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ResearchReport

Program of All-Inclusive Care for the Elderly (PACE)

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Issue

This report answers questions on the Program of All-Inclusive Care for the Elderly (PACE), including PACE programs in other states, federal limits and requirements, and relationship to other state programs.

What are PACE Programs?

PACE programs provide medical and social services to program participants who (1) are at least age 55, (2) live in a PACE organization's service area, (3) are eligible for nursing home care, and (4) can safely live in the community. Services are provided by PACE organizations, which are nonprofit or for-profit entities approved by the federal Centers for Medicare and Medicaid Services (CMS). An organization seeking to become a PACE organization must apply to CMS with assurance from the state Medicaid agency that the state considers the organization qualified and is willing to enter into a PACE agreement with the organization.

PACE organizations receive a capitated payment to provide Medicare and Medicaid services (e.g., primary care, hospital care, prescription drugs), as well as services that are not always reimbursable under Medicare or Medicaid (e.g., meals and social services). Medicaid and Medicare limits on services (duration, amount, scope of service) and cost-sharing do not apply. While enrolled in PACE, the participant receives all their Medicare and Medicaid benefits solely through the PACE organization (42 C.F.R. § 460.90). PACE organizations must provide certain services through a PACE center in an accessible location for its participants.

What services do PACE programs provide to seniors?

As described in federal regulations, PACE's purpose is to provide pre-paid, capitated, comprehensive health care services designed to meet the following objectives:

1. enhance the quality of life and autonomy for frail, older adults;
2. maximize the dignity of, and respect for, older adults;
3. enable frail, older adults to live in the community as long as medically and socially feasible; and
4. preserve and support the older adult's family unit (42 C.F.R. § 460.4(b)).

PACE organizations provide services primarily in an adult day health center (a "PACE center"). Each PACE organization must operate at least one PACE center in or contiguous to its designated service area with sufficient capacity to allow routine attendance by participants. The PACE center must provide at least primary care, social services, restorative therapies (physical therapy and occupational therapy), personal care and supportive services, nutritional counseling, recreational therapy, and meals (42 C.F.R. § 460.98).

In addition to PACE center services, the PACE organization may provide in-home services and referrals for other services as needed, including for nursing home care. To determine which services a participant receives, an interdisciplinary team assesses his or her needs and develops care plans. According to CMS, the team consists of at least the following:

1. dietitian,
2. driver,
3. home care liaison,
4. nurse,
5. occupational therapist,
6. PACE center supervisor,
7. personal care attendants,
8. physical therapist,
9. primary care physician,
10. recreational therapist or activity coordinator, and

11. social worker (42 C.F.R. § 460.102).

Participants may also make a service determination request to initiate new services or modify services they receive (42 C.F.R. § 460.121).

Federal regulations generally prohibit PACE organizations from covering cosmetic surgery, experimental procedures, and services furnished outside the United States, with certain exceptions (42 C.F.R. § 460.96).

How are PACE programs funded for dual-eligible seniors?

For PACE participants who are eligible for both Medicaid and Medicare ("dual-eligible"), PACE organizations receive two capitation payments per month: one Medicare payment from CMS based on Medicare Advantage Plans and one Medicaid payment set by the state but subject to CMS approval. Approximately 90% of PACE participants are dual-eligible, according to the National Pace Association (NPA), an advocacy organization for PACE programs.

The Medicaid payment for dual-eligible participants must comply with federal regulations that require states to make their Medicaid payment as a prospective payment to the PACE organization for each Medicaid participant. The payment amount must meet the following criteria:

1. be less than the amount that the state would otherwise pay if the participant were not enrolled in the PACE program,
2. take into account the comparative frailty of PACE participants,
3. be a fixed amount regardless of changes in the participant's health status, and
4. be able to be renegotiated annually (by the state and the PACE organization)(C.F.R. 42 § 460.182(b)).

With certain exceptions, regulations generally prohibit PACE organizations from requiring any kind of cost-sharing (e.g., copays or deductibles) from Medicaid recipients, including dual-eligible participants (42 C.F.R. § 460.182(c)).

Does the law limit the number of PACE programs a state may have?

