

Chapter 6:

# Exploring the Role of the State Medicaid Agency in the Program of All-Inclusive Care for the Elderly

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## Recommendations

- 6.1** The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update audit protocols and three-way program agreements to facilitate joint audits of Program of All-Inclusive Care for the Elderly organizations with state administering agencies. Audit coordination should include joint planning of audit scopes, sharing documentation requests, and reviewing evidence concurrently, while preserving CMS's responsibility for assessing federal requirements and states' responsibility for assessing state-specific requirements.
- 6.2** The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to aggregate and publicly release, in a user-friendly format on the CMS website, existing Program of All-Inclusive Care for the Elderly (PACE) performance data, including data PACE organizations submit through CMS's Health Plan Management System as well as enrollee satisfaction data collected as part of PACE organization quality improvement programs pursuant to 42 CFR 460.134(a)(2).
- 6.3** The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to amend regulations at 42 CFR 460 Subpart H to develop a standardized, national quality measure set for Program of All-Inclusive Care for the Elderly (PACE) organizations. Quality data should be compiled and made publicly available in an accessible format. CMS should follow three key principles when developing a PACE quality measure set: engage stakeholders collaboratively; minimize reporting burden by focusing on the most meaningful measures; and prioritize standardized measures that enable comparability across programs where feasible.

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## Key Points

- The Program of All-Inclusive Care for the Elderly (PACE) is a provider-led, home- and community-based care model serving adults age 55 and older who are eligible for nursing home care but can live safely in the community at the time of enrollment.
- Findings from our review of federal and state PACE oversight documents and stakeholder interviews identified variation in how states oversee PACE organizations, including differences in oversight tools, monitoring practices, data collection, and coordination with the Centers for Medicare & Medicaid Services (CMS).
- PACE programs operate under a required, standardized three-way program agreement among the PACE organization, CMS, and the state. Some states also use optional two-way program agreements between the state and PACE organizations to supplement the federal oversight framework by clarifying expectations, adding specificity, and supporting enforcement of requirements that may not be explicitly detailed in federal regulations.
- Oversight of PACE organizations is a shared responsibility between CMS and states, requiring coordination across multiple activities, including monitoring, audits, and data use. Stakeholders described this relationship as collaborative and also identified opportunities to improve coordination between federal and state oversight efforts, particularly in audit processes.
- Stakeholders highlighted challenges related to limited transparency and inconsistent availability of PACE performance and quality data. Limited and non-standardized data as well as the relatively small and heterogeneous PACE population make it difficult to compare performance and outcomes across PACE organizations and states.
- These findings point to three key policy needs: (1) improved coordination of oversight activities, (2) greater transparency of program performance data, and (3) a standardized approach to data collection and quality measurement.

# CHAPTER 6: Exploring the Role of the State Medicaid Agency in the Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a provider-led, home- and community-based care model serving adults age 55 and older who are eligible for nursing home care but can live safely in the community at the time of enrollment.<sup>1</sup> Approximately 75 percent of participants are dually eligible for Medicare and Medicaid (CMS 2024a). PACE delivers fully integrated medical and non-medical services primarily through adult day care centers, with additional services provided in the home and post-acute care settings, and is designed as a community-based alternative to institutional care aimed at delaying or preventing nursing facility and hospital use (CMS 2011).

Understanding how PACE operates and is overseen has been a key focus of the Commission's recent analytic work. During the 2024–2025 cycle, staff conducted a policy scan and stakeholder interviews to examine the program's statutory and regulatory framework and highlighted findings on eligibility, enrollment, service delivery, oversight, and payment in the Commission's June 2025 report to Congress (MACPAC 2025). The prior chapter discussed research on PACE participant outcomes, including studies examining hospitalization, nursing facility use, mortality, and behavioral health outcomes (MACPAC 2025).<sup>2</sup> Although PACE is widely recognized as a highly integrated care model for dually eligible individuals, Commissioners and stakeholders raised concerns about transparency and ambiguity in state-level oversight, particularly regarding the role of state Medicaid agencies.

In response, the Commission sought to better understand state oversight of PACE and its interaction with federal oversight activities. Our analysis focused on states' legal authority and capacity to establish,

monitor, and enforce standards in PACE programs, including their statutory and regulatory responsibilities (as distinct from federal oversight), the tools states use to oversee PACE organization performance and compliance, operational resources and capacity constraints that affect oversight, and the extent to which states measure and evaluate the quality of Medicaid services provided to PACE participants.

To inform this work, staff conducted a review of key federal and state oversight documents, including required three-way program agreements among the Centers for Medicare & Medicaid Services (CMS), states, and PACE organizations; optional two-way agreements between states and PACE organizations; and waiver requests submitted under Section 903 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554), known as "BIPA 903 waivers." Staff also conducted stakeholder interviews with state Medicaid officials, CMS officials, and PACE experts.

Findings from this work identified key challenges and barriers to transparency in PACE program performance. State and federal officials reported variation in oversight practices, including differences in state and CMS roles, the use of two-way program agreements, and oversight tools. They also noted limited and non-standardized data and inconsistent approaches to measuring performance and outcomes. Some states reported capacity constraints, particularly staffing and resource limitations in growing programs. In addition, stakeholders highlighted coordination gaps, including misalignment and duplication in oversight activities. These challenges point to three key policy needs: (1) improved coordination of oversight activities, (2) greater transparency of program performance data, and (3) a standardized approach to data collection and quality measurement.

Based on these findings, the Commission makes three recommendations to improve coordination between state and federal oversight activities and to enhance the availability of accessible information on PACE performance and quality. The Commission's recommendations are:

- 6.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update audit protocols and three-way program

agreements to facilitate joint audits of Program of All-Inclusive Care for the Elderly organizations with state administering agencies. Audit coordination should include joint planning of audit scopes, sharing documentation requests, and reviewing evidence concurrently, while preserving CMS's responsibility for assessing federal requirements and states' responsibility for assessing state-specific requirements.

- 6.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to aggregate and publicly release, in a user-friendly format on the CMS website, existing Program of All-Inclusive Care for the Elderly (PACE) performance data, including data PACE organizations submit through CMS's Health Plan Management System as well as enrollee satisfaction data collected as part of PACE organization quality improvement programs pursuant to 42 CFR 460.134(a)(2).
- 6.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to amend regulations at 42 CFR 460 Subpart H to develop a standardized, national quality measure set for Program of All-Inclusive Care for the Elderly (PACE) organizations. Quality data should be compiled and made publicly available in an accessible format. CMS should follow three key principles when developing a PACE quality measure set: engage stakeholders collaboratively; minimize reporting burden by focusing on the most meaningful measures; and prioritize standardized measures that enable comparability across programs where feasible.

To provide context for these recommendations, the chapter begins with our analytic approach in this work and background on the PACE model, including oversight documents used by CMS and states. It then describes our findings on state oversight of PACE organizations, coordination between state and federal oversight efforts, and the collection of quality and performance data. The chapter then presents the Commission's three recommendations with supporting rationale and implications for federal spending, state Medicaid agencies, PACE organizations, and enrollees.

## Analytic Approach

We contracted with the Center for Health Care Strategies to review the primary federal and state documents used to govern and operate the PACE model and to conduct stakeholder interviews with states and other PACE subject matter experts. The document review focused on three key document types: required three-way program agreements among CMS, states, and PACE organizations; optional two-way program agreements between state administering agencies (SAAs) and PACE organizations; and BIPA 903 waiver requests submitted by PACE organizations to states and CMS. We partnered with the Center for Health Care Strategies to compare a publicly available three-way program agreement template with two-way program agreements from 16 states and the District of Columbia and review BIPA 903 waiver requests from PACE organizations in 9 states to assess how these flexibilities might affect state oversight responsibilities. In total, we reviewed 65 distinct documents between August and December 2025. Because there is no centralized database of two-way program agreements or BIPA 903 waivers, these documents were collected directly from states and CMS.

We also spoke with key state officials and one state PACE association in six states: California, Colorado, Kentucky, New Jersey, North Carolina, and Ohio. These states were selected to capture variation in geography, political context, integrated care offerings, PACE program maturity, and oversight approach—specifically, the presence or absence of two-way program agreements. We also interviewed federal stakeholders from CMS, including the Center for Medicaid and CHIP Services, the Center for Medicare, and the Office of Program Operations & Local Engagement as well as the National PACE Association (NPA) and an independent national PACE expert.

## Background

PACE is designed as a community-based alternative to institutional care, aimed at delaying or preventing nursing facility and hospital use (CMS 2011).

To achieve this, PACE organizations rely on an interdisciplinary team of providers who assess participants' needs; develop care plans; and provide continuous, coordinated care in the community. As a fully integrated model combining Medicare and Medicaid financing and service delivery, PACE relies on a shared federal-state oversight structure involving CMS and states.

PACE's design and oversight structure create unique challenges for federal and state regulators (MACPAC 2025). For example, statutory and regulatory guidance do not always clearly delineate how oversight responsibilities are divided between CMS and state Medicaid agencies. In the first phase of this work, stakeholders—including federal and state officials and PACE organizations—described the oversight structure as complex and, at times, lacking clear ownership, noting that responsibilities are distributed across multiple units within CMS and between federal and state entities.<sup>3</sup> Stakeholders also highlighted that PACE does not fit neatly within existing oversight frameworks, relying in part on Medicare Advantage infrastructure while operating as a distinct provider-led model. Interviewees further reported that limited and non-standardized data, combined with a small and heterogeneous PACE population, make it difficult to assess performance and compare outcomes across programs (MACPAC 2025). Together, these factors complicate coordination of oversight activities and limit transparency into PACE program performance. These challenges are reflected in the findings presented in this chapter, including variation in oversight practices, gaps in coordination, and limitations in available data.

During 2024, more than 14 million people were dually enrolled in Medicare and Medicaid (CMS 2025a). Of these, 73 percent were eligible for full Medicaid benefits, referred to as “full-benefit dually eligible beneficiaries,” and the remaining 27 percent were eligible only for Medicaid assistance with certain Medicare premiums, cost sharing, or both, referred to as “partial-benefit dually eligible beneficiaries.” As of December 2024, just over 735,000 full-benefit dually eligible beneficiaries received care through one of

the three models that provide fully integrated care: Medicare Advantage fully integrated dual eligible special needs plans, Medicare-Medicaid Plans, and PACE (ICRC 2025).<sup>4</sup>

As of May 2026, nearly 78,000 dually eligible individuals were enrolled in 202 PACE programs across 33 states and the District of Columbia (CMS 2026, NPA 2026). Because monthly enrollment data from CMS exclude Medicaid-only beneficiaries, total PACE enrollment is closer to 92,000 individuals (NPA 2026).<sup>5</sup> CMS has reported that approximately 75 percent of PACE enrollees are dually eligible for Medicare and Medicaid, while the remaining 25 percent are primarily Medicaid-only beneficiaries, although this estimate is based on a different data source than the monthly enrollment counts (CMS 2024a).<sup>6</sup>

PACE began in San Francisco, California, in 1971 as a community-based model to provide comprehensive care to older adults and was later authorized as a permanent Medicare program and a Medicaid state plan option (§ 1894 and § 1934 of the Social Security Act (the Act)) through the Balanced Budget Act of 1997 (P.L. 105-33) (CMS 2011). The statute established the nation's first permanent integrated care model (MACPAC 2020). It also specified five core principles of the PACE model that the Secretary of the 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 interdisciplinary team 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.

