



Bipartisan Policy Center

Improving Access to and Enrollment in Programs of All- Inclusive Care for the Elderly (PACE)

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STAFF

Lisa Harootunian, J.D.

Associate Director, Health Program

Allison Buffett

Policy Analyst, Health Program

Brian O’Gara

Research Analyst, Health Program

Kamryn Perry

Project Associate, Health Program

Marilyn Serafini

Executive Director

Oliver J. Kim, J.D.

Director, Health Policy

G. William Hoagland

Senior Vice President

HEALTH PROGRAM

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., the Bipartisan Policy Center’s Health Program develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The program focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

ADVISORS

The Bipartisan Policy Center (BPC) staff produced this report in collaboration with a distinguished group of senior advisors and experts, including Sheila Burke, Jim Capretta, and Chris Jennings.

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DISCLAIMER

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Glossary of Terms

ASPE	Assistant Secretary for Planning and Evaluation
BBA	Balanced Budget Act of 1997
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
D-SNP	Dual Eligible Special Needs Plan
EHR	Electronic Health Record
FTE	Full-Time Equivalent
HCBS	Home and Community-Based Services
HHS	U.S. Department of Health and Human Services
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HNHC	High-Need, High-Cost
IDT	Interdisciplinary Team
IRA	Inflation Reduction Act of 2022
LTSS	Long-Term Services and Supports
MA	Medicare Advantage
MMCO	Medicare-Medicaid Coordination Office
OBRA	Omnibus Budget Reconciliation Act
PACE	Programs of All-Inclusive Care for the Elderly
PHE	Public Health Emergency
SAE	Service Area Expansion

Executive Summary

For the last decade, the Bipartisan Policy Center's Health Program has advanced federal policy reforms to improve chronic and long-term care for individuals with complex needs. This work began with four of BPC's health leaders—former Senate Majority Leaders Tom Daschle and Bill Frist, former Health and Human Services Secretary and Gov. Tommy Thompson, and former Congressional Budget Office Director Alice Rivlin. BPC has since released reports that include a range of bipartisan, federal policy solutions to improve access to long-term services and supports (LTSS); simplify and streamline authorities for Medicaid home and community-based services (HCBS); and better integrate care for individuals dually eligible for Medicare and Medicaid.

Building on those efforts, BPC seeks to improve access to and enrollment in Programs of All-Inclusive Care for the Elderly (PACE). PACE is a fully integrated, comprehensive care model available to qualifying beneficiaries through Medicare, Medicaid, and private payments (by individuals without Medicare or Medicaid.) The provider-led, home and community-based care model generally centers around an adult day care center and is available to frail, older adults (ages 55 years and older).

Access to community-based, high-value, fully integrated care models such as PACE is increasingly important as the U.S. population ages rapidly and demand for LTSS grows. Improving the spread and scale of PACE would help address expected, growing demand for LTSS by providing eligible, older adults with access to comprehensive care in their homes and communities.

Through interviews with key stakeholders and a private roundtable discussion, BPC identified several challenges to the growth of PACE that policymakers and the Centers for Medicare & Medicaid Services (CMS) should address through legislative, regulatory, and policy reforms. These challenges include reducing administrative barriers to the submission and review of applications for new PACE programs and service area expansions (SAEs); high Part D premiums that make PACE unaffordable for Medicare beneficiaries who are ineligible for Medicaid; limits on eligibility that make PACE unavailable to certain high-need, high-cost (HNHC) populations who are likely to benefit from the model; strict federal rules around marketing PACE programs; lack of clear, easily accessible consumer information on PACE; quality and encounter data that do not adequately capture the full range of services delivered by PACE models and the value of PACE; and inadequate resources at the state and federal levels to support the appropriate growth of PACE.

This report contains new federal policy recommendations that would address the challenges to the spread and scale of PACE. As described in the [Policy Landscape](#) section below, both political parties have introduced legislation that aims to make PACE more affordable and accessible to current and new populations. Throughout this report, BPC describes how our recommendations align with or differ from any proposed legislation.

The PACE model originated from the deinstitutionalization movement of the 1950s and federal policy changes in the 1970s that began shifting the delivery of LTSS from institutional to home and community-based settings.^a In the early 1980s, [On Lok Senior Health Services \(On Lok\)](#) in San Francisco developed a home and community-based care model that integrated primary, acute, and long-term care services under a Medicaid demonstration waiver.¹ This model became known as the PACE model.

The Robert Wood Johnson Foundation made the growth of the model possible by providing funding to On Lok to examine the feasibility of replicating the model across states. Following this effort, in 1986, Congress authorized waivers for 10 replication sites. The Robert Wood Johnson Foundation further supported expansion of the model by authorizing start-up grants for replication sites and a grant to On Lok to provide technical assistance. By 1992, 10 replication sites were operating.

These initiatives paved the way for federal legislation that codified the PACE model into law. Through bipartisan efforts, Congress passed the PACE Coverage Act of 1997 as part of the Balanced Budget Act of 1997 (BBA), which established PACE as a permanent Medicare program and as a state option in Medicaid.^{b,2}

Today, 148 PACE programs operate 273 centers across 32 states and serve about 62,000 people.^{c,3} The vast majority (90%) of PACE participants are dually eligible beneficiaries, while 9% are enrolled only in Medicaid, and 1% are enrolled only in Medicare or pay privately.⁴ PACE currently serves a relatively small number of participants compared with other models serving dually eligible beneficiaries, such as dual eligible special needs plans (D-SNPs), but PACE is unique in that Medicare and Medicaid financing and services are fully integrated under this provider-led model.

PACE programs can fully integrate financing and services through their capitated financing structure. PACE organizations receive risk-adjusted, per

a See Kaiser Family Foundation's "[Long-Term Care in the United States: A Timeline](#)" (2015) for key legislation and court decisions affecting the delivery of long-term care in institutional- and home and community-based settings.

b Programs of All-Inclusive Care for the Elderly (PACE) Coverage Act of 1997 ([H.R.1464](#)) ([S.720](#)) had both Democratic and Republican co-sponsors in the House and Senate.

c Throughout this report, the term "PACE program" refers to both a PACE organization and site(s); "PACE organization" refers to an entity that operates the PACE program(s); and "PACE site" refers to a brick-and-mortar service building.

member per month payments to take on full financial risk for the total cost of participants' care. This financing structure allows the programs significant flexibility in care delivery while aiming to incentivize high value care and innovation.

Total federal spending on PACE includes Medicaid and Medicare spending on the program. In fiscal year 2021, federal and state Medicaid spending on PACE services totaled \$2.9 billion.⁵ Of that amount, the federal share of the costs was about \$1.8 billion, while the state share was about \$1.1 billion (from the 31 states with PACE programs at the time.)^{d, 6} BPC could not find publicly available data on Medicare spending on PACE, or the total cost of the PACE model to the federal government.