While there is no explicit limit on the number of PACE programs a state may have, federal regulations establish a general limit on the total number of approved PACE programs nationwide that increases by 20 annually (42 C.F.R. § 460.24(a)). The current limit (520) will increase by 20 on August 5, 2022. According to NPA, 142 PACE programs currently operate in 30 states, but some of these may be exempt from the regulatory limit if they were established under certain waivers (42

C.F.R. § 460.24(b)). (Connecticut does not have any PACE programs.)

Each PACE program has a geographic service area designated in its PACE program agreement, which must be approved by CMS and the state Medicaid agency (42 C.F.R. §§ 460.30 & 460.32). The agreement may identify the service area by county, zip code, street boundaries, census tract or block, or tribal jurisdictional area, as applicable. Federal regulations allow CMS to prevent multiple PACE organizations from serving the same area to avoid duplicating services or impairing an existing program's financial viability (42 C.F.R. § 460.12(c)).

Does the law limit the type of entities that may be PACE organizations?

Any organization seeking to become a PACE organization must apply to CMS with assurance from the state Medicaid agency that the state considers the organization qualified and is willing to enter into a PACE agreement with the organization (42 C.F.R. §§ 460.10 to 460.28). According to CMS, the application process also includes a state readiness review conducted by the state at the applicant's PACE center.

Both non-profit and for-profit entities may apply to become PACE organizations. CMS removed the requirement that PACE organizations be non-profit entities in 2015 after a demonstration evaluation of for-profit providers, as authorized under the federal Balanced Budget Act of 1997 (P.L. 105-33)(42 U.S.C. § 1395eee(a)(3)). Before this change, for-profit organizations needed a waiver from CMS to act as PACE organizations.

Among other things, PACE organizations must also take the following actions:

1. employ or contract with (1) a program director to oversee and administer the organization and (2) a medical director to deliver participant care, implement and oversee quality improvement programs, and be responsible for clinical outcomes (42 C.F.R. § 460.60);

2. maintain a current organizational chart showing organization officials and their relationships to any other entities (42 C.F.R. § 460.60);

3. operate under the control of an identifiable governing body (e.g., board of directors) or designated person with full legal authority and responsibility for governing the organization (42 C.F.R. § 460.62);

4. identify members of the governing body or their immediate family members with an interest in any contract supplying administrative or care-related services or materials to the PACE organization and develop policies to handle conflicts of interest (42 C.F.R. § 460.68);
5. establish a participant advisory committee to advise the governing body (42 C.F.R. § 460.62);

6. have a fiscally sound operation and a documented insolvency plan (42 C.F.R. § 460.80);

7. adopt and implement effective compliance oversight requirements (42 C.F.R. § 460.63); and

8. provide training to maintain and improve staff members' skill and knowledge (42 C.F.R. § 460.66)

Federal regulations additionally establish qualification requirements for staff with direct contact with PACE participants (42 C.F.R. §§ 460.64 & 460.71).

What relationship do PACE programs have with Area Agencies on Aging?

Area Agencies on Aging (AAAs) are local entities that oversee a comprehensive and coordinated service system to deliver social supports, nutrition supports, and long-term services and supports to older people in their service area. AAAs may do this directly or through contracts with local service providers. Most states (including Connecticut) have AAAs, as they were authorized under the federal 1973 Older Americans Act.

According to NPA, AAAs may (1) work with an existing PACE organization to expand access to the program, (2) partner with an existing PACE program to deliver services through a contract, or (3) develop a new PACE program and operate as a PACE organization. NPA discussed these options in a February 2020 webinar. A June 2021 publication from the Aging and Disability Business Institute (produced for NPA) provides three case studies involving AAAs working with or as PACE organizations in Arkansas, Massachusetts, and New York.

AAAs and PACE organizations are not required to have a formal relationship and states may be served by both entities. AAAs and PACE organizations may overlap or compete in the sense that they both provide similar services to older people and may work with other providers to deliver services.

How do states authorize PACE programs?

Federal law allows states to authorize PACE programs by amending their state Medicaid plans to elect PACE as an optional Medicaid benefit (42 U.S.C. § 1396d(a)(26)). To do so, states must submit a Medicaid state plan amendment (an "SPA") to CMS for approval. CMS provides more information for states on its website.

