April 10, 2025

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

Review of draft chapter for June report

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Medicaid and CHIP Payment and Access Commission

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Overview

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- Key findings
  - Eligibility and enrollment
  - Provider application and procurement
  - Service delivery
  - Grievances and disenrollment
  - Federal and state oversight
  - Financing
- Looking ahead

Background

The PACE Model

- A 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
- 80 percent of PACE participants are dually enrolled in Medicare and Medicaid
- As of March 2025, there were 82,016 PACE enrollees in 33 states and the District of Columbia

Analytic Approach

- Conducted literature review and contracted with the Center for Health Care Strategies to better understand model design, administration, and state and federal oversight
- We interviewed stakeholders in five states and the District of Columbia, including: California, Louisiana, Massachusetts, Michigan, Pennsylvania
- Spoke with stakeholders including federal officials from across the Centers for Medicare & Medicaid Services (CMS), the Office of the Assistant Secretary for Planning and Evaluation, and staff from a national provider association

Key Findings

Eligibility and Enrollment

- PACE organizations shared that most enrollment comes from word-of-mouth referrals
- Some stakeholders raised concerns that individuals may be institutionalized while waiting to complete eligibility determinations and enroll in PACE
- States determine the criteria by which PACE organizations evaluate if an individual can live safely in the community
- Once enrolled, a participant remains enrolled, regardless of changes in health

Provider Application and Procurement

- To become a PACE organization, expand a service area, or add a center, an entity must submit a complete application to CMS
- PACE centers enter a three-way agreement with CMS and the state that describes federal requirements for PACE
- Providers said there are several challenges that PACE organizations face throughout what they described as a lengthy approval process
- Though states differed in their approaches to procuring PACE organizations, most state officials expressed interest in further expanding PACE in their states, particularly into rural areas

Service Delivery

- An interdisciplinary team (IDT) of at least 11 federally mandated providers develops care plans and provides any necessary medical and non-medical care to enrollees, without benefit limitations
- PACE organizations must operate a PACE center from which the IDT coordinates and provides most, but not all, services
- Interviewees largely agreed that the PACE model, as designed, provides enrollees with a broad array of comprehensive benefits
- Consumer advocates told us that some PACE programs offer fewer home-based services compared to other MLTSS or HCBS programs

Grievances and Disenrollment

- States we spoke with use different processes for monitoring PACE enrollee complaints, appeals, and grievances
- Participants may voluntarily disenroll from PACE at any time, or be involuntarily disenrolled for certain reasons, such as relocation
- States actively monitor their PACE programs for voluntary and involuntary participant disenrollment through a variety of methods
  - Participant death and relocation out of a program’s service area were the most common reasons for disenrollment

Federal and State Oversight

- Federal oversight spans several divisions and offices within CMS
- Both federal and state oversight primarily consists of auditing providers and reviewing reported data
- PACE organizations are required to report some utilization data to CMS, in addition to submitting certain Medicare encounters
- States may include additional reporting requirements through two-way contracts with PACE organizations
- Federal officials and providers said that identifying and collecting Medicaid encounter data would be difficult for most PACE organizations

Financing

- Combined federal and state Medicaid spending for PACE was $3.9 billion in FY 2023
- Most states set Medicaid payment rates for PACE as a percentage of the amount that would have otherwise been paid (AWOP) if participants were not enrolled in PACE
  - Rates are not required to be actuarially sound, but many states use actuaries to develop rates
- States vary in how regularly their rates are reviewed and updated

Looking Ahead

Looking Ahead

- Obtain Commissioner feedback on draft chapter before publication in June 2025 report to Congress
- Staff will return with additional work on the PACE model

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APRIL MEETING

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