitation rate increases. And overall, PACE organizations said they lack the clarity from states on how Medicaid capitation rates are established.

Medicaid capitation rate development. CMCS provides states with guidance on rate setting, in addition to reviewing rates developed by states (42 CFR 460.182). The agency issued an updated Medicaid capitation rate setting guide effective January 1, 2025, which replaces the previous version from 2015 and requires thorough documentation of how states developed the AWOP and subsequent rates (CMS 2025e). Federal statute does not require PACE Medicaid capitation rates to be actuarially sound, unlike

other managed care rates under 42 CFR 438. Guidance from CMS instructs states to ensure consistency of their rate methodology with the AWOP and the rate description in their state plan (CMS 2025e). Most states rely on third-party actuaries to develop their Medicaid capitation rates for PACE. Officials shared that actuaries in several of the states we spoke with use past-year utilization data for the state's fee-for-service and managed care populations to inform PACE rates. Officials in one state said its capitation rates are set as a percentage of fee for service, though they noted the need for this approach to change as the state has less fee-for-service data to use as its dually eligible population increasingly receives coverage through managed care.[32] Several states mentioned relying on utilization data regarding nursing facility placements and hospital stays, although one state said that some PACE organizations have objected to including nursing facility utilization in developing the PACE capitation rate because PACE is not an institutional model. Federal officials said that CMCS contracts with an actuary to ensure that the costs used by a state to develop their AWOP are based on appropriate populations and allowable costs. In developing capitation rates, actuaries are bound by their profession to adhere to actuarial standards of practice regardless of whether the rates are required by law to be actuarially sound. One federal official discussed the difficulties of collecting and interpreting PACE cost data and associated challenges of analyzing the cost effectiveness of PACE compared to other integrated care models.

States varied in how regularly their rates are reviewed and updated. Officials in most states we interviewed said that rates are reviewed on an annual basis.[33] Federal officials said that most states update rates annually, but in interviews officials from three states described rates that had not been adjusted in years.[34]

FIGURE 4-5. Federal and State Program of All-Inclusive Care for the Elderly Expenditures, FYs 2011–2023



Notes: FY is fiscal year. "Federal Other" includes funds from the American Recovery and Reinvestment Act of 2009 (P.L. 111-5), Balancing Incentive Program, and American Rescue Plan Act of 2021 (P.L. 117-2) that the Centers for Medicare & Medicaid Services includes with federal medical assistance percentage (FMAP) reporting.

Source: CMS-64 data from FY 2011 to FY 2023 (CMS 2023).

For PACE organizations in one state, a PACE provider said that rates had not been increased in 15 years.[35] Officials across multiple states emphasized that rate increases depend entirely on the state budget, since the PACE program comprises a small portion of Medicaid funding allotted by the state legislature. One state official noted that rates in their state, which previously increased PACE rates two years earlier, may increase substantially pending state budget discussions active at the time of our interview. However, that official expressed frustration that the state Medicaid agency currently lacks the necessary data about PACE costs and performance to press the legislature for higher rates.[36]

As the only state in our study to develop rates using PACE utilization and experience data, officials in California said in an interview that the state shifted to that payment methodology in 2018 to better match Medicaid payments to PACE organization risk. State officials said that an experience-based payment methodology more directly paid PACE organizations for their projected costs rather than setting a statewide percentage of the AWOP.[37] However, some PACE stakeholders highlighted that the state uses experience-based payment only for PACE organizations rated as "fully credible," meaning that organizations must meet a member-month threshold with sufficient enrollment over a two-year period (CMS 2018). For organizations that do not meet this threshold, PACE representatives said that organizations receive a blended rate based on the experience of PACE organizations in the same county or region, or using an adjacent, nearby, or similar county or region, within the state. California officials added that they regularly engage PACE organizations in an effort to be transparent about how the state uses submitted data to develop rates, but they said they still receive feedback from the PACE organizations on transparency and lack of methodological understanding.[38] Some PACE organizations we spoke with disagreed that the state's rate-setting process has been transparent.