PACE programs must have an interdisciplinary team (IDT) that manages and provides participants' care. The comprehensive care model covers all Medicare and Medicaid services, including LTSS. PACE also covers any other service that the IDT determines is medically necessary.

PACE is thus well designed to cost-effectively address the needs of populations with high rates of chronic illness, including the dually eligible population. In fact, a 2021 report from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services (HHS) found that full-benefit dually eligible beneficiaries enrolled in PACE are significantly less likely to be hospitalized, to utilize emergency department care, or to be institutionalized than Medicare Advantage (MA) enrollees.⁷ The rate at which PACE participants experience potentially preventable hospitalizations is also substantially lower than similar populations: 44% lower than the rate for dually eligible Medicaid nursing home residents, and 60% lower than the rate for dually eligible HCBS waiver enrollees.⁸ Several studies across more than 20 years of medical data demonstrate this association between PACE enrollment and reduced hospitalization.⁹

As described in detail below, some data suggest that PACE could produce cost savings. In South Carolina, Oklahoma, Wyoming, and some other states, PACE led to cost savings serving beneficiaries, compared with providing care under a Medicaid waiver or in a nursing home.^{10, 11, 12} South Carolina saved almost \$9,000 per PACE participant per year, while Wyoming saved an estimated \$12,361 per participant annually.^{13, 14} Oklahoma, meanwhile, saved around \$1.2 million total per year.¹⁵

The value of this fully integrated and capitated model became particularly apparent during the COVID-19 pandemic. The high rates of coronavirus infection and mortality associated with congregate care settings, such as nursing homes, accelerated the shift toward delivering LTSS in home and

d 31 states had PACE programs in fiscal year 2021, but 32 states currently have PACE programs.

community-based settings. As a home and community-based care model with unique flexibilities, PACE sites were able to respond quickly to the pandemic, and many programs adapted by delivering care creatively in the home. For example, PACE programs increased their reliance on technology for telehealth, home monitoring, combating social isolation, and other activities.¹⁶ They also repurposed transportation vehicles to deliver meals, groceries, medications, durable medical equipment, and other items such as brain games for cognitive stimulation.¹⁷

Policymakers, advocates, and stakeholders have made important strides in establishing and growing PACE. However, the need to develop and promote policies that better help frail, older adults live as independently as possible has become clearer, particularly during the pandemic as well as through the public's preference and policymakers' desire for accessible alternatives to institutional care. As such, members of Congress should consider policy reforms that will substantially increase access to and enrollment in PACE, and improve care for individuals with chronic illness, including many dually eligible beneficiaries. The reforms would also address expected demand for LTSS among the rapidly aging U.S. population. Accordingly, this report includes legislative and administrative federal policy solutions to:

- Expand the capacity and geographic reach of PACE;
- Increase PACE enrollment;
- Raise consumer awareness of PACE; and
- Ensure and demonstrate the continued value of PACE.

BPC estimates that the federal costs associated with the policy recommendations in this report would include a one-time cost of \$38 million and an annual cost of \$12 million (see [Appendix](#)). Estimated costs could be slightly offset over the long term through potential savings from reduced hospitalizations, emergency department use, and institutional care. BPC also estimates that under one of BPC's policy recommendations, Medicare-only PACE participants could experience potential savings of roughly more than \$11,000 per year in premium payments.^e Please see the full report for additional details.

^e As discussed later in this report, final estimated savings for Medicare-only PACE participants requires subtracting, from the roughly \$11,000 per year savings, any costs for deductibles, copayments, coinsurance, or other cost-sharing under a qualified, standalone Part D plan.

RECOMMENDATIONS

I. Expand the Capacity and Geographic Reach of PACE Programs

- A. CMS should increase the frequency at which it accepts applications for new and expanding PACE organizations from quarterly to monthly.
- B. Congress should modify HHS's oversight of a new PACE program during the three-year trial period to require HHS, in coordination with the state administering agency, to conduct at least one comprehensive review of the PACE program before the end of the trial period. The HHS secretary and state administering agency should continue to have the authority to conduct oversight, as appropriate, following the trial period.
- C. CMS should clarify in the Readiness Review Tool that PACE organizations may attest to the employment of staff for State Readiness Review purposes. CMS should also allow PACE organizations that have completed the trial period to submit multiple SAE applications (for geographic service area expansion and/or the addition of a new PACE center site) per application cycle and clarify the contract requirements so that only one contract per organization (legal entity and/or parent organization) is allowed per state.
- D. Congress should reduce the time that CMS must approve, deny, or request more information from an applicant seeking to establish a PACE program from 90 days to 45 days.
- E. Congress should establish a grant program resembling the 2006 Rural PACE Provider Grant Program and appropriate \$15 million to organizations to help establish nonprofit PACE sites in regions with low PACE penetration rates or disparate access to PACE. Grantees—up to 15 new, nonprofit PACE organizations—should be eligible to receive up to \$1 million under the grant. See [Appendix](#) for a breakdown of the cost estimate.

II. Increase PACE Enrollment

- A. Congress should allow Medicare-only PACE participants the choice to enroll in either a qualifying, standalone Part D plan or the PACE Part D plan. The three-way PACE program agreement must describe how the PACE organization will coordinate care to the greatest extent practicable for Medicare-only PACE participants who enroll in a qualifying, standalone Part D plan.

- B. The Center for Medicare & Medicaid Innovation (CMMI) should test a model for expanded PACE eligibility that targets HNHC, full-benefit dually eligible populations. This demonstration project should include data collection, transparency, and quality improvement requirements (see recommendations [IV.A-IV.C](#)).

III. Raise Consumer Awareness of PACE

- A. CMS should allow established PACE organizations that are expanding their geographic service areas or adding a new PACE site to market their program earlier in the application process; this change would enable them to inform potential enrollees that the organization is working to bring a new PACE program or site to the service area.
- B. CMS should improve the Medicare.gov website to make it easier for users to navigate and to access information on PACE. This should include better integrating PACE in CMS's existing "Find Plans" coverage tool.

IV. Ensure and Demonstrate the Continued Value of PACE

- A. To improve transparency and support quality improvement, CMS should require PACE organizations to publicly post quality improvement plans, including a date when the PACE organization last reviewed and posted its plan. CMS should also require PACE organizations to publicly indicate their entity status (e.g., for-profit or nonprofit) on the homepage of their websites.
- B. To identify disparities, CMS should require PACE organizations to disaggregate their reported health outcomes and any standardized quality measures by race, ethnicity, sexual orientation, gender identity, primary language, and disability status.
- C. Congress should direct the HHS secretary to develop—in coordination with states, stakeholders, and policy experts—a voluntary set of procedure codes for frequently administered nonclinical PACE services. States would have the option of requiring PACE organizations to report on the set of procedure codes.
- D. To demonstrate and improve PACE's value, Congress should allow CMS to use encounter data for oversight purposes and require that PACE organizations submit enrollee encounter data to CMS. Congress should also appropriate \$20 million to CMS to award competitive grants to states to establish loan programs for PACE providers; the loans would fund the purchase or upgrade of

electronic health record (EHR) technology, the training of personnel on the use of EHR technology, and the improvement of the electronic exchange of health information. (See [Appendix](#) for a breakdown of the cost estimate.)

