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

Brian O'Gara and Drew Gerber

MACPAC

Medicaid and CHIP Payment and Access Commission

@macpacgov

www.macpac.gov

Overview

- Background
  - Eligibility and enrollment
  - Service delivery
- Financing
- Model evaluations
- Recent federal and state action
- Next steps

Background

PACE in Statute

- PACE is a provider-led, home- and community-based care model serving frail adults aged 55 and older
  - Those enrolled in PACE must have a nursing facility level of care (NFLOC) need but can live safely in the community
- Originated with On Lok Senior Health Services in 1971 before becoming a Centers for Medicare & Medicaid Services demonstration program in the 1980s
- In 1997, Congress permanently authorized PACE as a Medicare program and Medicaid state plan option (§1894 and §1934 of the Social Security Act (the Act))

Eligibility and Enrollment

- As of August 2024, more than 63,000 Medicare beneficiaries were enrolled in 179 PACE programs across 33 states and the District of Columbia, largely comprising dually eligible beneficiaries
- States and PACE organizations may include additional eligibility criteria, though it is unclear the extent to which this is done
- Upon electing to enroll in PACE, an individual's enrollment is effective the following month and continues until death, regardless of changes in health
  - Individuals may voluntarily disenroll at any time
  - Involuntary disenrollment may occur, including because of failure to pay premiums or no longer meeting the state NFLOC requirement
- States must annually evaluate PACE enrollees to ensure they continue to meet NFLOC requirements

Service Delivery

- An interdisciplinary team (IDT) develops care plans and provides care to enrollees
  - The team must include at a minimum 11 federally mandated provider types
- PACE organizations must operate a PACE center from which the IDT coordinates and provides most services
  - However, attendance at the center is not mandatory, and organizations have the option to provide services in the home and alternative community settings
- Common services offered include adult day care, dentistry, meals, primary care, and transportation
- PACE programs must provide any items or services the IDT deems necessary for each enrollee, with few exceptions
  - Typical Medicare and Medicaid benefit limitations and conditions on amount, duration, scope of services, deductibles, copayments, coinsurance, and other cost-sharing do not apply to those enrolled in PACE

Financing

Rate Setting

- PACE organizations receive a blend of monthly capitated payments from Medicare Parts A, B, and D, and state Medicaid agencies (and in rare cases, premiums)

- Medicare and Medicaid capitation rates must:
  - account for the frailty of PACE enrollees compared to the general Medicare or Medicaid population;
  - be fixed amounts that do not fluctuate with changes in a participant's health status;
  - represent full reimbursement for both Medicaid and Medicare participants, meaning providers cannot charge participants deductibles, copayments, or coinsurance; and
  - be less than the amount that would otherwise have been paid (AWOP) under Medicare or Medicaid if the participants were not enrolled in PACE

Medicaid Rate Setting

- States base the capitation amount for each Medicaid participant on a blend of the cost of nursing home and community-based care for the elderly in the area to account for the frailty of the PACE population

- State Medicaid rates for PACE do not have to be actuarially sound to be approved by CMS, but are subject to an upper payment limit (UPL), which is the AWOP

- Most states calculate the UPLs first and then set the capitation rates as a fixed percentage of the UPL (e.g., 95 percent of the UPL)

- States can create multiple rate cells based on participant age, gender, geographic region, eligibility category, or Medicare status to more accurately project AWOPs/UPLs

Example Medicaid Rates

PACE Rates July 2021

Effective with dates of service on and after July 1, 2021, reimbursement rates for each Program of All-Inclusive Care for the Elderly (PACE) organization in Kansas have been updated.

Via Christi Healthcare Outreach			
SG Region			
Population	AWOP	Rt% of AWOP	Rate Effective July 1, 2021
Dual 55-74 M&F	$4,502.26	90%	$4,052.03
Dual 75+ M&F	$4,776.36	90%	$4,298.72
Non-Dual M&F	$5,899.92	90%	$5,309.93

Midland Care PACE			
Blended SFY 2022 Rate Due to Multiple Regions			
Population	AWOP	Rt% of AWOP	Rate Effective July 1, 2021
Dual 55-74 M&F	$4,327.65	90%	$3,913.39
Dual 75+ M&F	$4,591.12	90%	$4,151.64
Non-Dual M&F	$5,671.10	90%	$5,128.25

Bluestem PACE Inc			
Blended SFY 2022 Rate Due to Multiple Regions			
Population	AWOP	Rt% of AWOP	Rate Effective July 1, 2021
Dual 55-74 M&F	$4,310.21	90%	$3,878.36
Dual 75+ M&F	$4,572.62	90%	$4,114.47
Non-Dual M&F	$5,648.26	90%	$5,082.34

Source: Kansas Department of Health and Environment, 2021.