State requirements around PACE organizations submitting Medicaid encounter data among our interviewed states were uncommon, even among states with Medicaid managed care and other mature integrated care models. California's PACE capitation rate setting may most closely reflect that of other managed care models because it pays PACE organizations within a rate range, developed based on experience data reported by organizations, while staying below the AWOP. Some PACE organizations said in interviews that current encounter reporting systems cannot be used for reimbursement due to a lack of PACE-specific encounter codes. Among states in our study, officials in two states said they develop their AWOP using similar populations in those states' integrated D-SNPs.

PACE organizations voiced mixed views on Medicaid rate-setting methodologies, and they said that they found state processes for developing PACE capitation rates to be unclear. PACE Medicaid capitation rates are risk-based payments made prospectively to cover the projected Medicaid expenses of the enrolled PACE participant, usually based on the average cost of a comparable population in alternative settings. This may result in financial gains or losses to the PACE organization when actual expenses vary from the capitation rate. One PACE organization said their organization faced a financial loss in the past year due to housing costs for participants who no longer have family supports. Meanwhile, another PACE organization said that Medicaid capitation rates in its state have failed to keep up with inflation and changes to patient acuity. PACE stakeholders in California voiced the most substantial complaints about the adequacy of Medicaid capitation rates. Most PACE organizations we interviewed that operate in the state said that because PACE organizations can use the capitation payments to provide services not covered under Medicaid or Medicare but determined necessary by the IDT, current encounter reporting does not accurately capture organizational costs. However, one PACE organization acknowledged that it benefits from cost savings when services it provides can generate reductions in hospitalizations and nursing facility placements.

State Medicaid capitation rates to PACE organizations can vary widely based on factors such as local cost of living and health care costs, and most states do not provide public data on capitation rates or how they are calculated. Officials in one state said that PACE organizations benefit from a capitation rate that blends nursing facility and community populations, noting that these organizations receive a capitation rate that assumes a level of nursing facility placements that officials said PACE organizations rarely meet. However, an official in another state remarked that PACE reimbursement may always appear insufficient

to providers when compared with rates received in nursing facilities and through other HCBS since PACE capitation rates are statutorily required to be below those rates.

Looking Ahead

Although its market presence remains small compared to other integrated care approaches, enrollment, spending, and interest in PACE have grown substantially over the past decade. As demonstrated in our interviews, stakeholders largely view PACE as a comprehensive and effective approach for integrating a full spectrum of medical, social, and supportive services for individuals age 55 and older with complex health needs, most of whom are dually eligible. More than 25 years after PACE became a permanent Medicaid and Medicare program, there remains ample room to explore the program as part of the Commission's long-standing interest in policies affecting dually eligible beneficiaries.

Endnotes

[1] FIDE SNPs are MA plans that limit enrollment to dually eligible beneficiaries, offer fully integrated coverage, and are typically responsible for all Medicaid and Medicare benefits. Medicare-Medicaid Plans operate under a three-way contract with the Centers for Medicare & Medicaid Services (CMS), the state, and the plan to provide all Medicaid and Medicare benefits (MACPAC 2022).

[2] The control populations used for PACE participants in these studies are varied, with evaluations matching PACE enrollees to people enrolled in home- and community-based services (HCBS) 1915(c) waivers, new nursing home entrants, and other non-PACE dually eligible individuals across states (Ghosh et al. 2015, JEN Associates 2015, Segelman et al. 2014, Wieland et al. 2010, Beauchamp et al. 2008). One important limitation to note is that ineligible populations, such as HCBS waiver users who do not meet NFLOC requirements or nursing home entrants who cannot safely remain in their home, make less comparable control groups.

[3] To be eligible for PACE, an individual must meet the NFLOC requirement established in the state's Medicaid plan (42 CFR 460.150(b)(2)). The NFLOC is a proxy for the comparative frailty of PACE enrollees, a factor that the Balanced Budget Act of 1997 required that states incorporate into PACE capitation rates (MACPAC 2013).