PACE organizations must offer a comprehensive range of services, including all Medicare- and Medicaid-covered services as well as other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status, without typical benefit limitations and on a continuous basis across settings (42 CFR 460.90, 460.98). An interdisciplinary team coordinates care and assesses participants, develops care plans, and manages services delivered in PACE centers, participants' homes, and institutional settings when needed. An estimated 95 percent of PACE participants live at home (NPA 2019). This flexibility allows PACE organizations to deliver a tailored mix of medical and non-medical services across the full continuum of care, supporting participants' ability to remain in the community for as long as possible.

Oversight of PACE organizations reflects the model's unique dual-authority structure under Section 1894 (Medicare) and Section 1934 (Medicaid) of the Act, which establish PACE as a permanent program jointly administered by the federal government and participating states. This statutory framework assigns shared responsibility to CMS (through the HHS Secretary) and states to approve, monitor, and oversee PACE organizations. Within this framework, CMS establishes implementing regulations and requires PACE organizations to collect, maintain, and report data needed to monitor program operations, outcomes, compliance, and financial performance. States administer the Medicaid component of the benefit and oversee state-specific program implementation and operations. Federal regulations further operationalize these requirements by establishing detailed standards for program administration, service delivery, quality assurance, and oversight (42 CFR 460). CMS may also incorporate updates to PACE regulations in its annual rulemaking on Medicare Advantage and Medicare Part D prescription drug coverage (CMS 2024b).

## PACE Oversight Framework

Both Section 1894 and Section 1934 of the Act require CMS and states to share responsibility for key monitoring and enforcement functions. CMS and states collaborate to oversee PACE organizations, including jointly reviewing program operations, determining eligibility, and assessing compliance with regulatory requirements. They also monitor performance and quality, including by reviewing program data submitted by providers and, in some cases, developing outcome measures. CMS retains ultimate authority over federal PACE regulations and enforcement of federal program requirements, including issuing regulations; approving, denying, or deeming approved provider applications; and taking enforcement actions such as requiring corrective action plans (CAPs), withholding payments, or terminating agreements.<sup>7</sup> States may also independently oversee compliance with state requirements, conduct audits, implement corrective actions, and terminate program agreements in accordance with state authority and contract provisions. Together, this structure establishes PACE as a collaborative federal-state model in which states serve as active coadministrators and CMS provides overarching regulatory direction and primary authority over federal program requirements.

This federal-state oversight framework is operationalized through required three-way program agreements that define the roles and responsibilities of CMS, SAAs, and PACE organizations. States may also use additional tools to operationalize and supplement this framework, including optional two-way program agreements that establish state-specific requirements and processes. In addition, Section 903 of BIPA authorizes CMS to grant waivers of certain regulatory requirements, providing another mechanism that can shape how oversight is implemented in practice.

## Required three-way program agreements

PACE organizations operate under a three-way program agreement among the PACE organization, CMS, and the SAA (CMS 2000). The agreement is divided into seven articles with standardized language. Many of the articles have related appendices that contain state- and organization-specific information (e.g., service area or disenrollment policies). Table 6-1 provides additional details on the structure of the three-way program agreement.

Although the core sections of the agreement are standardized, CMS allows states to include two types of optional content. First, the agreement may include additional PACE organization-specific requirements for determining PACE eligibility (42 CFR 460.150(b)(4)). Second, the agreement may include additional terms and conditions agreed upon by all three parties, provided they are consistent with Section 1894 and Section 1934 of the Act and regulations (42 CFR 460.32(b)(2)).

**TABLE 6-1.** Program of All-Inclusive Care for the Elderly Three-Way Program Agreement Structure

| Section   | Description  | Related appendix      |
|---|--|-----------------------|
| Article I. Term of Agreement                                  | Time frame for contract year   | –                     |
| Article II. A. Governing Body                                 | Contact information for PACE organization management   | Appendix A            |
| Article II. B. PACE Structure                                 | Description of the organizational structure of the PACE organization   | Appendix B            |
| Article II. C. Service Area and PACE Sites                    | Description of designated service area of PACE organization  | Appendix C            |
| Article II. D. Participant Bill of Rights                     | PACE organization makes available to all enrollees a list and explanation of the rights to which they are entitled   | Appendix D            |
| Article II. E. Services                                       | Required health care services that include, at a minimum, all services required by 42 CFR 460.92 and 460.94  | –                     |
| Article II. F. Eligibility, Enrollment, and Disenrollment     | General PACE eligibility criteria, PACE organization's eligibility and enrollment policies, state role in eligibility determinations, and voluntary and involuntary disenrollment processes  | Appendices E, F, G, H |
| Article II. G. Grievances and Appeals                         | Rights of PACE enrollees to grieve medical and non-medical decisions and submit appeals  | Appendices I, J       |
| Article II. H. Quality Assessment and Performance Improvement | Description of PACE organization's quality assessment and performance improvement program, CMS and state standardized quality measures, and how the PACE organization will provide data and information on participant care activities | Appendices K, L       |
| Article II. I. Data Collection and Reporting Requirements     | The PACE organization collects data and submits reports as required by CMS and the state, and CMS and the state have the right to inspect, evaluate, and audit PACE organizations  | –                     |
| Article III. Payment  | Description of Medicare and Medicaid payment rates   | Appendices M, N       |

**TABLE 6-1.** (continued)

| Section  | Description   | Related appendix         |
|--|---|--------------------------|
| Article IV. Termination of the Agreement             | CMS or the state may terminate the agreement at any time for cause, the PACE organization may terminate agreement after timely notice, and the PACE organization must provide a detailed written plan for phasedown | Appendix O               |
| Article V. Requirements of Laws and Regulation       | PACE organization agrees to comply with all applicable federal, state, and local laws and regulations   | –                        |
| Article VI. Changes to the Program Agreement         | CMS has the authority to incorporate any additional terms agreed upon by all parties  | –                        |
| Article VII. State Administering Agency Requirements | Description of the role and related activities of the state, including compliance monitoring, enrollment and disenrollment, marketing, and state licensure requirements   | Appendices P, Q, R, S, T |

**Notes:** PACE is Program of All-Inclusive Care for the Elderly. CMS is Centers for Medicare & Medicaid Services.

– Dash indicates no related appendix for the article.

**Source:** CMS 2000.

Article VII of the agreement defines key responsibilities of the SAA in implementing and overseeing PACE programs. These responsibilities include establishing enrollment and disenrollment processes, reviewing PACE marketing materials, setting optional licensure requirements for PACE organizations, and monitoring program compliance. The agreement specifies that states and CMS conduct certain oversight activities jointly, such as trial period monitoring, ongoing program monitoring, and oversight of CAPs. It also assigns states primary responsibility for other activities, such as conducting readiness reviews and monitoring level of care determinations and redeterminations, with limited or no direct CMS involvement in those areas.

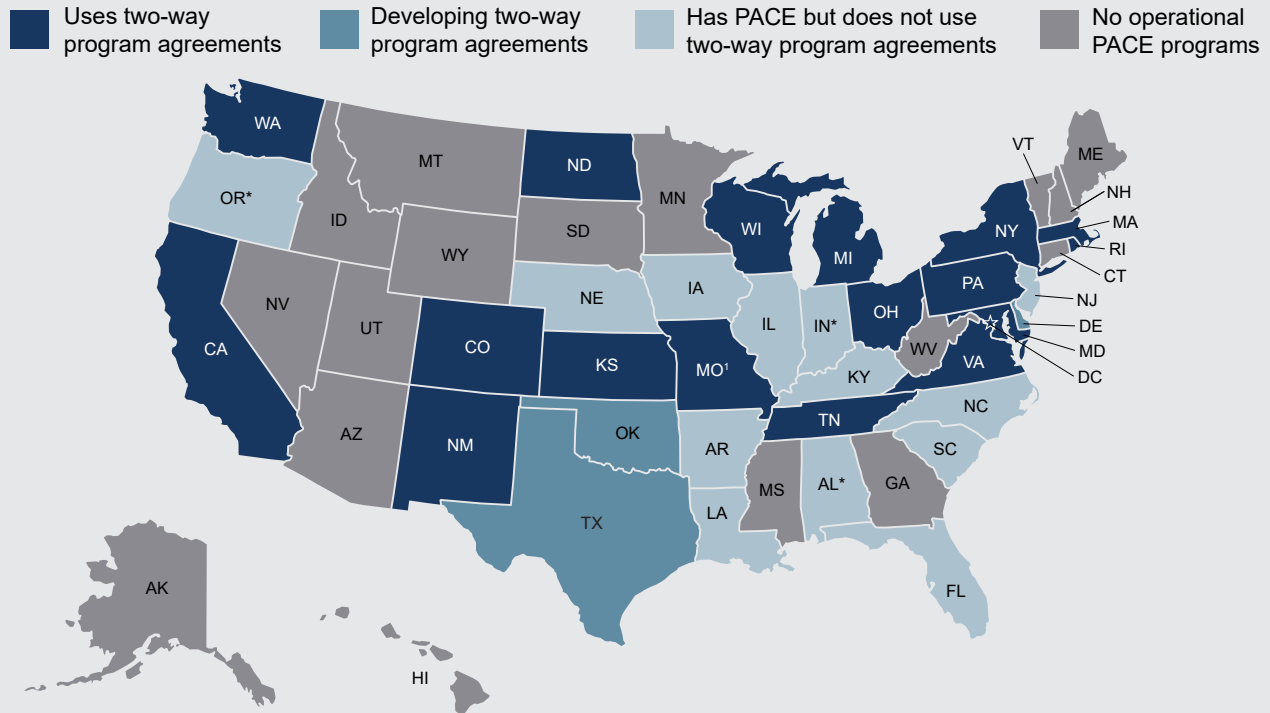
## State two-way program agreements

In addition to the required three-way program agreements, some states use optional two-way program agreements between SAAs and PACE organizations to supplement the federal oversight framework. Among the 33 states and the District of Columbia with active PACE programs, 16 states and the District of Columbia reported using two-

way program agreements, and 3 additional states reported that they are developing them (Figure 6-1). Washington, which is included among the 16 states, uses a two-way program agreement alongside state statutory provisions. Missouri is not included in the count of states using two-way program agreements because it no longer maintains an active agreement; however, Missouri is included in this analysis because the state codified PACE requirements in statute based largely on a previous two-way program agreement. States that do not use two-way agreements generally rely on the three-way program agreement and federal regulations, while some have adopted alternative approaches, such as codifying requirements in state statute or developing program manuals.

**State use of two-way program agreements.** To understand how SAAs define and implement oversight responsibilities, we analyzed two-way program agreements submitted by 16 states and the District of Columbia. We found that states generally use these agreements to supplement the federal oversight framework by adding more detailed and state-specific requirements, resulting in substantial variation across states (Table 6-2, Table 6A-1).