A 2004 article in the Millbank Quarterly described additional steps states may need to take to implement PACE programs including determining (1) whether new legislation is required, (2) provider licensure or certification requirements, and (3) whether any financial requirements beyond those stipulated by the federal government will be needed in view of the state's regulations. Additionally, "states must pay for any information system modifications needed for claims processing and data reporting, the development of payment rates for PACE and program criteria,

clinical oversight and quality assurance activities, and the review and approval of PACE site applications."

Describe PACE programs in Massachusetts, New York, and Rhode Island, including their start date and experience.

Massachusetts

According to NPA, as of December 2021, Massachusetts has eight PACE programs serving 4,982 participants, as shown in Table 1.

Table 1: PACE Programs in Massachusetts (December 2021)

Program	City	Start Date	Participants
CHA PACE	Cambridge	4/1/1995	517
Element Care	Lynn	4/1/1995	984
Harbor Health Services	Dorchester	2/1/1996	516
Mercy LIFE of Massachusetts (Trinity)	Holyoke	3/1/2014	242
Neighborhood PACE	East Boston	6/1/1990	715
Serenity Care	Springfield	6/1/2014	536
Summit ElderCare	Worcester	11/1/1995	1,212
Upham's Elder Service Plan/PACE	Boston	2/1/1996	260
Total Participants			4,982

Source: NPA

Several studies have evaluated PACE programs in Massachusetts, but data limitations and other challenges persist. A 2005 evaluation, conducted by the Massachusetts Division of Health Care Finance and Policy, compared PACE hospitalization rates with those of nursing home residents and Medicaid waiver participants. The authors noted that while the analysis suggested some encouraging findings for the PACE program, data limitations make it difficult to tell whether findings result from the programs themselves or other issues. A 2013 literature review conducted by Mathematica Policy Research described the evaluation as having somewhat limited validity and characterized its evidence as moderate to weak. The review also discussed the challenges inherent in evaluating PACE programs generally and assessed findings from additional studies of PACE programs in other states.

A 2015 study, conducted by JEN Associates, Inc. (a healthcare data analytics firm), showed evidence for shorter nursing home stays for PACE participants. Another 2015 study, conducted by Mercer Health & Benefits LLC (a consulting group), noted that the approach to care in the PACE model was beneficial to participants and family members, but also recommended more robust data collection.

In a 2019 CommmonWealth article, Susan Ciccariello, then director of coordinated care for the state's Executive Office of Health and Human Services, acknowledged that the data on PACE program effects were limited. The article went on to say the program's impact on quality of life, mortality rates, and costs remained unclear, but noted that interest in PACE programs was growing.

Local news coverage during the COVID-19 pandemic noted that PACE programs in Massachusetts increased reliance on video technology, home visits, and daily telephone calls, in lieu of services provided at PACE centers.

New York

PACE programs have operated in New York since at least 1992. Recently considered legislation has sought to establish a statutory framework for PACE, but it has not become law (Assembly Bill A7903 and Senate Bill S6664). According to NPA, as of December 2021, New York has nine PACE programs serving 5,284 participants, as shown in Table 2.

Table 2: PACE Programs in New York (December 2021)

Program	City	Start Date	Participants
ArchCare Senior Life	New York	11/1/2009	678
Catholic Health LIFE	Buffalo	11/1/2009	266
CenterLight Healthcare	New York	2/1/1992	2,371
Complete SeniorCare	Niagara Falls	9/1/2011	118
Eddy SeniorCare (Trinity)	Schenectady	10/1/1996	293
ElderONE	Rochester	5/1/1992	730
Fallon Health Weinberg	Amherst	3/1/2016	129
PACE CNY	North Syracuse	12/1/1997	558
Total Senior Care	Olean	2/1/2009	141
Total Participants			5,284

Source: NPA

According to recent reporting in a homecare industry publication, New York has recently sought to pilot a PACE expansion program that would allow Medicare beneficiaries to buy into PACE at a tiered rate depending on the level of services they would need. According to the article, New York's PACE program currently only serves dual-eligible participants.