[4] One state described an instance in which a PACE organization's application was marked incomplete because the PACE center did not yet have a street address. This was because the town had not yet named the new street on which the PACE center was located. An official from this state said that CMS is often too strict with PACE applications, leading to delays in approving and operationalizing new programs.

[5] Federal officials confirmed that the use of multiple H-numbers also creates administrative challenges for CMS as audits are conducted on the contract level.

[6] Although two states do permit PACE organizations to operate in some of the same areas, the majority of states do not allow PACE organizations to compete in the same service area (42 CFR 460.12(c)(2)).

[7] Services furnished outside the country may be allowed as indicated at 42 CFR 424.122 and 42 CFR 424.124 or through the state's Medicaid state plan. Surgery to improve the function of a body part after an injury and reconstruction after a mastectomy are included.

[8] PACE organizations we spoke with reported serving diverse populations. Two PACE organizations serve primarily Black populations, with program censuses of 93 percent and 100 percent Black participants. Another organization noted its sizeable Hispanic and Vietnamese populations. The state association we interviewed shared that across the state, 44 percent of PACE enrollees identified as Hispanic, 21 percent as white, 19 percent as Asian, 8 percent as other, 7 percent as Black, and 1 percent as American Indian.

[9] PACE organizations must have at least one PACE center within or next to its designated service area, which may be defined by county, zip code, street boundaries, census tract, block, or tribal jurisdictional area and which is established in the program agreement signed by the PACE organization, state, and CMS (42 CFR 460.32, 42 CFR 460.98(e)(1)).

[10] Surveys and qualitative interviews conducted in one study suggest that PACE programs were able to make substantial service delivery changes in response to the PHE. The majority of respondents increased the amount of in-home care provided to compensate for the reduction

in center-based direct care, with home-based staff delivering services such as nursing; primary care; personal and home health care; physical, occupational, and speech therapy; and medication administration, along with various other health care and social support services (Perry et al. 2024).

[11] At least one state official said in an interview that their state's two-way agreement specifies that PACE organizations must use a community-based assessment for all HCBS in the state.

[12] One state interviewed requires PACE organizations to assist with participant transfers between PACE organizations via subregulatory guidance. An official said that the state had seen several nursing facilities and assisted living facilities close and that the state would prefer participants who have elected to enroll in PACE to be able to remain in PACE rather than dropping into fee for service. This state manually reviews and approves each participant transfer to ensure PACE organizations are not poaching participants who live in areas served by multiple providers.

[13] Frequency of PACE center attendance is determined by the IDT, but participants may refuse to partake in PACE center activities if they wish while still receiving services from the center.

[14] Medicare and Medicaid oversight are required for any PACE program, regardless of participant makeup, given its status as a program under both Sections 1894 and 1934 of the Social Security Act.

[15] Federal officials pointed to the PHE as the initial reason for conducting audits virtually. However, the officials said they have continued to conduct most audits after the trial period—during which audits are statutorily required to be conducted on site—virtually because they said it reduces burden for PACE organizations. One PACE organization interviewee said their site is heavily documenting all of its processes in anticipation of a future audit as the PACE organization has not been audited by CMS in the last six years.

[16] CMS officials noted that two recent rounds of rulemaking related to PACE arose due to audits that identified the need for certain safeguards.

[17] PACE programs may be able to offer plan debit cards without affecting participants' financial eligibility for Medicaid, but they must follow different marketing guidelines than MA plans (ATI Advisory 2024).

[18] Officials in one state, which has had turnover in its office that oversees PACE, said they struggle to interpret CMS audit reports and would prefer those results to be shared automatically with the state rather than over calls with the PACE organization.

[19] Federal regulations do require general time frames for arranging and providing services, which became effective in 2025, and will be included in oversight efforts going forward (42 CFR 460.98(c)(2)).