**FIGURE 6-1.** Use of Program of All-Inclusive Care for the Elderly Two-Way Program Agreements by State, 2026



**Notes:** PACE is Program of All-Inclusive Care for the Elderly. MACPAC was unable to review Maryland’s two-way program agreement due to state delays in Freedom of Information Act requests. However, the Maryland Code of Regulations Section 10.09.44.04 references a two-way program agreement.

<sup>1</sup> Missouri relies on state statute largely derived from a previous two-way program agreement.

\* State did not respond to outreach.

**Source:** MACPAC, 2026, analysis of two-way program agreements and state statute submitted by states.

Across states, two-way program agreements most commonly address areas already identified in the three-way program agreement: (1) trial period monitoring; (2) ongoing monitoring; (3) CAPs; (4) enrollee level of care redeterminations; and (5) reporting on quality, financial performance, and encounter data. However, the scope and specificity of these provisions vary substantially. Some states include detailed requirements. For example, Ohio requires CAPs to identify root causes of deficiencies, specify corrective actions and methodologies, and assign responsible staff within defined time frames. Wisconsin authorizes intensive oversight

activities, including the deployment of state staff or representatives on site to support compliance. Other states include more general provisions that largely mirror federal requirements. States also vary in how they define encounter data reporting requirements, ranging from narrower definitions tied to Medicaid-covered services for which the PACE organization is financially responsible (e.g., California) to broader frameworks that encompass a wider range of services and reporting circumstances (e.g., North Dakota). For a detailed review of two-way program agreements, see Appendix 6A.

Despite this variation, two-way program agreements generally do not substantively modify or expand the statutory role of the SAA. Instead, they function as a mechanism for operationalizing oversight within the existing federal-state framework by clarifying expectations, adding specificity, and supporting enforcement of requirements that may not be explicitly detailed in federal regulations.

Stakeholder interviews reinforced these findings. Among the six states interviewed, three reported using two-way program agreements and described them as useful tools for incorporating state-specific contractual details beyond the three-way program agreement. Officials noted that these agreements allow states to reference and enforce requirements that extend beyond federal regulations and strengthen oversight expectations.

**TABLE 6-2.** Use of Program of All-Inclusive Care for the Elderly Two-Way Program Agreements by Category and State

| Category                                     | States   |
|--|--|
| Trial period monitoring                      | CA, ND, VA   |
| Ongoing monitoring (after trial)             | CA, CO, DC, KS, MA, MI, MO, ND, NM, NY, OH, PA, RI, TN, WA, WI |
| Corrective action plan requirements          | CA, CO, MA, ND, OH, PA, TN, VA, WI                             |
| Level of care redeterminations (adds detail) | CA, ND, NY, OH, TN, WI   |
| <b>Reporting requirements</b>                |  |
| Grievances and appeals                       | CA, MA, MI, NY, TN, VA, WI                                     |
| Enrollments                                  | CA, CO, MI, ND, TN, WI   |
| Disenrollments                               | CA, CO, ND, TN, WI   |
| Incidents                                    | CA, CO, OH, TN   |
| Enrollment denials                           | CO, ND   |
| Media events                                 | CO   |
| Financial data                               | CA, CO, KS, MI, NM, NY, PA, VA, WI                             |
| Quality improvement plans                    | CA, MA, MI, ND, NY, OH, PA, TN                                 |
| Encounter data                               | CA, CO, ND, NY, OH, TN, WI                                     |
| Service utilization data                     | CA, KS, MA, NM, OH   |
| Fraud and abuse                              | ND, NY, OH, VA, WI   |
| Statistical data                             | CA, MA, ND, NM   |
| Provider listings                            | CA, MI, MO, TN   |
| Other/miscellaneous                          | CA, MA, MI, TN, ND   |
| <b>Additional SAA roles</b>                  |  |
| Marketing materials/plan review              | CA, MA, OH, TN   |
| Outreach/beneficiary education               | CA, KS, WI   |
| Clinical operations                          | MI   |
| Technical assistance/administrative support  | CA, WI   |

**Notes:** SAA is state administering agency. Missouri's provisions appear in state statute, reflecting a prior two-way program agreement.

**Source:** MACPAC, 2026, analysis of two-way program agreements submitted by states.

In these states, officials emphasized that two-way agreements support oversight by aligning expectations across programs and incorporating state-specific contractual provisions. In one state, officials described the agreement as the result of ongoing collaboration with PACE organizations, in which providers reviewed draft language and provided feedback, resulting in a shared understanding of oversight expectations. In another state, officials reported that they modeled the agreement on Medicaid managed care and dual eligible special needs plan (D-SNP) contracts, allowing the state to align oversight standards across programs while maintaining PACE-specific requirements. In a third state, officials highlighted that the agreement's requirement for PACE organizations to submit operational policies and procedures on an ongoing basis improves the state's ability to monitor compliance in real time. Across these states, officials emphasized that more detailed contractual structures strengthen their ability to articulate compliance expectations and support enforcement actions.

Among states that do not use two-way program agreements, officials generally viewed them as redundant with existing federal regulations and the three-way program agreement. One state reported that an additional agreement was unnecessary given the broad authority already provided under federal regulations and the three-way program agreement, while another previously used a two-way agreement but later concluded that the three-way agreement alone sufficiently defined roles and responsibilities. In a third state, perspectives differed across agencies: The department of aging (the state's SAA) viewed a two-way agreement as potentially useful, while the state Medicaid agency considered the existing three-way agreement sufficient; as an alternative, the Medicaid agency is developing a state PACE manual to document program requirements and policies.

Federal officials reported that they are generally not involved in the development or implementation of state two-way program agreements and do not routinely review them, although they may review agreements upon state request to ensure consistency with federal regulations. They noted that an increasing number of states are developing these agreements as the PACE program expands and described them as tools that allow states to incorporate state-specific requirements

or licensing provisions, provided they do not conflict with federal rules.

## BIPA 903 waiver requests

Section 903 of BIPA authorizes CMS to approve waivers of certain Medicare and Medicaid regulatory requirements for PACE organizations. Under this process, PACE organizations submit waiver requests to the SAA, which reviews the request before forwarding approved requests to CMS for final determination. Although CMS retains final approval authority, certain core elements of the PACE model may not be waived under Section 1894 and Section 1934 of the Act, including requirements related to the population served, comprehensive service delivery, the interdisciplinary care model, and the program's financing structure and assumption of full financial risk (CMS 2024c).

To better understand the use of BIPA 903 waiver authority, we reviewed waiver requests submitted by PACE organizations to states, including both approved and denied requests from nine states with active PACE programs. However, many of the waiver requests staff reviewed did not contain information about whether they were approved or denied.

Analysis of nearly 50 waiver requests indicates that organizations primarily use this authority to seek operational flexibility. Nearly all waiver requests clustered around two areas: flexibility in conducting enrollee assessments and service determinations and modifications to interdisciplinary team staffing requirements. Requests related to enrollee assessments most commonly sought to continue the use of remote or telehealth-based assessments following temporary flexibilities granted during the COVID-19 public health emergency. Requests related to staffing typically sought permission to substitute other qualified professionals for master's level social workers in response to workforce shortages. For a detailed analysis of the BIPA 903 waiver requests reviewed, see Appendix 6B.

Federal officials described the waiver process as discretionary and case specific, with CMS generally less likely to approve requests for remote assessments after the end of the public health

emergency while more frequently granting temporary flexibility for workforce-related requests. Although CMS retains final approval authority, federal officials noted that waiver requests are rarely approved without state support in practice, effectively making state approval a prerequisite and positioning the process as a jointly conditioned federal-state oversight mechanism. Despite this practice, state interviewees reported limited engagement with BIPA 903 waivers and generally did not view them as a central component of their oversight activities.

## State Oversight of PACE Organizations

States play a central role in overseeing PACE organizations, and their approaches vary across multiple areas, including oversight tools, quality measurement, data use, and available resources. Although all states operate within a common federal framework, differences in how they implement oversight result in variation in monitoring practices and the extent to which states assess performance and outcomes. The following sections describe these differences and the factors that shape states' oversight activities.

### States use a range of tools to oversee PACE organizations with variation in enforcement and application

State officials reported using a variety of tools to support oversight and monitoring of PACE organizations, many of which were developed specifically for their state PACE program. For example, one state developed a state-specific audit tool used annually to collect data from PACE organizations, while another used policy letters to communicate state requirements. This state also relies on clinical coverage policies developed for each Medicaid provider type, and all interviewed states use state regulations and licensing requirements to support oversight efforts.

All states we interviewed have PACE-specific regulations in their administrative code. Most officials did not describe in detail how they apply these

regulations to oversight activities. However, one official noted that state regulations allow flexibility to interpret and implement federal requirements in line with state priorities, rather than relying solely on CMS's interpretation. Federal officials and a PACE provider association reported that not all states regularly update their PACE regulations, and some older state regulations or licensing requirements have conflicted with recent federal updates.

Five states reported including enforcement tools, such as enrollment restrictions or financial penalties, in their oversight approach, though these tools are used infrequently. One state reported using enrollment sanctions only once since 2019, while another recently added sanction authority through state regulations. A PACE provider association observed that federal enforcement actions typically occur during a PACE organization's initial three-year trial period and speculated that CMS's focus on trial period audits, rather than routine audits, may contribute to higher enforcement rates during that period.

### States vary widely in how they measure and assess PACE performance

States use a range of approaches to assess PACE organization performance, including participant experience measures, state-specific reporting requirements, and, in some cases, more structured quality measurement strategies. States also vary in the types of data they require PACE organizations to report beyond federal requirements, reflecting differences in how states define and monitor program performance. For example, some states require additional reporting on service utilization, fraud and abuse, and enrollee characteristics, while others emphasize outcome measures or operational data such as provider listings or day center attendance (Appendix 6A). Although all PACE organizations report certain quality data to CMS in accordance with federal requirements (e.g., enrollment, appeals and grievances, immunizations, falls, and critical incidents), states differ in how they supplement these data and the extent to which they use available information to monitor performance and outcomes.

**State approaches to quality measurement.** PACE organizations report a variety of quality data to CMS in accordance with federal regulatory requirements (CMS 2024d). However, this reporting is specific to PACE organizations and not based on standardized quality measures that both Medicare and Medicaid managed care organizations commonly submit to CMS, such as the Healthcare Effectiveness Data and Information Set (HEDIS), the Medicare Advantage and Prescription Drug Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, or the CAHPS Home- and Community-Based Services (HCBS) survey. Although some of the information that PACE organizations report to CMS overlaps with information reported in managed care programs—such as immunizations, emergency department (ED) visits, and grievances and appeals—PACE organizations do not report this information to CMS in the same format as managed care plans, making it difficult to compare programs (CMS 2023).