- E. CMS should publicly post Medicare and Medicaid spending data on PACE and disaggregate data by payer type and consumer demographics.
- F. Congress should ensure the inclusion of diagnoses obtained through audio-only telehealth when determining risk adjustment for PACE participants who have established relationships with PACE providers during the COVID-19 public health emergency (PHE).
- G. Congress should appropriate \$15 million in additional resources to CMS to support CMS and states' administrative activities related to the appropriate growth of PACE; these resources could include hiring additional staff, improving operations, and providing technical assistance. (See [Appendix](#) for specific activities and a breakdown of the cost estimate.)
- H. Congress should provide the Medicare-Medicaid Coordination Office (MMCO) with funding and regulatory authority to establish and oversee full integration in all programs serving dually eligible beneficiaries, including PACE.

Background

As the U.S. population continues to age rapidly, the need for cost-effective community-based long-term care and fully integrated care for Medicare and Medicaid beneficiaries is increasing. In 2018, an estimated 14 million adults in the United States reported a need for LTSS.¹⁸ And in 2019, about 12.3 million people qualified for both Medicare and Medicaid.¹⁹

Over the past 10 years, there has been a significant shift from delivering long-term care in institutional settings, such as nursing homes, to home and community-based settings.²⁰ Concerns about the high cost of institutional care, as well as beneficiaries' consistent preference to live in the community, is driving this trend. The demand for HCBS became more evident with COVID-19 and remains great. In FY2020, 39 states reported having at least one HCBS waiver waiting list, with nationwide waiting list enrollment totaling more than 660,000 people and an average wait time of over three years.²¹

Community-based integrated care has also grown in recent years. Enrollment in D-SNPs—a MA plan designed for those enrolled in Medicare and Medicaid—grew from 1.16 million in 2012 to 4.12 million in 2022.²² However, the level of integration between D-SNPs and Medicaid continues to be generally low, with only 18% of D-SNP enrollees in plans with significant Medicare/Medicaid integration.²³ Medicare-Medicaid plans created as part of the Affordable Care Act’s Financial Alignment Initiative demonstration offer substantial integration for dually eligible beneficiaries, but they are currently available in only 11 states on a nonpermanent basis.²⁴ Despite nearly 50 years of data showing the benefits of integration for dually eligible individuals, only about 12% (1.1 million of the 12.3 million dually eligible beneficiaries) receive care through an integrated model.²⁵ BPC has previously recommended federal policy changes that would guarantee that all full-benefit, dually eligible beneficiaries have access to fully integrated care models, such as the community-based PACE model.²⁶

Both individuals with long-term care needs and dually eligible beneficiaries account for a disproportionate share of Medicare and Medicaid spending, and they are of great interest to policymakers seeking to advance high-quality, cost-effective health care. Medicaid and Medicare are the first- and second-largest payers of LTSS, respectively, accounting for 60.4% of all LTSS spending nationwide in 2020—or about \$287 billion.²⁷ Medicaid fee-for-service spending on beneficiaries who used LTSS was about 33% of total Medicaid spending in 2019, even though individuals utilizing long-term care represented only 5.4% of Medicaid beneficiaries.²⁸ In 2019, dually eligible beneficiaries accounted for 19% and 14% of enrollees in Medicare and Medicaid, respectively, yet 34% and 30% of spending.²⁹ That year, combined Medicare and Medicaid spending on dually eligible beneficiaries totaled \$440.2 billion.³⁰

A Brief History of the PACE Model and Regulations

1970s

The PACE model begins in 1971 in San Francisco, California. Dr. William L. Gee and social worker Marie-Louise Ansak seek to provide innovative care that supports the needs of San Francisco's elderly Asian American population while still allowing them to age at home. Together, they create On Lok Senior Health Services as a community-based model of health care and supportive services. Through its adult day care center, On Lok provides medical care, meals, and social programming to participants, before eventually offering in-home services.³¹

1980s

In 1983, On Lok begins a three-year waiver demonstration, under the Social Security Amendments of 1983, to test capitated payments in which a fixed, per person monthly payment from Medicare, California's Medicaid program, or a private payer covers all primary, acute, and long-term care services for eligible individuals.³² The Omnibus Budget Reconciliation Act (OBRA) of 1986 authorizes CMS to conduct a PACE demonstration program to replicate On Lok's model of care across the country. With additional funding from the Robert Wood Johnson Foundation, the John A. Hartford Foundation, the Retirement Research Foundation, and the OBRA of 1990, 15 PACE demonstration programs become operational.³³

1990s

In 1994, On Lok and other programs form the National PACE Association. By 1996, 21 PACE programs are operating in 15 states.³⁴ Bipartisan support for the PACE Coverage Act of 1997, which Congress passes as part of the BBA, establishes the PACE model as a permanent Medicare provider and Medicaid state plan option. Another provision of the 1997 BBA requires CMS to publish a rule establishing additional requirements for PACE programs. The rule (first published in 1999 but approved in 2006) establishes many requirements around eligibility, application procedures, services, payment, participant rights, and quality assurance that remain essential to the PACE model today.³⁵



2000s

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Modernization Act) establishes the Medicare Part D prescription drug benefit, which begins in 2006. Notably, the Medicare Modernization Act shifts the prescription drug payer source for PACE enrollees who are full-benefit dually eligible individuals from Medicaid to Medicare; it also shifts the source, in part, from the beneficiary to Medicare for partial-benefit dually eligible beneficiaries who elect to enroll in Part D.³⁶ In 2006, Congress incentivizes the expansion of PACE programs serving rural communities by authorizing the Rural PACE Provider Grant Program in the Deficit Reduction Act of 2005. The program awards \$535,000 each to 14 grantees to support the establishment of rural PACE programs across 12 states.³⁷

2010s

Congress passes the bipartisan PACE Innovation Act in 2015, which authorizes CMS to test a demonstration program expanding a PACE-like model to previously ineligible populations. CMS releases a request for information on a PACE-like model provisionally named Person Centered Community Care in 2017.³⁸ The federal government does not move forward with testing a PACE-like model, but it includes some provisions of the proposal in a 2019 CMS rule on PACE. The 2019 rule gives greater operational flexibility to PACE organizations and codifies existing provider practices.³⁹ By 2019, 130 PACE organizations are serving more than 50,000 participants across 31 states.⁴⁰

2020s

Today, about 62,000 individuals participate in 148 PACE programs.⁴¹ In 2022, three states announce they will be adding PACE programs. Kentucky authorizes two PACE providers to operate in 19 counties.⁴² Illinois selects eight organizations to provide PACE in five service areas across the state beginning in FY2024.⁴³ The District of Columbia is expected to launch its first PACE program in 2022.⁴⁴