Total Medicaid Spending on PACE, FY 2023
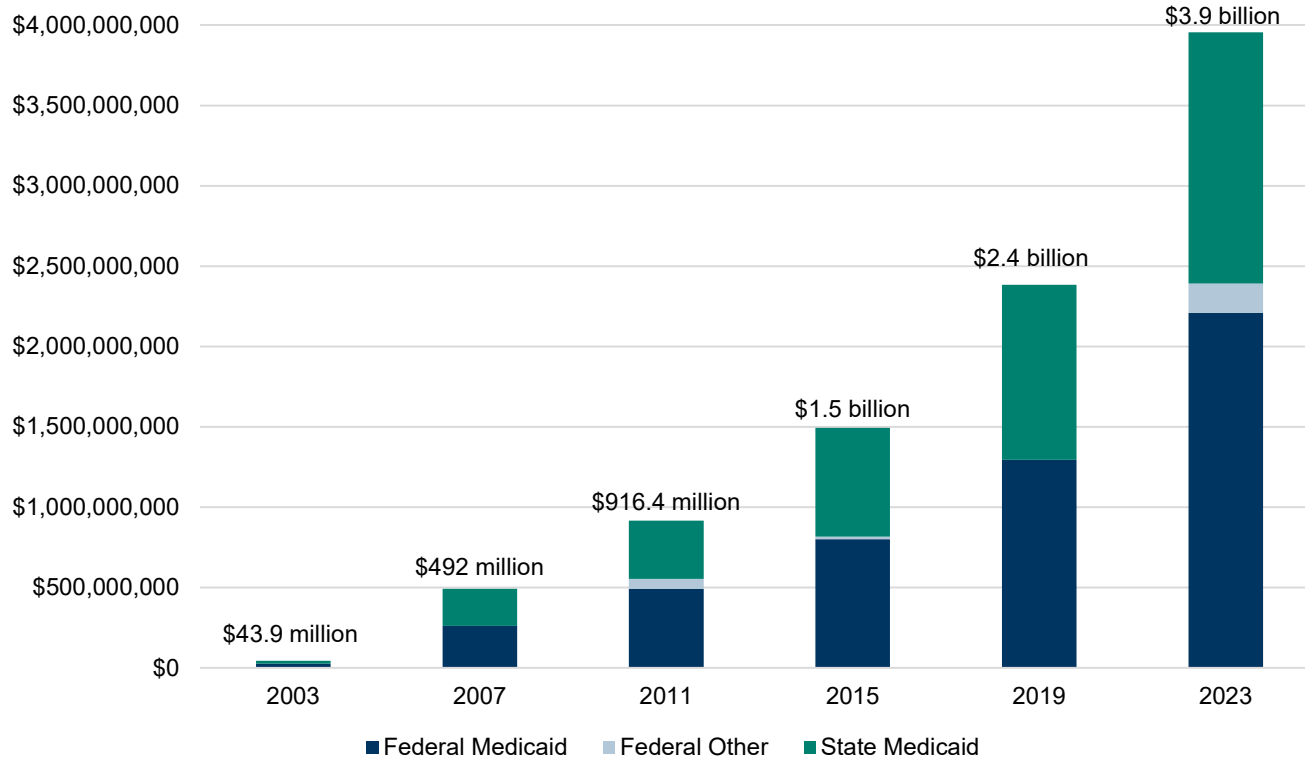
Notes: PACE is the Program of All-Inclusive Care for the Elderly. FY is fiscal year. "Federal Other" includes funds from the American Recovery and Reinvestment Act of 2009 (P.L. 111-5), Balancing Incentive Program, and American Rescue Plan Act of 2021 (P.L. 117-2) that CMS includes with FMAP reporting.

Sources: MACPAC, 2024, analysis of CMS-64 data from FY 2003 to FY 2023.

State Medicaid Spending

- State Medicaid payments to PACE organizations can vary widely based on factors such as local cost of living and health care costs, and most states do not provide public data on capitation amounts or how they are calculated

- One recent analysis of Medicaid rates from 7 states found:
  - A range from a low of $2,737 PMPM for a full-benefit dually eligible beneficiary in Oklahoma in 2023-2024 to a high of $8,279 lower-bound PMPM for a full-benefit dually eligible beneficiary in San Francisco, California in 2022

Model Evaluations

Health and Financial Outcomes

- Existing research supports claims that enrollment in PACE helps improve health outcomes and preserve independence, but is less clear about the impact of PACE on Medicaid spending

- PACE participants experience lower mortality rates, and reduced nursing facility use, hospitalizations, and potentially avoidable hospitalizations

- Mixed results on PACE's design yielding savings for Medicaid programs. Studies on impact to Medicaid rely on substantive assumptions about participants' alternative placement and service utilization

Next Steps and Questions

Next Steps

- Work so far has revealed significant gaps in publicly available data on the PACE model. Questions remain about how the model functionally operates and fulfills the goals initially laid out by Congress and CMS

- Scheduling interviews with Medicaid officials, PACE providers, and consumer advocates from 5 states, as well as CMS officials and other national stakeholders

- Will present interview findings at January 2025 Commission meeting

Questions

- What questions do Commissioners have about the policy framework of the PACE model?

- What areas of the model would Commissioners like to see explored in upcoming interviews?

Panelists

- Kayla King
  - PACE and Senior Care Options (SCO) Program Manager at the Massachusetts MassHealth Office of Long-Term Services and Supports

- Sabrena Lea
  - Deputy Director for Long-Term Services and Supports in the North Carolina Department of Health and Human Services, Division of Health Benefits

- Cindy Proper
  - PACE Technical Director within the Division of Health Homes, PACE and COB/TPL in the Medicaid Benefits and Health Programs Group, Center for Medicaid and CHIP Services