Four of the states we interviewed require PACE organizations to report participant satisfaction. One of these states uses its two-way program agreement to specifically require PACE organizations to report satisfaction survey results from the Integrated Satisfaction Measurement for PACE (I-SAT) tool, which our interviews revealed is the most common tool that PACE organizations use to comply with federal requirements to conduct satisfaction surveys. A PACE provider association noted that 95 percent of PACE organizations use the I-SAT to collect data on participant satisfaction. Two of these states request results from PACE organization satisfaction surveys annually, though they do not specify which survey PACE organizations must use. Another state administers the National Core Indicators—Aging and Disabilities (NCI-AD) survey to PACE participants at all its PACE centers, though NCI-AD is not designed specifically for the PACE population. Previous interviews with state and federal officials revealed that participant satisfaction survey results are not routinely shared with CMS, although CMS may review quality-improvement measures during audits or discuss survey results with PACE organizations as part of quality improvement plans.

One state we interviewed has a more comprehensive quality strategy for its PACE organizations. The state developed a value-based payment (VBP) program to

provide incentives for performance improvement and requires PACE organizations to report on 15 quality measures, 8 of which are tied to the VBP program. The state requires PACE organizations to use a quality reporting template included in the state's two-way program agreement. The measures used in the VBP program include both process and outcome measures, such as PACE participant satisfaction survey response rates, participant engagement after inpatient discharge, medication reconciliation, percentage of participants not in nursing homes, percentage of voluntary disenrollment, fall rates, and hospital admission rates. Another state uses a portal for PACE organizations to submit quality data on a quarterly basis, including data on flu and pneumococcal vaccinations, ED visits, hospital admissions and readmissions, falls, and demographics. Although the state noted that some of these metrics overlap with data PACE organizations submit to CMS, the state said it is tracking them in greater detail. For example, state data collection on ED visits and hospital admissions includes documentation of reasons for admission so the state can determine whether a readmission is occurring for the same reason as the original admission.

PACE provider associations also noted that some states require PACE organizations to submit a variety of data to NPA's DataPACE system. The system includes the following quality measure domains: rate of deaths, voluntary disenrollments, ED visits, fall rates, immunizations for influenza and pneumonia, and hospitalization admissions and number of days admitted. States can require PACE organizations to submit data to the NPA system, but the state cannot request the data directly from NPA. Officials in one state we interviewed noted they request the NPA data from each individual PACE organization in the state. In addition to broader quality measurement approaches, states also monitor specific indicators of program performance through required reporting.

**Appeals and grievances.** PACE organizations must submit data on appeals and grievances to CMS through the Health Plan Management System (HPMS). Most of the states interviewed review these quarterly data and do not impose any additional requirements around submission of appeal and grievance data. However, one state requires PACE organizations to directly report appeals and grievances to the state

using the state's templates. Another state requires real-time notification of service denials rather than the quarterly reporting of service denials in HPMS that the federal government requires.

**Eligibility and disenrollment.** All state interviewees reported deferring to federal requirements for PACE participant eligibility, with no PACE organizations including any additional eligibility requirements. Some states reported slight variation in their level of monitoring for involuntary and voluntary disenrollments. For example, in addition to the federal regulation requiring that PACE organizations report involuntary disenrollment in HPMS, one state also requires documentation demonstrating the steps taken before initiating an involuntary disenrollment. These steps may include efforts to address participant non-compliance or disruptive behavior as well as development of transition plans for alternative care arrangements.

CMS requires PACE organizations to report voluntary disenrollments in HPMS. CMS reviews this information, including the number of disenrollments and the reason for disenrollment, and discusses any trends on quarterly or monthly calls with PACE organizations. States also require PACE organizations to report disenrollment information, with varying timelines for review. One state requires PACE organizations to conduct exit surveys with individuals who voluntarily disenroll and then submit aggregated survey results annually to the state for analysis of patterns or trends in reasons for disenrollment. Another state reported that two common reasons for PACE disenrollment are enrollment in a Medicare Advantage plan and relocation outside of the PACE service area.

## Data limitations and lack of standardization constrain oversight and comparability

States rely on a combination of federal and state data sources to support oversight of PACE organizations; however, stakeholders consistently noted that limitations in data availability and a lack of standardization constrain states' ability to assess outcomes and compare performance across programs.

States use these data to monitor enrollment, utilization, and quality-related indicators but reported variation in how consistently data are accessed, analyzed, and applied to oversight activities.

**Use of HPMS data for oversight.** Officials from all states reported using data submitted by PACE organizations into HPMS as part of their monitoring processes. PACE organizations collect and submit quality reporting data to CMS on a quarterly basis, in accordance with federal regulations and CMS guidance (42 CFR 460) (CMS 2024d). These data include enrollment, appeals and grievances, ED visits, immunizations, medication administration errors, and a number of incidents that PACE organizations must report with a root cause analysis such as falls, infectious disease outbreaks, abuse, and adverse outcomes.<sup>8</sup> States request access to relevant HPMS modules and generally review the data during quarterly CMS-led meetings with PACE organizations. Federal officials indicated uncertainty about how many states regularly access HPMS or how the data are used for oversight purposes. Although state officials described reviewing these data as part of ongoing monitoring activities and discussions with PACE organizations, interviewees generally did not describe standardized processes for using the data to systematically identify performance concerns or trigger corrective actions.

Despite their use in oversight activities, PACE performance data are generally not publicly available, unlike Medicare managed care programs. For example, Medicare Advantage Star Ratings performance data for Medicare Advantage and Medicare Part D plans are publicly available through CMS's consumer-facing Medicare Plan Finder tool. PACE organizations are not included in the Plan Finder tool and are not subject to the Medicare Advantage Star Rating system (CMS 2025b). In addition, plan-specific or patient-level PACE data submitted through HPMS are restricted to authorized users. Federal officials confirmed that HPMS access requires a CMS-specific user ID and is limited to authorized Part D plans, states, and CMS staff.

**Data limitations and challenges.** Several states highlighted limitations to their ability to measure PACE organization performance and participant outcomes. For example, the state that implemented a VBP program noted that current state budget constraints and limited access to data that could be used to inform payment incentives have prevented the state from fully implementing the VBP program. Another state mentioned challenges identifying standard quality performance and outcome measures for PACE organizations and requested CMS’s assistance developing standardized national PACE quality measures.

Several interviewees noted the tension between viewing PACE organizations as provider organizations or viewing them as payers. Federal officials and one state mentioned they aligned their approach to PACE oversight with managed care oversight, which can be helpful for creating efficiencies. However, PACE provider organizations and a national PACE expert highlighted the challenges of using a managed care approach for PACE oversight rather than an approach more suited to providers. Federal officials, a national expert, and a PACE association noted the challenges of applying managed care encounter data policies to capture the full range of services provided at PACE centers. Unlike traditional providers, a PACE enrollee may interact with multiple members of the interdisciplinary team during a single visit, each delivering a mix of services that could be covered under Medicare or Medicaid. As a result, capturing these interactions as standardized encounters—and fully reflecting the scope of services provided, including care coordination and other non–visit-based activities—can be challenging. Federal officials noted that CMS requires PACE organizations to submit additional data to the CMS encounter data system to fill in gaps that remain from encounter data reports. Two of the states interviewed also request that their PACE organizations submit encounter data to the state. Another state includes the option for the state to require encounter data reporting in its two-way program agreement but has not yet implemented the requirement because the state does not have the staff capacity to review and analyze the data. Federal officials also noted that one or two states have requested encounter data from CMS but were not sure of the extent to which the states were using the data.

As states and federal officials consider additional data sources to improve oversight and monitoring of PACE organizations’ performance, one national expert noted that some opportunities are available in data already collected. For example, the interviewee noted that standardized assessments like the HCBS CAHPS survey or the I-SAT could provide meaningful insights into PACE participant experience and quality, although the small number of PACE participants creates challenges with data collection. The interviewee suggested that states and the federal government could consider creative use of existing data sources, such as Medicare Part D data for medication safety and hospital admissions data for falls.

## State capacity constraints vary and are more pronounced in states monitoring performance

In our interviews with state officials, we found that states that focus more on monitoring compliance than on assessing performance are less likely to report concerns with capacity limitations. States with more and newer PACE organizations tended to report more constraints on available resources and capacity for oversight.

Of the six states interviewed, three reported adequate staffing capacity and bandwidth for overseeing and monitoring PACE organizations. Two of these states noted recent expansions in the number of PACE organizations operating in their state but did not raise any concerns about state capacity in light of these expansions. In contrast, three states mentioned concerns with limited state resources and capacity for conducting oversight, especially with rapid growth in the number of PACE organizations and increases in PACE enrollment in their states.

The variation in state oversight capacity reflects different perspectives of states’ roles and responsibilities for oversight and monitoring. The three states that noted concerns with state capacity also reported that they monitor the performance of PACE organizations as well as their compliance with state and federal regulations, compared to some other states that tend to focus more on monitoring compliance only.

One state with capacity concerns noted that it is pausing its review of applications for new PACE organizations or service area expansions for the next two years. In this time, the state will review its PACE oversight process to determine if modifications are needed given the rapid expansion of PACE organizations. During this pause, the state is also considering opportunities to integrate PACE oversight with its overall oversight approach for the other integrated models, including D-SNPs, operating in the state. The state noted that it has also requested that CMS implement stricter federal application guidelines for new PACE organizations and service area expansions to close what the state described as loopholes that have allowed some organizations to submit multiple, simultaneous applications to a state.

## Federal-State Coordination in Oversight

Oversight of PACE organizations is a shared responsibility between CMS and states, requiring coordination across multiple activities, including monitoring, audits, and data use. Although stakeholders consistently described this relationship as collaborative, they also identified variation in how coordination occurs in practice and highlighted opportunities to improve alignment between federal and state oversight efforts, particularly in areas such as audit processes.

### Coordination practices

State and federal officials all agreed on the utility of the quarterly and monthly calls that CMS holds with states and PACE organizations. Federal officials noted that they set the agenda for these calls but regularly solicit input from states. Several states also mentioned the importance of working with CMS account managers who are assigned to individual PACE organizations and regularly participate in the quarterly and monthly calls as part of monitoring activities. However, one state suggested it was more of a listener than an active participant on quarterly calls with CMS and PACE organizations. Another state said the monthly and quarterly calls can be somewhat redundant, given similar state oversight activities, but were valuable opportunities for alignment and relationship-building with CMS and PACE organizations.

## Federal oversight emphasizes compliance

Federal officials described their focus as monitoring compliance with requirements rather than advancing program quality. Federal officials explained that they become involved in quality-related issues occurring within individual PACE organizations, and these issues are discussed in quarterly and monthly calls with individual states and PACE organizations. Federal officials also expressed an interest in sharing more PACE data across states, including data trends, to better support coordinated oversight and the joint provision of targeted technical assistance with the goal of identifying and improving PACE organizations that may be poor performers.

Representatives from PACE associations discussed what they see as a federal focus on monitoring compliance rather than also assessing PACE organization performance and quality. As one PACE provider association commented, federal compliance protocols are not designed to capture how a PACE organization implements care planning and delivers care day to day. The PACE association highlighted federal and state gaps in oversight and monitoring, including standardized evaluation of care delivery, participant experience, and satisfaction. The PACE association suggested that the federal and state partnership to oversee PACE organizations could be structured so that federal oversight could focus on monitoring compliance and responding to challenges identified during the three-year trial period, while states could focus on monitoring operations and conducting oversight of quality of performance among PACE organizations beyond the trial period.