OVERVIEW OF THE PACE MODEL

Under current law, the PACE model is characterized by the following five essential elements, which the HHS secretary may not modify or waive:

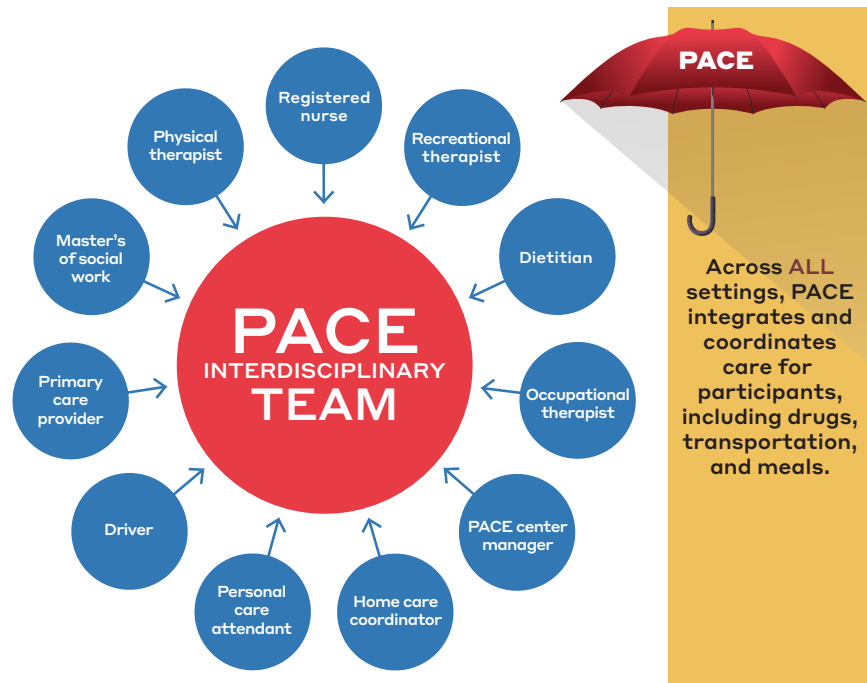
1. The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility, as defined by the state;
2. The delivery of comprehensive, integrated acute, and long-term care services;
3. The interdisciplinary approach to care management and service delivery;
4. Capitated, integrated financing that allows the provider to pool payments received from public and private programs as well as individuals; and
5. The assumption by the provider of full financial risk.⁴⁵

Since the first prototype involving On Lok, the PACE model has been designed to care for older adults with ongoing chronic care needs in their homes and communities. To be eligible for PACE, participants must be 55 years or older, meet state eligibility criteria for nursing home level-of-care, reside in the service area of a PACE program, and be able to live safely in the community.^{46, 47}

Although most MA health plans have large networks of independent providers, PACE organizations are health care providers that assess participants' care needs, develop care plans, and provide care. One of the cornerstones of the PACE model is the 11-member IDT that provides beneficiaries with fully integrated, 24-hour care. The IDT consists of at least the following members, who are employed or contracted by the PACE organization:

- primary care provider;
- registered nurse;
- master's level social worker;
- physical therapist;
- occupational therapist;
- recreational therapist or activity coordinator;
- dietitian;
- PACE center manager;
- home care coordinator;
- personal care attendant or a patient's representative; and
- driver or a patient's representative.⁴⁸

Figure 1: The PACE Model Interdisciplinary Team



Source: [National PACE Association](#)

In 2019, CMS issued a final rule providing PACE organizations with additional staffing flexibility. The rule allows physician assistants, nurse practitioners, and community-based physicians to serve as the primary care provider in lieu of physicians who treat only PACE participants. To help address provider shortages, the rule also allows providers to fill up to two roles on the IDT if they are properly licensed and qualified.⁴⁹

Under current law, PACE organizations are required to provide all Medicare and Medicaid covered benefits, as well as any services the IDT determines to be medically necessary.⁵⁰ PACE organizations and IDTs develop individualized patient-centered care plans that include the full range of medical and long-term care services. Some of the core PACE services include but are not limited to:

- adult day care;
- dentistry;
- emergency services;
- home care;
- hospital care;
- laboratory/X-ray services;
- meals;
- medical specialty services;
- nursing home care;

- nutritional counseling;
- occupational therapy;
- physical therapy;
- prescription drugs;
- primary care (including doctor and nursing services);
- recreational therapy;
- social services;
- social work counseling; and
- transportation.⁵¹

The broad flexibility that PACE organizations have to deliver care means that many also use capitated payments to provide nonmedical services that maximize the well-being of participants and allow them to remain in the community, such as social programming, home modifications, and even dog walking.

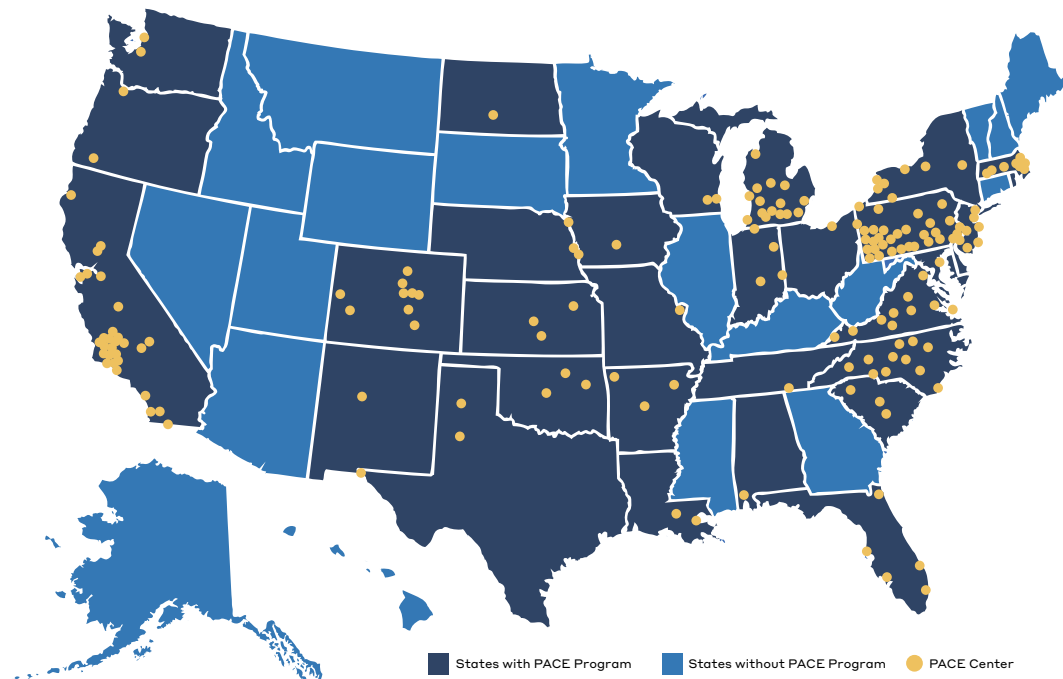
Federal regulations require that each PACE organization operate a brick-and-mortar facility to provide medical care and social services—although there is no requirement mandating how often enrollees must visit the center.⁵² PACE centers are where participants receive primary care, recreational therapy, restorative therapies, socialization, personal care, and meals, and they serve as the setting for coordination and delivery of most PACE services.⁵³ PACE organizations must operate at least one center in, or next to, its approved service area with accessible and adequate services to meet the needs of all participants.⁵⁴ If a PACE organization has multiple centers, it must offer the full range of services and have enough staff to meet participant needs at each location.⁵⁵