Rhode Island

State law authorized the Department of Human Services to elect PACE as an optional Medicaid benefit in 2005 (Gen. Laws, 1956 § 40-8.8-1 et seq.). According to NPA, Rhode Island has one PACE program, administered by PACE Organization of Rhode Island (PACE-RI), that started in

December 2005 and currently serves 346 participants in Providence. According to Providence Business First, PACE-RI recently moved into an expanded facility and expects to serve 500 participants by 2023. The article noted that the typical participant is 76 years old with eight medical conditions and nine medications. Additionally, 87% of participants have a behavioral health diagnosis, 40% have dementia, and all require assistance with activities of daily living.

What impact have PACE programs had on Medicare supplemental insurance providers?

Medicare supplemental insurance (also known as "Medigap") is a set of federally regulated private health insurance policies that Medicare beneficiaries may purchase to address Medicare coverage gaps (e.g., services for which beneficiaries must pay deductibles, copayments, or coinsurance).

In states that have them, PACE programs are a possible alternative to purchasing Medigap policies. It is unclear what effect, if any, the establishment of a PACE program has on Medigap providers, as we found no studies on this topic. Theoretically, establishing a PACE program could reduce the number of Medicare beneficiaries who purchase a Medigap policy, but the extent of that effect depends on (1) how many people the PACE program serves and (2) the proportion of those PACE participants who would have purchased Medigap policies had the PACE program not been established, rather than paying out of pocket or relying on other sources of coverage (e.g. employersponsored coverage or Medicare Savings Programs).

However, it appears that there is a limited amount of overlap between the populations served by Medigap policies and PACE, respectively. Table 3 compares 2018 Medigap enrollment with current PACE enrollment in states with PACE programs. As the table shows, the number of Medicare beneficiaries who purchased Medigap plans was 176 times higher than the number of PACE participants.

Table 3: Medigap and PACE Enrollment in States With PACE Programs

State	Medigap Enrollment (2018)	PACE Participants (current)
Alabama	202,752	166
Arkansas	184,968	430
California	591,240	13,331
Colorado	207,779	4,799
Delaware	64,170	252
Florida	901,389	2,459
Iowa	305,743	609

Indiana	390,219	413
Kansas	248,506	749
Louisiana	153,054	426
Massachusetts	335,911	4,982
Maryland	243,175	140
Michigan	429,663	4,127
North Carolina	505,388	2,039
North Dakota	53,831	173
Nebraska	180,773	218
New Jersey	480,748	1,077
New Mexico	67,447	484
New York	481,178	5,284
Ohio	587,953	605
Oklahoma	203,944	665
Oregon	158,188	1,672
Pennsylvania	700,155	7,763
Rhode Island	50,713	346
South Carolina	276,077	470
Tennessee	308,067	283
Texas	873,514	1,092
Virginia	429,851	1,509
Washington	301,349	1,122
Wisconsin	299,988	517
Total	10,217,733	58,202

Source: America's Health Insurance Plans (AHIP), NPA

Additionally, because most PACE participants are also eligible for Medicaid, they may not have been likely to purchase Medigap plans in any case, as Medicaid would cover some or all of their Medicare cost-sharing. According to NPA, in March 2020, 90% of PACE participants were dually eligible for Medicaid and Medicare. Another 9% were eligible only for Medicaid and therefore would not be eligible to purchase Medigap policies.

Resources

AHIP, "State of Medigap: Trends in Enrollment and Demographics," June 2020.

CMS, "Programs of All-Inclusive Care for the Elderly (PACE) Manual," 2011.

CMS, "PACE Medicaid Capitation Rate Setting Guide," December 2015.

CMS, "Report to Congress: The Centers for Medicare and Medicaid Services' Evaluation of For-Profit PACE Programs under Section 4804(b) of the Balanced Budget Act of 1997," May 2015.

CMS, "2017 Programs of All-Inclusive Care for the Elderly (PACE) Audit and Enforcement Report," July 2018.

Congressional Research Service, "Older Americans Act: Overview and Funding," April 2021.

Mathematica Policy Research, "Evaluating PACE: A Review of the Literature," December 2013.

Mathematica Policy Research, "Study of Access and Quality of Care in For-Profit PACE," October 2013.

NPA, "PACE in the States," December 2021.

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