## Misalignment and duplication in state and federal audits increase administrative burden

State and federal officials described changes in audit practices over time, particularly in the level of state involvement in federal audits and the frequency and timing of audit activities. These changes, combined with differences in how states conduct their own audits, have contributed to misalignment and duplication in oversight processes.

**Changes in federal audit practices.** Federal officials confirmed that CMS conducts three audits of PACE organizations during the initial three-year trial period for a PACE organization. A PACE provider association noted that the first federal audit during the trial period has evolved to become a consultative audit, through which CMS provides new PACE organizations with the opportunity to understand federal expectations for demonstrating compliance and helps them understand how CMS will conduct subsequent trial period audits.

All states and federal officials we interviewed discussed the evolution of the federal audit process and the effect on state involvement. Several states noted that before the COVID-19 pandemic, states regularly participated in CMS audits of PACE organizations; however, state and federal officials reported that federal audits are now conducted with limited state involvement. One state reported that CMS does not invite the state to participate in federal audits beyond being informed of the timing of the audit and potentially participating in a few calls during the audit process, a change in the typical prepandemic practice. However, one state noted that it attends and participates in CMS trial period audits, sitting in on daily calls with PACE organizations in which CMS auditors review documentation and findings. Federal and state officials also mentioned that states can access HPMS to review a summary of CMS audit findings. Federal officials noted that CMS invites states to participate in key discussions in the federal audit process but noted that states do not invite CMS to participate in state audit activities. Another state said CMS asks states to be mindful not to schedule state audits with a PACE organization near the time of a federal audit.

CMS does not have a set schedule for conducting routine audits after the trial period. Instead, CMS uses a risk assessment process to determine the need to conduct a routine audit with a PACE organization. Federal officials noted that the risk assessment includes a variety of factors, including a PACE organization's enrollment, growth, past audits, and information received from other entities within CMS. Federal officials also noted that a factor in determining the frequency of routine audits is based on availability of CMS resources and capacity. State interviewees noted an apparent decline in the

frequency of routine CMS audits. One state noted that CMS had not conducted a routine audit of long-term PACE organizations in the state in the past five years. Another state official noted that there had been no CMS audits during her three-year tenure with the state agency that conducts PACE oversight.

**Overlap between state and federal audits.** Federal officials noted that they encourage states not to duplicate what CMS covers in the federal PACE audit process in the state audit. One state noted this request and reported that its state audits focus on monitoring compliance with state-specific regulations and requirements. Other states noted that information and data collected as part of their state audit processes replicate parts of the federal audit process. A PACE association also commented that states regularly audit aspects of PACE organization operations that overlap with federal audits, including level of care assessments, grievances, and serious disciplinary reports. However, the PACE association also noted that state audits in those areas are typically done on a smaller scale, with a review of only a handful of records, for example. The PACE association noted that PACE organizations often find that state monitoring and audits can help PACE organizations prepare for federal audits and encourage partnership and learning between the state and PACE organizations. Despite this, the state and federal audit processes can present challenges, particularly in terms of timing. In some cases, a federal audit is followed by a state audit within weeks, or the reverse, which can lead to challenges for the PACE organization and its ability to be fully responsive to audit-related data collection requests. Some states suggested there could be an opportunity to partner with federal officials to conduct audits together or better align the audits.

## Opportunities for improved coordination

In addition to concerns about duplication in state and federal audits, one state commented on the opportunity for federal officials to streamline data sharing with states. The state noted that because they do not have visibility into Medicare data (e.g., Medicare capitation payments), they cannot get a complete assessment of PACE organizations' financial

stability and other aspects of their performance and operations that are primarily Medicare focused.

PACE provider associations noted gaps in federal and state oversight activities. One provider association noted a lack of federal or state technical assistance to PACE organizations to improve operations and performance. The PACE association noted that PACE organizations tend to improve their performance in response to an incident, when they develop and implement CAPs, rather than before an incident occurs. The PACE association suggested that additional state and federal technical assistance could help PACE organizations shift from this reactive approach to a proactive one. The association also noted that there are opportunities for states to support new PACE organizations before their launch to help them meet state and federal requirements.

## Commission Recommendations

The Commission makes three recommendations to CMS to improve coordination between state and federal oversight of PACE organizations and to increase transparency of PACE program performance. Together, these recommendations address key challenges identified in this chapter, including duplication in oversight activities, limited access to performance data, and the absence of standardized quality measures.

### Recommendation 6.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update audit protocols and three-way program agreements to facilitate joint audits of Program of All-Inclusive Care for the Elderly organizations with state administering agencies. Audit coordination should include joint planning of audit scopes, sharing documentation requests, and reviewing evidence concurrently, while preserving CMS's responsibility for assessing federal requirements and states' responsibility for assessing state-specific requirements.

### Rationale

This recommendation addresses coordination challenges between CMS and states in overseeing PACE organizations identified by stakeholders, particularly related to overlapping audit activities and limited sharing of oversight findings and data. Sections 1934(e)(4)(A) and (B) of the Act and regulations at 42 CFR 460.190 and 192 require CMS to cooperate with the SAA in evaluating PACE organizations during the first three years of a program's trial period and periodically thereafter. Statute further specifies that reviews conducted during the PACE organization's trial period must assess the organization's PACE center, fiscal soundness, capacity to provide all PACE services to all enrolled participants, compliance with important statutory and regulatory requirements, and any other elements that CMS or the SAA considers necessary.

Despite these requirements, 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." Nor does policy guidance in CMS's PACE manual and publicly available three-way program agreement template language elaborate on how CMS and SAAs should coordinate trial period or ongoing oversight (CMS 2011, 2000).

Across both phases of interviews, federal and state officials described audits as the central mechanism for overseeing PACE organizations. CMS audits assess several areas, including compliance and quality improvement, and involve reviewing whether organizations collect and analyze required quality data and take corrective action when necessary. States also rely heavily on audits to monitor PACE organizations, although the frequency and scope of these reviews vary across states.

Existing systems and requirements suggest that CMS and states are well positioned to share audit documentation and oversight data systematically. For example, CMS currently provides states access to several data modules within HPMS upon request. CMS could potentially use the system to automatically share audit results and supporting documentation with appropriate redactions to protect participant privacy with states, rather than only summaries of findings. In addition, CMS and states are required under 42 CFR

460.196 to promptly report audit results to the PACE organization along with any recommendations for program changes, indicating that processes already exist for communicating audit findings.

Under this recommendation, joint audits would go beyond aligning audit timing to include coordination in audit design and execution. For example, CMS and states should jointly plan audit scopes, share documentation requests, conduct joint entrance and exit conferences with PACE organizations, and review evidence concurrently. Coordinated audit approaches could allow CMS and states to assess overlapping federal and state requirements at the same time—particularly where state requirements closely mirror federal requirements—reducing duplicative review and administrative burden for both PACE organizations and oversight entities. CMS would continue to assess compliance with federal requirements, while states would retain responsibility for evaluating compliance with state-specific requirements. Joint audits could also enhance visibility across oversight entities by facilitating more systematic sharing of information on issues that may be more readily identified at one level, such as enrollment concerns or grievances reported to states, and support the development of aligned or complementary findings where appropriate, while allowing for independent determinations when federal and state priorities differ.

This recommendation does not assume that CMS would assess compliance with state-specific requirements or that states would assess compliance with federal requirements beyond their existing roles. Rather, it is intended to improve transparency and reduce duplication by ensuring that both entities have access to relevant information and a shared understanding of PACE organization performance. Such coordination would not preclude CMS or states from conducting independent oversight activities when necessary (e.g., responding to complaints or performance concerns), and states could continue to conduct audits more frequently than CMS, with coordination occurring when federal audits take place. This approach would establish formal expectations for coordination while allowing flexibility for CMS and states to determine when joint audits are feasible based on resources, program size, and other considerations.

## Implications

**Federal spending.** The Congressional Budget Office (CBO) estimates this recommendation would not have a direct effect on federal Medicaid spending.

**States.** Greater coordination with CMS would reduce duplication in oversight activities and improve states' access to federal audit findings.

**PACE organizations.** Coordinated audits would reduce the administrative burden associated with preparing for and responding to multiple oversight reviews. More coordinated oversight, such as joint audits or shared review processes, would reduce duplicative information requests and streamline corrective action processes.

**Enrollees.** To the extent that improved coordination allows CMS and states to more effectively identify compliance issues or performance concerns, it would strengthen oversight of PACE organizations and help ensure participants receive services and care.

## Recommendation 6.2

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to aggregate and publicly release, in a user-friendly format on the CMS website, existing Program of All-Inclusive Care for the Elderly (PACE) performance data, including data PACE organizations submit through CMS's Health Plan Management System as well as enrollee satisfaction data collected as part of PACE organization quality improvement programs pursuant to 42 CFR 460.134(a)(2).

### Rationale

This recommendation addresses the limited availability and accessibility of PACE performance data identified in our findings. Greater transparency in PACE performance data would help beneficiaries, caregivers, policymakers, and researchers better understand PACE program performance and compare it with other long-term services and supports (LTSS) options, which is not currently possible. PACE organizations already report a range of performance data to CMS through HPMS—including information on enrollment;

grievances and appeals; ED utilization; and reportable incidents such as falls, infections, and other adverse events—yet these data are not publicly accessible. In contrast, CMS routinely publishes performance information for other Medicare and Medicaid plans, allowing beneficiaries and policymakers to compare plan performance. PACE organizations are not meaningfully included in these public reporting systems. Publicly available data would support more informed beneficiary and caregiver decision making about whether to enroll in PACE, including in areas with multiple PACE programs. Researchers and policymakers would be able to evaluate the PACE model and its outcomes. In addition, PACE data could enable states to benchmark performance across PACE programs, helping them to identify recurring challenges, emerging trends, or gaps in oversight practices. A standardized dataset or dashboard could allow states to compare programs on measures such as participant outcomes, grievances, or reportable incidents, similar to approaches used in other managed care programs. Currently, these data are primarily used for internal oversight, with CMS, states, and PACE organizations addressing issues on a case-by-case basis through mechanisms such as CAPs. Aggregated, publicly accessible data would allow CMS, states, and other stakeholders like beneficiary advocates and provider associations to identify trends more easily and address any challenges with more systemic policy changes, in addition to individual corrective actions. Public-facing performance data would also provide incentives for PACE organizations' quality improvement.

This recommendation would deliver these benefits with a limited burden on CMS, states, and PACE organizations because it would rely on existing data submissions. Although CMS may need to ready existing data for public release, this option would not require the creation of new reporting requirements or additional data collection from PACE organizations. CMS could initially focus on publicly reporting a limited set of existing indicators or summary statistics to improve transparency while minimizing burden and expand reporting over time as appropriate. For instance, CMS may work toward standardizing the use of the I-SAT survey for PACE organizations, given that the vast majority of PACE organizations already use this tool. PACE organizations may also need to work

with CMS and states to ensure that reported data are presented in ways that accurately reflect the unique characteristics of the PACE model and the populations it serves and to ensure consistent reporting practices. We recognize that data aggregated at the PACE organization level may have limitations for researchers and policymakers, and individual-level data may be needed to adjust for differences in PACE populations. CMS may work toward collection of individual-level data as a next step in its monitoring and reporting.