Also, PACE organizations may provide services in the participant’s home or alternate community settings as the IDT determines appropriate.⁵⁶ This flexibility allows the IDT to continuously adapt care plans to best meet participants’ needs and external factors, such as the COVID-19 pandemic. Importantly, if a PACE participant requires institutional care—such as a nursing home stay—they stay enrolled in PACE and the provider is responsible for the costs of the institutional care. Although all PACE participants must meet nursing home level-of-care criteria to enroll, the model aims to help participants age in place and live as independently as possible in the community. In fact, 95% of PACE participants live in a community setting rather than a nursing home.⁵⁷

As of 2022, 148 PACE programs operate 273 centers across 32 states, serving about 62,000 participants (see [Figure 2](#)). Women make up 69% of PACE enrollees, while men constitute 31%. The average participant is 77 years old, has 5.8 chronic conditions, and visits their PACE center seven times per month. BPC

could not find publicly available racial and ethnic demographic information on PACE participants, highlighting the need for more detailed data reporting to capture this information. The top five chronic conditions of PACE participants are vascular disease; major depressive, bipolar, and paranoid disorders; diabetes with chronic complication; congestive heart failure; and chronic obstructive pulmonary disease. A plurality of participants (33%) need help with five or six activities of daily living.⁵⁸

Figure 2: 147 PACE Programs Operate 273 Centers in the U.S., August 2022



Source: [National PACE Association](#)

Note: Kentucky approved two PACE programs to begin operating in August 2022, which is not reflected in the figure.

Although a large majority of PACE participants (90%) are dually eligible for Medicare and Medicaid, 9% of PACE participants are only enrolled in Medicaid, and 1% are either qualifying Medicare beneficiaries who are ineligible for Medicaid (referred to throughout this report as Medicare-only beneficiaries) or pay privately.⁵⁹ The coverage of PACE participants has important implications for how the model is financed and its affordability for eligible consumers.

PACE is a dually capitated model, as it is both a Medicare program and a Medicaid state plan option. Medicare and Medicaid each provides a fixed, monthly capitation payment to PACE organizations, which allows providers to deliver all services that participants need rather than limit them to reimbursable care under Medicare and Medicaid fee-for-service plans.

In FY2021, Medicaid spending on PACE services totaled \$2.9 billion.⁶⁰ Sixty-one percent (about \$1.8 billion) of that spending came from the federal share of Medicaid costs, while 39% (about 1.1 billion) came from the 31 states with PACE programs at the time.⁶¹ BPC could not find publicly available data on Medicare spending, or the total cost of the PACE model to the federal government.

Before receiving approval to operate, PACE organizations negotiate the two monthly capitation payments with CMS and the state administering agency. Apart from Medicare enrollees who require end-stage renal disease services, the capitation amount for each Medicare participant is based on pre-Affordable Care Act county rates set by CMS, a participant's individual risk score, and the organization frailty score.⁶² State administering agencies generally base the capitation amount for each Medicaid participant on a blend of the cost of nursing home and community-based care for the frail elderly in the area.⁶³ Medicaid rates can be renegotiated annually.

For both Medicare and Medicaid payments, the monthly capitation payment must:

- consider the frailty of the PACE enrollees compared to the general Medicare/Medicaid population;
- represent a fixed amount, regardless of changes in the participant's health status;
- be accepted by the PACE organization as payment in full for Medicaid and/or Medicare participants—providers may not charge participants; and
- total less than the projected payment under Medicare/Medicaid for a comparable population not enrolled in PACE.⁶⁴

As Medicare's capitation includes only payment for Part A and B benefits, PACE participants who only qualify for Medicare pay monthly premiums for the long-term care portion of the PACE benefit and for Medicare Part D drugs.⁶⁵ Because PACE organizations are required to offer all Medicare and Medicaid benefits, but are not allowed to charge deductibles or copays, Medicare-only PACE enrollees are responsible for the full cost of the Part D drug benefit. Monthly premiums for the PACE Medicare Part D benefit can range from \$800 to \$1,100, presenting a significant barrier to Medicare-only beneficiaries looking for comprehensive community-based care.⁶⁶ (For more information, see recommendation [II.A.](#)).

For private-pay individuals (without Medicare or Medicaid) who choose to enroll in PACE, the statute does not specify the premium that PACE organizations may charge.⁶⁷ CMS has indicated that it is acceptable for a PACE organization to charge the combined Medicare and Medicaid capitation rates as the premium for private-pay participants.⁶⁸

VALUE OF PACE

PACE's unique model structure makes it especially well equipped to address the complex care needs of dually eligible individuals. Both the interdisciplinary team approach and fully capitated financing allows providers to continuously address the full scope of participants' medical and nonmedical needs within a flexible budget, and within the community. At the same time, establishing and operating a PACE program requires a substantial initial investment—from hiring a care team to building or purchasing an adult day center site—making PACE less scalable and flexible than other models of care for this population. BPC recommends expanding the model's reach while recognizing that other models of long-term care, such as D-SNPs and Medicaid HCBS waiver programs, are still necessary to care for the country's growing population with complex care needs.

Although research on the effects of the PACE model is limited compared with other models of delivering and financing long-term care—such as nursing home care, D-SNPs, and Medicaid HCBS waiver programs—the evidence, described in more detail below, suggests that the PACE model appears to be particularly effective at (i) addressing excessive, inappropriate, and sometimes dangerous health care utilization rates; (ii) improving participants' health outcomes and reducing disparities; and (iii) moderating spending on long-term care.

