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

Interviews with key stakeholders

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Overview

- Background
  - Purpose
  - Methodology
- Key findings
  - State program goals
  - Provider application process
  - Beneficiary enrollment, services, and disenrollment
  - Federal and state oversight
  - Payment development
- Next steps

Background

Purpose

- In September, we presented an overview of the PACE model's design and regulatory structure, as well as evaluations
  - Fully integrated Medicare-Medicaid program that serves adults ages 55 and older who qualify for a nursing facility level of care but can live safely in the community
  - Providers receive a monthly blend of capitated payments from Medicare Parts A, B, and D, and state Medicaid agencies
  - 84 percent of PACE participants are dually enrolled in Medicare and Medicaid
  - As of December 2024, 80,749 PACE enrollees in 33 states and the District of Columbia
- Since then, staff have conducted interviews to gain insights on:
  - how the PACE model provides care for individuals with complex care needs
  - challenges states and providers face establishing and operating PACE programs
  - experiences of individuals receiving care through PACE
  - considerations for overseeing PACE at the state and federal level

Methodology

- We interviewed stakeholders in six states
  - Stakeholders included state Medicaid officials, PACE organizations, and consumer advocates
- Interviewed federal officials across several divisions of the Centers for Medicare & Medicaid Services (CMS) and the Office of the Assistant Secretary for Planning and Evaluation; also interviewed the National Pace Association

Key Findings

State Program Goals

- Stakeholders view PACE as a comprehensive integrated care option for dually eligible individuals
  - Designed to serve a specific population, PACE complements other state programs offering long-term services and supports (LTSS) and Medicaid home- and community-based services (HCBS)
  - Several state officials and consumer advocates described the level of care coordination in PACE as exceeding that of other integrated care options
- State officials expressed interest in expanding PACE within their states, but they noted challenges in serving rural areas
  - Most states interviewed said they intend to eventually expand PACE statewide
  - PACE organizations have concerns about financial viability and meeting federal minimum staffing requirements in rural areas
- States emphasized the importance of sustainable growth of the model and PACE organization compliance with federal regulations

Provider Application Process

- Some states require new PACE organizations to go through a request for proposal process, while others ask for a letter of interest or conduct outreach to gauge organization interest in operating PACE
  - Several states also require PACE organizations to apply to state licensing boards, such as obtaining licensure to operate as an adult day center
- Provider organizations enter a three-way agreement with CMS and the state that describes federal requirements for PACE
  - They highlighted that application windows only allow submissions one day per quarter, and a lengthy approval process
  - They often submit an application to CMS while building their facilities and completing state readiness review, meaning the state has not yet signed off which delays federal approval
- States may include additional requirements in a separate two-way contract with PACE organizations but such requirements tend to be minimal

Beneficiary Enrollment

- PACE organizations shared that most enrollment comes from word-of-mouth referrals
  - Worried that PACE is not included when beneficiaries are counseled on HCBS options; lengthy enrollment processes
- One state and several consumer advocates raised concerns about PACE organizations selectively enrolling participants
  - Noted that PACE organizations sometimes use the eligibility criterion of being able to live safely in the community to exclude high cost, high need individuals
  - States are responsible for establishing the process by which PACE organizations determine who can live safely in the community, but state officials noted the language is often broad and open to interpretation

Beneficiary Services

- Consumer advocates told us that some PACE programs offer fewer home-based services compared to other MLTSS or HCBS programs
- All providers we spoke with use participant and caregiver satisfaction surveys and participant advisory committees to identify issues and make continuous improvements to their organizations
- States we spoke with use different processes for monitoring PACE enrollee complaints, appeals, and grievances
  - Consumer advocates highlighted that PACE denial notifications are often vague and lack clear explanations
  - PACE organizations are both health care providers and plans which can complicate appeal