### Implications

**Federal spending.** CBO estimates this recommendation would not have a direct effect on federal Medicaid spending.

**States.** States would benefit from improved access to information about PACE program performance, particularly in states with multiple PACE organizations. Public reporting would also support state oversight activities by providing a clearer view of program performance trends and allowing states to compare outcomes across programs. States may also need to coordinate with CMS to ensure that publicly reported data align with existing state reporting requirements and oversight processes.

**PACE organizations.** Public reporting would provide PACE organizations with additional opportunities to demonstrate program performance of the PACE model.

**Enrollees.** Greater transparency around PACE program performance would help beneficiaries and caregivers better understand the services offered by PACE organizations and how the program compares with other LTSS options.

## Recommendation 6.3

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to amend regulations at 42 CFR 460 Subpart H to develop a standardized, national quality measure set for Program of All-Inclusive Care for the Elderly (PACE) organizations. Quality data should be compiled and made publicly available in an accessible format. CMS should follow three key principles when developing a PACE quality measure set: engage stakeholders

collaboratively; minimize reporting burden by focusing on the most meaningful measures; and prioritize standardized measures that enable comparability across programs where feasible.

### Rationale

This recommendation addresses the absence of standardized quality measures and challenges in comparing PACE program performance across states. In the first phase of our PACE work, nearly all stakeholders we interviewed expressed interest in the development of a standardized national PACE quality measure set that would allow for comparisons within and across states. PACE organizations expressed a desire to have uniformity in quality measures across states, which they said would allow for easier expansion across states. CMS officials shared that they previously undertook a project to develop PACE quality standards, but questions of whether measures would be comparable across PACE organizations nationally hindered the project's success. Standardized measures would need to be applicable for PACE programs of various sizes and with different patient mixes, a potential challenge in creating a standardized national measure set. However, our findings suggest that progress has been made toward developing standardized PACE measures. Some states, including New York and California, have incorporated state-specific quality improvement, reporting, and performance monitoring requirements into their PACE oversight frameworks. For example, California requires PACE organizations to use measurable quality indicators and report outcomes from quality improvement projects and consumer satisfaction surveys, while New York requires reporting on grievances and appeals, annual performance improvement projects, and enrollee functional status data. NPA also noted it is conducting ongoing work to develop a standardized measure set and a PACE performance recognition program through their Alliance for PACE Innovation and Quality and highlighted DataPACE, a voluntary dataset that NPA produces with data that PACE organizations submit on enrollee characteristics and utilization.<sup>9</sup>

A renewed CMS effort to create standardized PACE quality measures would build on this existing work while addressing persistent gaps in comparability and oversight. Although states and PACE organizations

have made progress, the absence of a federally required, standardized measure set continues to limit CMS's and states' ability to assess program performance consistently, compare outcomes across PACE organizations and states, and identify systemic quality issues. CMS is well positioned to act as a convener to gather both information on existing quality measurement efforts and input on a new comprehensive quality approach because of the regular meetings it hosts with states and PACE organizations. Given challenges related to comparability across PACE organizations, CMS should work closely with quality measurement and PACE experts to implement this option.

CMS has created a standardized national HCBS quality measure set, which can serve as an example for development of a standardized national PACE quality measure set. CMS noted the intent of the HCBS measure set was to create opportunities for CMS and states to have comparative quality data on HCBS programs (CMS 2022). The development of the HCBS measure set suggests it is feasible to develop a standardized measure set even with small population sizes and programs that vary across states. This option includes a similar aim for PACE.

### Quality measurement principles for PACE

Based on our findings and rationale outlined above, we identified the following principles for a national PACE measure set:

- **Collaborative.** CMS should develop the PACE quality measure set with input from states, PACE organizations, PACE participants and their families or caregivers, quality experts, researchers, and other stakeholders. Because the PACE population is small and has a narrow set of demographic characteristics, yet varies across states and PACE organizations, gathering meaningful stakeholder feedback on an overall PACE quality measurement approach as well as specific quality measures to include should be a priority for CMS.
- **Minimizes burden.** CMS should aim to minimize burden for PACE organizations in developing a standardized quality measure set. Quality measures should be limited to the

most meaningful health outcome and enrollee satisfaction measures that reflect stakeholder priorities and the demographics and needs of the PACE population.

- Sets priorities for comparability where possible.** Both our interview findings and feedback from Commissioners raised the issue of a lack of ability to compare outcomes across various programs serving dually eligible individuals, including Medicare Advantage D-SNPs. Quality measures used in other managed care programs serving dually eligible individuals may be challenging to apply to PACE, given the relatively small size of the PACE program and the LTSS needs of PACE participants. CMS will need to balance this challenge with the need for comparability across programs. CMS should set priorities, including quality measures, that are also used in Medicare Advantage Star Ratings, Medicaid, and other programs serving dually eligible individuals, such as HEDIS and CAHPS measures, to allow for an apples-to-apples comparison where possible. CMS should also look to its recent development of the HCBS quality measure set, given some similarities in the populations.

## Implications

**Federal spending.** CBO estimates this recommendation would not have a direct effect on federal Medicaid spending.

**States.** Many states already collect a variety of data from PACE organizations that may duplicate or overlap with existing federal reporting requirements. Creating a standardized national quality measure set would reduce burden and confusion for states by creating a clear baseline of reporting that all PACE organizations across all states would be required to submit to CMS and states. States would no longer need to create their own quality measures to gather information about PACE organization performance, for instance. However, states would retain the flexibility of requiring additional state-specific reporting from PACE organizations if they choose to through their two-way agreement, state regulations, or other state policy tools.

States would be able to better compare performance across PACE organizations within and across states. This would allow states to focus on quality improvement with PACE organizations, as indicated by performance data, and to provide incentives for improved performance through initiatives like VBP programs.

**PACE organizations.** This recommendation would likely create some initial burden for PACE organizations as they adjust to new reporting requirements.

**Enrollees.** PACE enrollees would likely not see an immediate impact to their day-to-day care with this option. However, with full implementation of this option, enrollees should see improvements in quality of care as PACE organizations are encouraged to improve quality measure outcomes, particularly with public reporting. Prospective PACE enrollees and their family members or caregivers may also benefit, with more transparent information about PACE organization performance and outcomes to inform their choices. Depending on whether standardized PACE quality measures include some measures in common with other LTSS programs, they may be able to make comparisons across programs as well.

## Looking Ahead

States' varied oversight approaches to PACE programs highlight the importance of promoting greater consistency and coordination while preserving flexibility for state Medicaid programs to address local needs. The Commission is committed to improving access to HCBS and integrated care for dually eligible beneficiaries, which is reflected in this multicycle work on PACE. While this work is concluding, staff will continue to examine how federal and state Medicaid policies, along with coordination between CMS and states, support oversight and transparency across integrated care models.

## Endnotes

<sup>1</sup> PACE participants are not required to be able to live safely in the community after enrollment as a condition for continuing enrollment, per 42 CFR 460.160.

<sup>2</sup> For further reading, see studies finding that PACE participants generally experience lower rates of hospitalization, nursing facility use, and mortality compared to similar populations, despite having higher levels of medical complexity and functional need (Feng et al. 2021, Segelman et al. 2017, Meunier et al. 2016, Ghosh et al. 2015, JEN Associates 2015, Segelman et al. 2014, Meret-Hanke 2011, Wieland et al. 2010, Beauchamp et al. 2008). Additional research suggests that the PACE interdisciplinary team model may support improved behavioral health outcomes and more culturally responsive care (Travers et al. 2022, Vouri et al. 2015, Ginsburg and Eng 2009).

<sup>3</sup> 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.

<sup>4</sup> The Medicare-Medicaid Plans ended on December 31, 2025, with the sunset of the Financial Alignment Initiative demonstration.

<sup>5</sup> To be eligible for PACE, an individual must be 55 years or older, meet the nursing facility level of care 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. 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)).

<sup>6</sup> CMS annual enrollment data report that enrollment are for full-benefit dually eligible beneficiaries and a combined total of Medicaid-only and dually eligible beneficiaries enrolled in PACE (CMS 2024a). CMS monthly enrollment data are reported by Medicare Part D contract and may include both dually eligible and Medicare-only PACE participants (CMS 2026). These data sources do not separately identify Medicare-only enrollment, but prior analyses suggest Medicare-only enrollees account for less than 1 percent of total PACE enrollment (NPA 2023).

<sup>7</sup> Under Section 1934(e)(8) of the Act, any application for PACE program provider status is deemed approved if CMS does not deny the application or request additional

information within 90 days of submission. If CMS requests additional information, the application is deemed approved unless CMS denies it within 90 days after receiving the requested information.

<sup>8</sup> The full list of incidents that PACE organizations are required to report to CMS through HPMS includes abuse incidents, appeals, adverse drug reactions, adverse outcomes, second-degree or higher burns, elopements, ED or urgent care visits, enrollment data, equipment-related occurrences, falls (with and without injury), fires or other disasters, foodborne outbreaks, grievances, immunizations, infectious disease outbreaks, media-related events, medication administration errors (with and without an adverse effect), motor vehicle accidents, pressure injuries, restraint use, suicide attempts or suicides, and unexpected deaths (CMS 2024d).

<sup>9</sup> The Alliance for PACE Innovation and Quality is an affiliated organization of the NPA and provides support for PACE organizations in increasing enrollment and improving operational performance as well as evaluating and recognizing PACE organizations for quality performance.

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# APPENDIX 6A: Detailed Review of State Two-Way Program Agreements

Some states operate two-way program agreements between the state administering agency (SAA) and Program of All-Inclusive Care for the Elderly (PACE) organizations. Among the 33 states and the District of Columbia with active PACE programs, 16 states and the District of Columbia reported using two-way program agreements, and 3 additional states reported that they are developing them. Washington, which is included in the 16-state count, uses a two-way program agreement alongside state statutory provisions. Missouri is not included in the 16-state count because it no longer maintains an active two-way agreement; however, Missouri was included in this analysis because its state law codified PACE requirements based on a previous two-way agreement framework.

The two-way program agreements we reviewed include both standardized templates and executed contracts with PACE organizations. These agreements vary widely in length, ranging from 4 pages (Missouri’s statute and New Mexico’s agreement) to 298 pages (Washington), with a median length of 43 pages. They also vary in duration and renewal structure. Some specify fixed performance periods (one-year terms in New York and Colorado), while others span multiple years (such as North Dakota’s 2025–2027

agreement). Four other states (Colorado, New Mexico, Tennessee, and Wisconsin) also shared contract language dated 2025, but it is unclear how frequently states update or amend these agreements. Virginia originally issued its two-way program agreement in 2007 and subsequently updated it several times but allows extensions unless either the PACE organization or the SAA provides notice to terminate. Two-way program agreements from at least four other states (California, Colorado, North Dakota, and New York) include provisions for extensions of varying durations and frequencies.