[20] State officials described PACs as a useful source for uncovering issues within and trending across PACE organizations. However, they also noted that typical complaints are about the quality of the food or transportation, similar to those voiced in other integrated care models.

[21] An official in a different state said it was updating its two-way agreement for the first time since 2014 and distinguished the length and complexity of the PACE agreement—which they said was about 14 pages—from that of the state's agreement with its integrated MA dual eligible special needs plans, which extends hundreds of pages.

[22] This state official said they believe the CMS audit is sufficient and that the state should audit only in response to critical incidents.

[23] PACE Medicare encounter claims are usually generated by specialty services delivered outside the PACE center, such as audiology, cardiology, dentistry, and other specialty services listed in 42 CFR 460.70.

[24] One state official said they looked to encounter reporting procedures developed by New York and Colorado for a model to adapt for their own state. Although the official said they are working to have all integrated care offerings in the state reporting in a similar way to allow for insights, such as trends in nursing facility utilization, they added that they would not recommend comparing PACE to D-SNPs using encounters because services are less clear-cut in PACE. For example, the official said that transportation in PACE is often far more involved than a similar transportation benefit offered through a D-SNP because drivers for PACE may end up assisting a participant inside and then aiding them in a related task within their home.

[25] One PACE organization official noted that it collects and reports encounter data to its parent organization, which requires it in support of a grant the organization receives. The state in which this organization operates does not collect Medicaid encounter data.

[26] Current quarterly data reporting requirements give PACE organizations 45 days after the end of the reporting quarter to submit data to CMS (CMS 2024e).

[27] Federal regulations require that the IDT document all recommendations for care or services as well as the reasons for not approving or providing those services (42 CFR 460.102(d)(iii)). State officials said they review SDRs and will, in some cases, walk through service request denials with the IDT as part of their audit.

[28] PACE organizations must use a set of outcome measures for internal quality-improvement activities (42 CFR 460.136).

[29] Although this state requires PACE organizations to submit an annual quality-improvement report, officials said that it primarily relies on participant satisfaction surveys as a proxy for quality.

[30] Although some states include a risk adjustment component in their Medicaid rates, most use a flat rate for all participants receiving Medicaid (Stitt and Higgins 2021). In prior examinations of Medicaid capitation rates for integrated care plans, MACPAC found that few states used risk adjustment in PACE due to the limitations of risk adjustment models for long-term services and supports. Wisconsin and New York risk adjusted for PACE services by combining the PACE and D-SNP rate-setting efforts and using the long-term services and supports risk adjustment process for both programs (MACPAC 2013).

[31] Currently, federal officials said that PACE organizations use a legacy diagnosis reporting system as the basis for reimbursement while CMS helps familiarize organizations with submitting service-level encounter data, although the agency uses the encounter data it receives to assist in calculating costs. However, utilization data are not as complete as they would be from an MA plan.

[32] This state does not currently enroll dually eligible individuals in Medicaid managed care.

[33] Medicaid capitation rates can be renegotiated annually (42 CFR 460.182).

[34] In contrast, one state official said their state updates capitation rates annually and has even issued mid-year capitation rate updates as needed, which CMS permits under specific circumstances, such as legislation mandates, on a case-by-case basis.

[35] The PACE organization speculated that capitation rates were finally increased because PACE organizations in the state were beginning to struggle to demonstrate financial soundness to CMS. State officials confirmed that the capitation rate was increased for 2024 and will likely be increased again for the coming rate year.

[36] A PACE organization in one state said it saw a 10 percent cut in its capitation rate one year due to state budget constraints, which they said created vulnerability for their organization.

[37] One PACE organization in the state said that California is still statutorily limited in its payment rates by the AWOP. Therefore, some PACE sites in the state may near that ceiling with their experience-based rates.

[38] Although state officials said that reimbursement is calculated based on reported costs, they also noted that the state's contracted actuary also considers whether reported costs are reasonable. The officials said that some PACE organizations may report extraordinary costs that the state does not find reasonable.

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