Beneficiary Disenrollment

- States actively monitor their PACE programs for voluntary and involuntary participant disenrollment through a variety of methods
  - They stressed that disenrollments are not common, given the small census of programs and generally high satisfaction of participants
- Participant death and relocation out of a program's service area listed as the most common reasons for disenrollment
  - Federal and state officials acknowledged that voluntary disenrollments often occur when enrollees transition to nursing facilities, but cited PACE programs with limited nursing facilities in network as the reason
  - Were not concerned about incentives for PACE organizations to disenroll individuals that need nursing facility care

Federal Oversight

- Occurs across several CMS divisions between the Center for Medicare, the Center for Medicaid and CHIP Services, and the Medicare-Medicaid Coordination Office
- Primarily consists of auditing providers and reviewing reported data
  - CMS conducts annual on-site audits during initial three years of operation, then virtual audits at a frequency determined based on risk factors that CMS identifies
  - PACE organizations are required to submit data on 23 medical and non-medical utilization elements on a quarterly cadence to the Health Plan Management System, in addition to submitting Medicare encounter data to CMS
- Federal officials and providers said that identifying and collecting Medicaid encounter data would be difficult for most PACE organizations

State Oversight

- Efforts are typically designed to check for PACE provider compliance with federal regulations without duplicating CMS activities
  - States oversee specific program elements, such as reviewing and approving involuntary disenrollments and determining if participants can live safely in the community
- Audits are the main oversight tool, with frequency varying by state
  - One state audits new PACE organizations annually and more established organizations tri-annually
  - Three states said they manually pull information from electronic medical records, patient files, and service determination requests to validate whether participants were receiving all approved services
- Many states require PACE organizations to conduct satisfaction surveys with participants and report the results

Quality Measures

- Stakeholders said that quality, like service utilization, is difficult to measure
- CMS does not collect data on quality through its audit process, and most states do not require substantial reporting on quality
  - Even where some measures exist, lack of standardization means that PACE organizations are measured against their prior performance
- Nearly every interviewee discussed the creation of national quality measures for PACE
  - compare PACE program performance
  - understand the level of care PACE organizations provide

Payment Development: Rate-Setting

- Most states set Medicaid PACE rates as a percentage of the amount that would have otherwise been paid (AWOP) if participants were not enrolled in PACE and rely on actuaries to determine the rates, using data from fee-for-service and managed care populations
- Most states said they review and update PACE rates annually, though in some cases rates had not been updated for years
- Medicaid rates for PACE do not have to be actuarially sound, but CMS contracts with an actuary to ensure that the costs used by a state to develop their AWOP are based on comparable populations and allowable costs

Payment Development: Methodologies

- States and PACE organizations shared mixed opinions on Medicaid rate-setting
  - Only one state interviewed develops PACE rates using utilization and experience data; providers voiced concerns that states do not capture the full cost to providers when basing PACE rates on models that cover different services and populations
  - One provider acknowledged Medicare savings help cover Medicaid shortfalls
  - One state explained that PACE organizations beneficially receive a rate based on nursing facility placements they rarely meet, while another said that rates may always seem insufficient to providers as long as PACE rates are designed as a percentage of rates for nursing facility care and other HCBS

PACE and Managed Care Approaches

- States are increasingly aligning administration of PACE with Medicaid managed care and integrated D-SNPs, though some stakeholders believe PACE does not fit neatly within these existing systems
  - Officials mentioned using D-SNP populations to help develop PACE rates, and using MLTSS encounter data to try and capture PACE services
  - One state official said that PACE organizations want to be treated like other managed care plans but are unwilling to provide the financial information those plans must regularly report
  - Federal regulations prevent states from making targeted, non-capitated payments to PACE providers, unlike other Medicaid managed care plans

Next Steps

June 2025 Report to Congress

- We will incorporate our interview findings, as well as the Commission's discussion, into a draft report chapter that describes the PACE model, the challenges identified by stakeholders, and potential areas the Commission may choose to explore in future work.
- Staff will return in April to present the draft chapter to the Commission.
- For discussion:
  - Are there areas where the Commission needs clarification about PACE and its operations?
  - Where would the Commission want staff to potentially explore how the PACE model might be updated?

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