States generally use two-way program agreements to supplement the federal oversight framework by incorporating state-specific requirements and providing additional operational details. These agreements most often address areas already identified in the three-way program agreement but expand on them through additional specificity or reporting requirements: (1) trial period monitoring; (2) ongoing monitoring requirements; (3) corrective action plans (CAPs); (4) enrollee level of care redeterminations; and (5) reporting on quality, financial performance, and encounter data (Table 6A-1). However, states rarely use these agreements to substantively modify or expand the statutory role of the SAA.

**TABLE 6A-1.** Use of Program of All-Inclusive Care for the Elderly Two-Way Program Agreements by Category and State

| Category                                     | States   |
|--|--|
| Trial period monitoring                      | CA, ND, VA   |
| Ongoing monitoring (after trial)             | CA, CO, DC, KS, MA, MI, MO, ND, NM, NY, OH, PA, RI, TN, WA, WI |
| Corrective action plan requirements          | CA, CO, MA, ND, OH, PA, TN, VA, WI                             |
| Level of care redeterminations (adds detail) | CA, ND, NY, OH, TN, WI   |
| <b>Reporting requirements</b>                |  |
| Grievances and appeals                       | CA, MA, MI, NY, TN, VA, WI                                     |
| Enrollments                                  | CA, CO, MI, ND, TN, WI   |
| Disenrollments                               | CA, CO, ND, TN, WI   |
| Incidents                                    | CA, CO, OH, TN   |

**TABLE 6A-1.** (continued)

| Category                                    | States                             |
|---|------------------------------------|
| Enrollment denials                          | CO, ND                             |
| Media events                                | CO                                 |
| Financial data                              | CA, CO, KS, MI, NM, NY, PA, VA, WI |
| Quality improvement plans                   | CA, MA, MI, ND, NY, OH, PA, TN     |
| Encounter data                              | CA, CO, ND, NY, OH, TN, WI         |
| Service utilization data                    | CA, KS, MA, NM, OH                 |
| Fraud and abuse                             | ND, NY, OH, VA, WI                 |
| Statistical data                            | CA, MA, ND, NM                     |
| Provider listings                           | CA, MI, MO, TN                     |
| Other/miscellaneous                         | CA, MA, MI, TN, ND                 |
| <b>Additional SAA roles</b>                 |                                    |
| Marketing materials/plan review             | CA, MA, OH, TN                     |
| Outreach/beneficiary education              | CA, KS, WI                         |
| Clinical operations                         | MI                                 |
| Technical assistance/administrative support | CA, WI                             |

**Notes:** SAA is state administering agency. Missouri’s provisions appear in state statute, reflecting a prior two-way program agreement.

**Source:** MACPAC, 2026, analysis of two-way program agreements submitted by states.

## Detailed findings by category

**Trial period monitoring.** Federal regulations and the three-way program agreement require the Centers for Medicare & Medicaid Services (CMS) and the SAA to conduct comprehensive annual reviews of PACE organizations during the trial period to ensure compliance with program requirements (42 CFR 460.190). These reviews include on-site visits, assessments of compliance, fiscal soundness, organizational capacity, and other operational elements. In practice, only three states explicitly address trial period monitoring in their two-way program agreements. California and North Dakota allow the SAA to request additional data from PACE organizations to support monitoring, while Virginia requires quarterly financial statements comparing budgeted versus actual spending reports.

**Ongoing monitoring requirements.** Federal regulations and the three-way program agreement provide limited specificity regarding states’ roles in the

ongoing monitoring of PACE organizations (42 CFR 460.192). For example, 42 CFR 460.192(a) states that the SAA, in cooperation with CMS, will continue to conduct reviews as appropriate, considering quality of care and compliance with state and federal requirements, following the trial period. Similarly, 42 CFR 460.192(b) indicates that SAAs and CMS will jointly conduct reviews as appropriate, based on a risk assessment of the PACE organization’s performance and regulatory compliance.

All of the two-way program agreements that we reviewed, with the exception of Virginia’s, include provisions addressing ongoing monitoring after the trial period. However, these provisions are generally broad and only modestly expand on the requirements in the three-way program agreement. For example, nine states (Colorado, Kansas, Massachusetts, New Mexico, New York, North Dakota, Ohio, Washington, and Wisconsin) require PACE organizations to retain records for specified periods.

All two-way program agreements reviewed besides Virginia's also require PACE organizations to make records and facilities available for state review or inspection, with some states specifying the scope of these reviews. Missouri's statute, for instance, outlines both remote and on-site audit activities, which may include reviews of enrollee files, grievance and appeals logs, service and call logs, personnel files, and observations of enrollees and organizational compliance with policies and procedures. Pennsylvania's agreement similarly notes that monitoring activities may include on-site visits, including to PACE enrollees' homes.

Most two-way program agreements do not clearly articulate the goals or objectives of ongoing monitoring, with the exception of Massachusetts and Michigan. Massachusetts's two-way program agreement specifies that monitoring is intended to (1) annually assess the impact and effectiveness of the PACE organization's Quality Assurance and Performance Improvement plan; (2) evaluate compliance with the two-way program agreement; and (3) assess, in conjunction with CMS, the quality, appropriateness, and timeliness of services. Michigan conducts annual on-site reviews of administrative processes, financial management, provider networks, covered services, quality assurance, utilization review, data reporting, claims processing, and documentation. Its two-way program agreement identifies 15 specific performance measures.

**CAPs.** A CAP is one of three types of compliance actions that CMS may take based on the type of non-compliance (the other two being issuance of a notice of non-compliance or a warning letter). CAPs are issued for particularly serious or continued non-compliance with PACE requirements (42 CFR 460.119(c)). Federal regulations require PACE organizations to correct deficiencies identified by CMS or the state, with both parties responsible for monitoring CAP effectiveness (42 CFR 460.194). Nine states (California, Colorado, Massachusetts, North Dakota, Ohio, Pennsylvania, Tennessee, Virginia, and Wisconsin) specify additional CAP requirements in two-way program agreements. Two states (North Dakota and Tennessee) define time frames for developing CAPs. Five other states (California, Massachusetts, North Dakota, Ohio, and Virginia) outline enforcement actions if CAPs are inadequate,

such as imposing sanctions, withholding payments, suspending agreements, or terminating programs.

Three states use two-way program agreements to take a more active role in monitoring CAPs. Ohio and Pennsylvania require PACE organizations to submit an annual written Quality Management Activities Report that includes an evaluation of implemented CAPs. Ohio further specifies that CAPs must identify the root causes of deficiencies; outline goals, objectives, methodologies, and corrective actions; and designate responsible PACE organization staff to achieve compliance within set time frames. Wisconsin's two-way program agreement allows the state to impose "intensive oversight" to bring a PACE organization into compliance, which may include placing state staff or designated representatives on site to provide technical guidance and support corrective actions.

**Enrollee level of care redeterminations.** Federal regulations assign states primary responsibility for conducting annual level of care redeterminations for PACE enrollees (42 CFR 460.160(b)). Six states (California, New York, North Dakota, Ohio, Tennessee, and Wisconsin) add details to this process in their two-way program agreements with PACE organizations. Ohio, Tennessee, and Wisconsin also establish specific time frames for completing redeterminations, such as within 30 days before the due date (Tennessee) or within 365 days of the most recent determination (Ohio and Wisconsin).

Several states delegate responsibility for completing level of care redeterminations to PACE organizations. North Dakota requires PACE organizations to use the state's Level of Care Check tool, which includes eight elements, while New York requires use of a state-developed redetermination tool. Tennessee does not require a specific tool but mandates that qualified assessors who have completed the state's home- and community-based services qualified assessor training conduct redeterminations. In Ohio, PACE organizations conduct redeterminations, but the state retains responsibility for validating all level of care determinations and requires PACE organizations to submit requests for determinations and redeterminations no later than seven business days before the due date.

Federal regulations allow states to waive annual level of care redeterminations when they determine that an enrollee's condition is unlikely to improve or change substantially due to the severity of a chronic condition or functional impairment (42 CFR 460.160(b)(2)). Tennessee is the only state whose two-way program agreement allows the state to waive the annual recertification requirement for specified conditions, including Alzheimer's disease or related dementias, chronic obstructive pulmonary disease, end-stage renal disease, and congestive heart failure.

**Reporting.** Federal regulations require PACE organizations to collect and report data, maintain records, and provide CMS and states access to specified enrollee, financial, and medical records (42 CFR 460.200, 460.204, and 460.70). CMS requires PACE organizations to submit quarterly data on 24 quality measures through the Health Plan Management System (HPMS). These measures cover both administrative processes, such as appeals, grievances, enrollments, disenrollments, and enrollment denials, and reportable incidents requiring investigation, including unexpected deaths, infectious disease outbreaks, and falls resulting in injury or serious trauma.<sup>3</sup>

State two-way program agreements require PACE organizations to submit a range of data and reports, including both measures already reported to CMS through HPMS and additional state-specific requirements. The quality-related reports states most commonly require that also overlap with HPMS submissions include grievances and appeals reports (seven states: California, Massachusetts, Michigan, New York, Tennessee, Virginia, and Wisconsin), enrollment reports (six states: California, Colorado, Michigan, North Dakota, Tennessee, and Wisconsin), disenrollment reports (five states: California, Colorado, North Dakota, Tennessee, and Wisconsin), incident reports (four states: California, Colorado, Ohio, and Tennessee), enrollment denials (two states: Colorado and North Dakota), and media event reports (one state: Colorado).

States also require PACE organizations to submit financial reports through mechanisms separate from HPMS. During the trial period, PACE organizations must submit quarterly financial statements to CMS, and after the trial period, CMS or states may require quarterly or monthly financial reporting. PACE

organizations must also submit annual certified financial statements to CMS. Nine states (California, Colorado, Kansas, Michigan, New Mexico, New York, Pennsylvania, Virginia, and Wisconsin) include provisions in their two-way program agreements requiring financial statements or financial reports, with reporting frequencies ranging from monthly to quarterly. Some states also require specific financial information, such as budget-to-actual comparisons (New Mexico, Pennsylvania, and Virginia) or balance sheets for PACE organizations that operate as separate corporate entities (New Mexico).

CMS requires PACE organizations to develop, implement, maintain, and evaluate a quality improvement program (42 CFR 460.130). PACE organizations' quality improvement plans appear as Appendix L in the three-way program agreements and must include objective performance measures related to service utilization, participant and caregiver satisfaction, outcomes, and service effectiveness and safety (42 CFR 460.134). Although CMS requires PACE organizations to internally review these data and use them to improve performance (42 CFR 460.132), federal regulations (42 CFR 460.202(b)) do not clearly specify whether or how PACE organizations must report quality improvement data to CMS or states, stating only that organizations must furnish data "in the manner, and at the time intervals, specified by CMS and the State administering agency." Eight states (California, Massachusetts, Michigan, New York, North Dakota, Ohio, Pennsylvania, and Tennessee) include provisions in their two-way program agreements requiring quality-related reports. For example, California requires an annual summary of quality assurance activities and semiannual progress reports, while Michigan requires an annual report that includes a Quality Assessment and Performance Improvement Plan (QAPIP), QAPIP work plan, and a review of QAPIP effectiveness.