First, evidence demonstrates that PACE may be associated with more favorable rates of health care utilization compared with similar populations enrolled in other long-term care programs. PACE participants are, on average, the oldest beneficiaries and have the most comorbidities across the dually eligible population. Despite this, full-benefit, dually eligible beneficiaries enrolled in PACE are significantly less likely to be hospitalized or readmitted, to utilize emergency department care, or to be institutionalized than MA enrollees.⁶⁹ The rate at which PACE participants experience potentially preventable hospitalizations is also substantially lower than similar populations: 44% lower than the rate for dually eligible Medicaid nursing home residents, and 60% lower than the rate for dually eligible HCBS waiver enrollees.⁷⁰ The association between PACE enrollment and reduced hospitalization has been demonstrated across several studies using more than 20 years of medical data.⁷¹

Multiple studies have found that despite being older and more cognitively impaired on average, PACE enrollees have a significantly lower mortality rate than individuals in nursing homes or HCBS waiver programs.⁷²

Second, evidence also suggests that PACE may be beneficial to participants' mental health.⁷³ One of the top chronic conditions among PACE enrollees is major depressive, bipolar, and paranoid disorders. At one PACE program in St. Louis, 80% of participants who met the clinical definition of depression upon

enrollment no longer met the criteria after nine months in the program.⁷⁴ Additionally, in a survey conducted by HHS, PACE participants reported higher levels of health status, including fewer indicators of depression than individuals enrolled in HCBS waiver programs.⁷⁵

Importantly, while additional data is needed, one study highlighted PACE's potential to reduce health disparities between white and racial and ethnic minority adults with long-term care needs.⁷⁶ There has been a disproportionate increase of racial and ethnic minorities utilizing nursing home care, and research shows that racial and ethnic minorities have poorer health outcomes than their white counterparts in nursing homes.⁷⁷ The study found that PACE aligned with the needs of elderly racial and ethnic minorities with chronic conditions partially because PACE organizations have increased flexibility to provide culturally competent care.⁷⁸

Third, although the financial cost of launching a PACE program has historically been a barrier to states looking to offer comprehensive long-term care, some evidence shows that operating PACE programs may be more affordable than traditional alternatives. However, savings vary between states. In South Carolina, PACE's capitation rate was found to be substantially lower than what the state would have otherwise paid to serve a comparable population through an aged/disabled waiver and nursing home care. PACE's Medicaid attrition-adjusted one-year capitation was \$27,648—28% below the lower limit of predicted fee-for-service payments (\$35,662). The average predicted cost for PACE-eligible patients in waiver and nursing home care was \$36,620 per year.⁷⁹

In a demonstration proposal submission to CMS, Oklahoma noted that with 100 participants, the Cherokee Elder Care PACE program saved the state \$103,587 per month, or \$1,243,044 per year.⁸⁰ Wyoming's Medicaid program paid less per PACE participant than it did for a nursing home resident each year from 2015 to 2020.⁸¹ The average annual cost of a PACE participant was \$19,283 in 2020, compared with \$31,644 for a nursing home resident.⁸² Expenditures per PACE recipient decreased by 18% over those five years, while total spending per nursing home resident grew by 7%.⁸³ Despite demonstrated savings, the state legislature defunded Wyoming's only PACE organization, which was budgeted at about \$3 million, in 2021 due to state budget cuts across the board.

Similarly, a rough BPC estimate also suggests that PACE may offer some modest Medicaid savings compared with care in a nursing facility. Based on data in the [Financial Management Report for FY2019](#) and the CMS [Medicaid Long Term Services and Supports Annual Expenditures Report for FY2019](#), BPC estimates that Medicaid per capita spending on PACE is, on average, about \$6,000 less than Medicaid per capita spending for nursing facility services.

LOOKING AHEAD

Stakeholders highlighted two transformations to monitor as the PACE model expands and adapts to a changing health care landscape: 1) changes to PACE program operations in response to the COVID-19 pandemic and 2) increases in for-profit PACE organizations.

PACE's capitated payment structure and spending discretion have allowed providers to adapt their programs throughout the pandemic. This adaptation is important because PACE participants are especially vulnerable to COVID-19, due to their increased risk of infection, serious illness, and death. Many PACE organizations, enabled by their flexible structure, modified their programs to minimize participants' risk of, and organizations' expenses from, inpatient hospitalizations and skilled nursing facilities. For example, to reduce participants' risk of contracting the virus, PACE organizations increased their use of telehealth and home monitoring services, conducted more frequent in-home visits, and deployed mobile exam rooms. PACE organizations also implemented interventions to help participants stay connected, such as virtual town halls, buddy-programs, and exercise classes.⁸⁴ Evidence suggests that PACE participants had lower rates of infection and death due to COVID-19 than nursing home residents.⁸⁵ Even before the pandemic, older adults preferred HCBS as opposed to nursing home care, and the higher COVID-19 mortality rates among nursing home residents will likely increase older adults' preference for HCBS.⁸⁶ As care delivery continues to shift in response to the COVID-19 pandemic and in preparation for future pandemics, some health policy experts and researchers have encouraged the expansion of PACE as a high value model offering HCBS.⁸⁷ The federal government has also conducted at least one study to better understand the potential value of PACE related to COVID-19.^f

Moving forward, stakeholders also anticipate an increase in for-profit PACE organizations. Federal law initially required PACE providers to be nonprofit organizations, but the BBA created a pathway for the HHS secretary to authorize for-profit PACE organizations by allowing demonstration waivers for for-profit organizations to operate PACE: The requirement that PACE organizations be nonprofit would not apply so long as the findings of the demonstration project showed similar outcomes related to quality and cost of care between for-profit and nonprofit PACE organizations.⁸⁸ The BBA required the HHS secretary to provide a report to Congress evaluating the effects of the for-profit PACE demonstration, which HHS released in May 2015.⁸⁹ Ultimately, the [HHS's report to Congress](#) found similar outcomes between for-profit and

^f HHS's Agency for Healthcare Research and Quality (AHRQ) funds a project titled, "Responses of PACE Organizations to COVID-19 Challenges: Effects and Lessons Learned" through December 21, 2022. More information on the project is available at: <https://reporter.nih.gov/search/XGRHF1GcJEalNMuCbWUFew/project-details/10192247>.

nonprofit PACE organizations, allowing for-profit PACE organizations to operate under the same terms and conditions as nonprofit PACE organizations.⁹⁰

Some stakeholders note the need to further study differences between for-profit and nonprofit PACE organizations. Specifically, stakeholders pointed to variability in research findings and an increase in private equity firms investing in PACE as evidence that additional research is needed. For example, while the HHS's report to Congress found similar outcomes between for-profit and nonprofit PACE organizations, a [2013 study](#) found some evidence that for-profit PACE organizations in Pennsylvania provided less access to and lower quality of care than nonprofit PACE organizations.⁹¹

Although the majority of PACE organizations are nonprofit, some health policy experts anticipate an increase in the number of for-profit PACE organizations as private equity firms and venture capitalists continue to invest in PACE. Private equity firms and venture capitalists currently fund some for-profit PACE organizations, supplying these PACE organizations with the significant financial resources needed to open PACE sites.^{8, 92} BPC found little transparency in private equity firms' involvement in PACE. Historically, two major for-profit PACE organizations, InnovAge and WelbeHealth, have operated; the former has 18 PACE sites and the latter five.⁹³ Private equity and venture capital firms invest in InnovAge and WelbeHealth. PACE presents an investment opportunity because the reimbursement rates for PACE are comparatively higher than nursing home rates, the older adult population continues to increase, and some states have laws that allow PACE organizations to have geographic monopolies.⁹⁴ As this report's recommendations aim to reduce barriers to expanding PACE, these recommendations might also increase the likelihood of private investment in PACE.

Stakeholders predict the expansion of for-profit PACE organizations could have several important impacts, but there is not enough research to affirm any of these predictions. For example, the increased investment in for-profit PACE could accelerate PACE's expansion because more organizations would have the financial resources necessary to open and operate PACE sites. The increased investment in for-profit PACE could also provide the funding needed to increase PACE organizations' adoption of technology, such as EHRs.

The investment in for-profit PACE could also shift PACE organizations' incentives. Both for-profits and nonprofits stand to remain financially solvent if their costs do not exceed their capitated payments; this structure incentivizes them to keep PACE participants healthy. However, PACE organizations could also reduce costs by rendering fewer high-cost services or enrolling

^g Private equity involvement has recently increased throughout the health care sector. BPC plans to release a report in the fall of 2022 on how to improve and strengthen employer-sponsored insurance. This report will include recommendations to increase transparency around private equity involvement in the private health care sector.

healthier participants. Although states and the federal government conduct audits to reduce these practices, stakeholders noted that resources to conduct these audits are limited. Unlike nonprofit PACE organizations, for-profits traditionally operate with the primary purpose of generating shareholder value. Increasing shareholder value can, but does not necessarily always, align with improving PACE enrollees' health. Some stakeholders are concerned that for-profit PACE organizations will sacrifice long-term quality by reducing costs to increase shareholder value. This concern stems from stakeholders' previous experiences with private equity firms' substantial investments in nursing homes; subsequent research showed this investment increased mortality and decreased patients' well-being as nursing homes cut costs and rendered fewer medically necessary services.⁹⁵

Although research is limited, some evidence suggests that investment in for-profits might shift PACE organizations' incentives. InnovAge owns six PACE sites in Colorado, where an audit found some of its PACE sites denied clients medically necessary services and unenrolled more expensive PACE participants.⁹⁶ Following further investigation, Colorado and Medicare have stopped paying InnovAge to care for new clients. Nationally, InnovAge is the largest for-profit PACE organization, operating its 18 sites across five states. InnovAge received \$196 million from the private equity firm Welsh, Carson, Anderson & Stowe in 2016.⁹⁷ Between 2016 and 2021, InnovAge doubled its enrollment and revenues, and paid its shareholders about \$66 million in dividends in May 2019.⁹⁸

If allowed by the state, for-profit PACE organizations can transition to a public benefit company, which may expand their primary interests beyond shareholder value.^h In June 2022, WelbeHealth became the first for-profit PACE organization to transition to a public benefit company.⁹⁹ With this transition, WelbeHealth will work to balance customers, employees, and shareholders' interests with the advancement of its intended public benefit goal.

As the number of for-profits increases, federal and state stakeholders and PACE organizations recommended that CMS strengthen transparency, quality improvement, and data collection for PACE programs. The goal is to monitor and ensure the value of PACE while transformations occur throughout the PACE landscape. Enhanced data collection and transparency requirements for both for-profits and nonprofits would provide researchers and policymakers with the data necessary to make evidence-based policy and practice decisions

^h Whether a PACE organization can operate as a public benefit company depends on the location of the PACE site and that state's laws. More information is available at: https://www.law.cornell.edu/wex/public_benefit_corporation.

and to strengthen consumer protections. As such, this report includes recommendations to ensure and demonstrate the continued value of PACE in Section [IV](#).

Policy Landscape

PACE has a long history of bipartisan support in Congress, and in recent years there has been bipartisan interest in growing PACE, with some Democratic and Republican lawmakers proposing legislation to improve access to PACE for current and new populations. As certain provisions in current legislative proposals may align with or differ from recommendations in this report, we describe how each compare within this report's [Policy Recommendation](#) section.

Much of the legislation that lawmakers have introduced aims to make PACE more affordable to Medicare-only beneficiaries. For example, Sens. Bob Casey (D-PA) and Tim Scott (R-SC) introduced the PACE Expanded Act ([S.3626](#)), which would allow PACE organizations to set premiums quarterly based on the Medicare-only beneficiary's health status and anticipated health care needs. Sen. Casey also included this proposal in his earlier bill, the PACE Plus Act ([S.1162](#)); Reps. Debbie Dingell (D-MI) and Earl Blumenauer (D-OR) introduced a companion bill ([H.R.6770](#)). To align with recent trends of moving away from health status rating, BPC's recommendation to make PACE more affordable to Medicare-only beneficiaries does not allow PACE organizations to set premiums based on the Medicare-only beneficiary's health status. BPC's approach to reducing Part D premiums for Medicare-only PACE participants somewhat resembles Rep. Blumenauer's PACE Part D Choice Act of 2021 ([H.R.4942](#)), which was co-sponsored by Reps. Jackie Walorski (R-IN), Dingell, and Christopher Smith (R-NJ). This bill would allow Medicare-only beneficiaries to choose between the PACE Part D plan as currently designed or to enroll in a qualified standalone prescription drug plan.ⁱ This change could

i The legislation defines a "qualified standalone prescription drug plan" as a prescription drug plan (i) that is not an MA prescription drug plan (MA-PD) plan; (ii) that is not operated by the PACE program under which the individual is enrolled; and (ii) for which the Secretary determines, with respect to the applicable PACE program enrollees enrolled in a PACE program offered by such PACE provider, that—(aa) the estimated beneficiary out-of-pocket costs for the plan year for qualified prescription drug coverage under the plan is equal to or less than the estimated out-of-pocket costs for such coverage under the prescription drug plan offered by the PACE program in which the applicable PACE program enrollee is enrolled; and (bb) the estimated total amount of federal subsidies for the plan year for qualified prescription drug coverage under the plan (which may be estimated using data from the previous plan year) is equal to or less than the estimated subsidy amount for such coverage under the prescription drug plan offered by the PACE program in which the applicable PACE program enrollee is enrolled.

make PACE more affordable to Medicare-only beneficiaries, because the Part D premium cost for a standalone Part D plan is significantly less than the Part D portion of the total PACE capitation payment.