Since 2013, CMS has required PACE organizations to submit Medicare encounter data for services that generate provider claims and, beginning in 2024, to also submit Chart Review Records to capture diagnoses from PACE center services that do not generate claims (CMS 2024e). Seven states (California, Colorado, New York, North Dakota, Ohio, Tennessee, and Wisconsin) also require PACE organizations to submit encounter data directly to the state. Five of these states (Colorado, New York, Ohio,

Tennessee, and Wisconsin) do not specify the scope of required encounter data submissions and instead leave those decisions to state discretion. California and North Dakota, however, further define the scope of required encounter data. California requires PACE organizations to, at a minimum, submit encounter data for all items and services provided to Medicaid enrollees for which the organization is financially liable. North Dakota requires encounter data for services provided to Medicaid enrollees, including examinations, diagnostic and treatment services, supplies, and medical equipment, and specifies that denied claims must be reported when Medicare pays. North Dakota also defines encounters broadly to include physician and professional services, inpatient and outpatient hospital services for which the PACE organization is responsible, prescription drugs, dental care, durable medical equipment, in-home services, and services provided in PACE centers. Although Colorado's two-way program agreement states that PACE organizations shall submit encounter data as directed by the SAA, the state's Department of Health Care Policy and Financing publishes encounter data guidance and allows submission for a wide range of services, including behavioral health, chaplain, home health, therapy, and transportation services (Colorado Department of Health Care Policy & Financing 2021).

Twelve states impose additional reporting requirements beyond those required by CMS. These include service utilization reports (five states: California, Kansas, Massachusetts, New Mexico, and Ohio), fraud and abuse reports (five states: New York, North Dakota, Ohio, Virginia, and Wisconsin), statistical reports (four states: California, Massachusetts, New Mexico, and North Dakota), and provider listings (four states: California, Michigan, Missouri, and Tennessee). Three states (California, Massachusetts, and Michigan) also require demographic data, subcontractor reports, cost reports, and enrollee satisfaction survey results. Other state-specific requirements include Medicare Healthcare Effectiveness Data and Information Set reporting (Tennessee) and day center attendance reporting (North Dakota). North Dakota further requires reporting on additional outcomes, such as risk of nursing facility admission, permanent nursing facility placement, mental health diagnoses, rates of selected infections, and hospital and nursing facility readmissions within 31 days of discharge.

# APPENDIX 6B: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 Section 903 Waiver Requests

Section 903 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) authorizes the Centers for Medicare & Medicaid Services (CMS) to approve waivers (BIPA 903 waivers) of certain Medicare and Medicaid regulatory requirements for Program of All-Inclusive Care for the Elderly (PACE) organizations. Under this authority, PACE organizations submit waiver requests to the state administering agency (SAA), which reviews the request and either approves or denies it before forwarding approved requests to CMS for final determination. Section 1894 and Section 1934 of the Social Security Act identify five regulatory provisions of the PACE model that cannot be waived:

- serving frail, elderly individuals who require a nursing facility level of care;
- providing comprehensive, integrated acute, and long-term services;
- using an interdisciplinary team;
- using capitated, integrated financing; and
- assuming full financial risk (CMS 2024c).

These requirements define the structural integrity of the PACE model and are treated as non-waivable statutory foundations. In addition, CMS established regulatory flexibilities through a 2019 final rule that reduced certain operational constraints on PACE organizations. These include:

- permitting one individual to fill two separate roles on the interdisciplinary team if the individual has the appropriate qualifications and licenses to fill both roles;
- permitting the required primary care provider role on the interdisciplinary team to be filled by not only physicians but also nurse practitioners, physician assistants, and community-based physicians;

- removing the requirement that interdisciplinary team members primarily serve PACE enrollees; and
- providing greater flexibility on unscheduled reassessments of PACE enrollees (CMS 2019).

**Waiver submission and review process.** CMS has issued standardized instructions for PACE organizations interested in developing and submitting waiver requests. These instructions specify that applications must include: (1) identification of the submitted document as a waiver request; (2) the specific regulation in 42 CFR 460 to be waived; (3) a rationale for the waiver request; and (4) if applicable, a description of processes to be followed to assure that enrollee care will not be compromised if the request is granted (CMS 2024c).

PACE organizations prepare waiver requests and submit them to the SAA for review. If the SAA does not approve the request, CMS automatically denies it. If the SAA approves the request, it forwards the submission to CMS with any additional comments. CMS then makes a final determination within 90 days of receipt.

**Data and methods.** To collect more detailed data on BIPA 903 waiver requests, we contacted the 33 states and the District of Columbia that have PACE organizations and requested copies of any waiver requests PACE organizations have submitted to the states, whether they were approved by the state and forwarded to CMS or denied at the state level. We collected waiver requests from nine states (California, Delaware, Massachusetts, Michigan, New York, North Dakota, Pennsylvania, Rhode Island, and Washington). Two additional states (Louisiana and New Jersey) reported that their PACE organizations had submitted waiver requests, but they could not provide copies.

We analyzed 47 waiver requests submitted after the 2019 regulatory changes to ensure comparability under the current flexibilities. We collected information on the submitting PACE organization, state actions, regulatory provisions requested for waiver, and approval outcomes, along with the following additional information: whether the requesting entity was an existing PACE organization or a new PACE applicant; the date of the waiver request; whether the request was new or a resubmission; a description of the requirements being waived, the PACE organization's rationale for waiving these requirements; whether the request was related to the COVID-19 public health emergency; waiver status (granted or denied), if available; date of CMS's final decision, if available; and any applicable comments or notes included in the request. We used additional sources to identify the CMS contract number and PACE organization's website to verify the profit status of the PACE organization (ICRC 2025).

The 47 waiver requests we reviewed were submitted by 32 different PACE organizations. Requests came from PACE organizations in seven states:

- California: 26 requests;
- Pennsylvania: 10 requests;
- Washington: 7 requests; and
- other states (Delaware, Massachusetts, North Dakota, Rhode Island): 1 request each.

California and Pennsylvania account for a disproportionate share of waiver activity, consistent with their larger number of PACE organizations (40 and 18 PACE organizations, respectively) (NPA 2026). Washington state has three PACE organizations, and one of these organizations submitted six waiver requests, more than any other PACE organization.

**Types of waiver requests.** Waiver requests must indicate the specific sections of 42 CFR 460 that the PACE organization is asking to be waived and the rationale for the request. Table 6B-1 summarizes the waiver requests we reviewed by regulatory section. Nearly all waiver requests clustered around two primary areas: enrollee assessment flexibility and staffing composition requirements.

- **Remote enrollee assessment and service determinations.** Most requests sought waivers of 42 CFR 460.104, which requires in-person enrollee assessments at enrollment, semiannually, and following changes in health status or when the PACE organization expects to deny or partially deny a service determination request. After the COVID-19 public health emergency, many PACE organizations sought to continue using telehealth or telephone-based assessments previously permitted under CMS guidance. PACE organizations offered a variety of rationales for requesting this flexibility, including staffing shortages, efficiency in completing assessments, improved access in

**TABLE 6B-1.** Program of All-Inclusive Care for the Elderly Federal Regulation Waiver Requests

| Section  | Number of requests |
|--|--------------------|
| Enrollee assessments (42 CFR 460.104)              | 40                 |
| Service determination requests (42 CFR 460.121)    | 17                 |
| Interdisciplinary team (42 CFR 460.102)            | 17                 |
| CMS evaluation of PACE application (42 CFR 460.18) | 4                  |
| Enrollment process (42 CFR 460.152)                | 2                  |
| Plan of care (42 CFR 460.106)                      | 1                  |

**Notes:** CMS is Centers for Medicare & Medicaid Services. PACE is Program of All-Inclusive Care for the Elderly.

**Source:** MACPAC, 2026, analysis of PACE organization waiver requests submitted to states and CMS under Section 903 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554). Requests were collected via outreach to states with PACE programs.

rural areas, and reduced burden for enrollees concerned about COVID-19 transmission reluctant to receive in-person visits. In addition, many PACE organizations said that remote assessments were sufficient to gather needed information about PACE enrollees. Remote assessment also appeared in waiver requests related to service determination processes under 42 CFR 460.121. In these submissions, PACE organizations requested waivers of the requirement that interdisciplinary team members conduct in-person assessments before approving or denying service determinations, instead seeking permission to conduct these assessments virtually. Most requests for waivers of 42 CFR 460.121 also included requests to waive the in-person assessment requirements in 42 CFR 460.104.

- **Master’s level social workers.** Many waivers also requested flexibility under 42 CFR 460.102, which governs interdisciplinary team composition and responsibilities. These requests primarily reflected shortages of master’s level social workers. Organizations frequently requested permission to substitute other qualified professionals, including licensed professional counselors or bachelor’s level social workers.

Not all the waiver requests we reviewed contained information about whether the request was approved or denied. Of the 47 BIPA 903 waiver requests we reviewed, CMS granted 12. Eleven waiver requests were denied at the state level, with 10 of those denials occurring in California and 1 in Pennsylvania. CMS denied four waiver requests that had been previously approved by the SAA, including three from PACE organizations in Washington and one from Rhode Island. The remaining 21 waiver request documents lacked information about whether they had been approved or denied.

## Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission’s policies regarding conflicts of interest, the Commission’s conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on May 7, 2026.

### Exploring the Role of the State Medicaid Agency in the Program of All-Inclusive Care for the Elderly

**6.1** The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update audit protocols and three-way program agreements to facilitate joint audits of Program of All-Inclusive Care for the Elderly organizations with state administering agencies. Audit coordination should include joint planning of audit scopes, sharing documentation requests, and reviewing evidence concurrently, while preserving CMS’s responsibility for assessing federal requirements and states’ responsibility for assessing state-specific requirements.

| 6.1 voting result | #  | Commissioner   |
|-------------------|----|--|
| Yes               | 17 | Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder |
| No                | 0  |  |

**6.2** The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to aggregate and publicly release, in a user-friendly format on the CMS website, existing Program of All-Inclusive Care for the Elderly (PACE) performance data, including data PACE organizations submit through CMS’s Health Plan Management System as well as enrollee satisfaction data collected as part of PACE organization quality improvement programs pursuant to 42 CFR 460.134(a)(2).

| 6.2 voting result | #  | Commissioner   |
|-------------------|----|--|
| Yes               | 17 | Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder |
| No                | 0  |  |

- 6.3** The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to amend regulations at 42 CFR 460 Subpart H to develop a standardized, national quality measure set for Program of All-Inclusive Care for the Elderly (PACE) organizations. Quality data should be compiled and made publicly available in an accessible format. CMS should follow three key principles when developing a PACE quality measure set: engage stakeholders collaboratively; minimize reporting burden by focusing on the most meaningful measures; and prioritize standardized measures that enable comparability across programs where feasible.

| 6.3 voting result | #  | Commissioner   |
|-------------------|----|--|
| <b>Yes</b>        | 17 | Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder |
| <b>No</b>         | 0  |  |