Other legislative provisions focus on expanding PACE to new populations and removing certain administrative barriers to PACE expansion. For example, both the PACE Expanded Act ([S.3626](#)) and the PACE Plus Act ([S.1162](#)) would establish a pilot program to test the expansion of PACE to HNHC populations currently ineligible to participate in PACE.^j Both bills include changes to mitigate the administrative burden that PACE organizations face when they apply to expand their programs, such as allowing new and existing PACE providers to apply at any time and shortening CMS's review of new and expansion applications from 90 days to 45 days. Also, both bills amend Sections 1894(c)(5) and 1934(c)(5) of the Social Security Act to allow PACE-eligible individuals to enroll in PACE at any time during the month. Another bill, the Ensuring Parity in Medicare Advantage for Audio Only Telehealth Act of 2021 ([H.R.2166](#)), with 26 Democratic and 42 Republican co-sponsors, allows PACE organizations to use information obtained through audio-only telehealth when determining risk adjustments. A related bill in the Senate, the Ensuring Parity in Medicare Advantage for Audio Only Telehealth Act of 2021 ([S.150](#)), also has bipartisan sponsorship but does not include PACE in its proposed changes. Some of BPC's policy recommendations, detailed in the [Policy Recommendation](#) section below, take a different approach than those legislative proposals, but BPC's recommendations would similarly extend PACE to new populations likely to benefit from the model, remove barriers to the growth of PACE, and address challenges related to telehealth and risk adjustments during the COVID-19 pandemic.

In August 2022, President Biden signed the [Inflation Reduction Act of 2022](#) (IRA) into law. The IRA includes provisions to reduce out-of-pocket costs for Medicare beneficiaries as well as the baseline cost of Medicare Part D drugs.¹⁰⁰ Among these provisions, the IRA establishes an annual \$2,000 limit on out-of-pocket costs for Part D prescription drug plan beneficiaries, beginning in 2025; eliminates out-of-pocket spending at the catastrophic threshold, beginning in 2024; authorizes Medicare to negotiate the prices of some high-cost prescription drugs, beginning in 2026; and requires drugs manufacturers to pay annual rebates to Medicare if they increase prices of certain Part D-covered drugs above an allowable inflation rate from a 2021 base period. While the provisions that limit Part D out-of-pocket costs are structured around copayments and deductibles, which PACE participants are protected against, the IRA could have a limited impact on PACE Part D premiums for Medicare-only beneficiaries by reducing the baseline cost of Medicare Part D drugs. Since

^j While the legislation does not specify the eligible HNHC populations in more detail, potentially eligible populations could include, for example, dually eligible beneficiaries under the age of 55 who have a disability and are ineligible for PACE due to age.

Medicare-only beneficiaries pay monthly premiums equal to the Medicaid capitation amount—which generally covers the long-term care portion and Part D drugs—the IRA’s reduction to the baseline cost for Medicare Part D drugs will likely result in lower PACE Part D premiums.¹⁰¹ However, the IRA’s out-of-pocket cost protections will increase the cost of the PACE Part D plan relative to other Part D options, and additional legislation is needed to address the high Part D premiums that remain a significant barrier to PACE participation for many Medicare-only beneficiaries.

Policy Recommendations

This report categorizes its recommendations into four drivers of PACE access. The first driver, “expand the capacity and geographic reach of PACE,” focuses on growing the spread of PACE organizations. The second driver, “increase PACE enrollment,” aims to diversify the PACE population by increasing PACE enrollment among Medicare-only beneficiaries and expanding PACE eligibility to target HNHC populations currently ineligible for PACE. The third driver, “raise consumer awareness of PACE,” improves consumer education of PACE and aims to grow the scale, or number of people served by PACE. The final driver, “ensure and demonstrate the continued value of PACE,” strengthens data collection and transparency related to PACE to ensure similar practices across Medicare and Medicaid programs and provide data necessary to study how changes within the PACE landscape, such as increased investment by private equity, impact the value of PACE.

This report includes an estimation of the federal costs associated with the policy recommendations. BPC estimates that costs to the federal government would include a one-time cost of \$38 million and an annual cost of \$12 million. Potential savings from reduced hospitalizations, emergency department use, and institutional care could slightly offset estimated costs. BPC also estimates that under one of our policy recommendations, Medicare-only PACE participants could see potential savings of roughly more than \$11,000 per year in premium payments.^k More information on the estimated costs is available in the [Appendix](#).

^k As discussed later in this report, final estimated savings for Medicare-only PACE participants requires subtracting, from the roughly \$11,000 per year savings, any costs for deductibles, copayments, coinsurance, or other cost-sharing under a qualified, standalone Part D plan.

I. Expand the Capacity and Geographic Reach of PACE Programs

To ensure more PACE-eligible populations have geographic access to PACE, BPC recommends administrative and legislative reforms to streamline the PACE application process, particularly for established PACE organizations seeking to expand their programs. Because we expect these reforms to increase the volume and frequency of PACE applications, BPC also recommends that Congress appropriate, in aggregate, \$15 million in additional resources to CMS (see recommendation [IV.G.](#)). Finally, to expand the geographic reach of PACE to new locations, BPC recommends that Congress support the development of new PACE organizations in areas with low PACE penetration rates and/or disparate access to PACE, such as rural areas.

A. CMS should increase the frequency at which it accepts applications for new and expanding PACE organizations from quarterly to monthly.

The limited number of days in which an organization may submit a PACE application to CMS is a barrier to the growth of PACE. Under current law, CMS has the authority to establish regulations to carry out federal PACE requirements outlined in Sections 1894 and 1934 of the Social Security Act, including establishing procedures for entering into PACE program agreements.¹⁰² Although federal law and regulations do not limit the dates in which CMS may accept PACE applications, current CMS policy allows organizations to submit either initial applications (to become a PACE provider) or SAE applications (to expand the currently approved geographic service area and/or add a new PACE center site) on only four designated dates per year.¹⁰³ PACE providers submit applications via the Health Plan Management System on a quarterly basis announced annually by CMS.¹⁰⁴ Because of the quarterly timeframe, organizations have limited opportunities to establish or expand PACE programs. PACE organizations also experience challenges with significant start-up costs and return on investment, because costly resources, such as the building for the PACE center, remain unutilized while PACE organizations wait for the designated date to submit their application to CMS.

Some lawmakers have recognized and sought to address this barrier to the growth of PACE. The proposed PACE Expanded Act ([S.3626](#)) and the PACE Plus Act ([S.1162](#); [H.R.6770](#)), would amend Sections 1894(e)(8) and 1934(e)(8) of the Social Security Act to ensure that organizations may submit initial PACE applications and SAE applications at “any

time.”¹¹ It is important to recognize, however, that federal review of PACE applications occurs on a 90-day timeline, and any timeframe for accepting applications must allow adequate time for review. During interviews with stakeholders, some raised concerns regarding the feasibility of an “any time” submission cadence.

Accordingly, BPC recommends that CMS use its current authority to change its policy on the timeframe for accepting initial PACE applications and SAE applications from quarterly to monthly; this approach would strike a balance between increasing PACE providers’ opportunities to expand and the supply of federal and state resources necessary to review PACE applications.¹⁰⁵ To ensure clear submission and approval timeframes, BPC also recommends that CMS continue to publish submission and approval application deadlines in advance of the start of an application cycle.

With more frequent application deadlines, CMS and states will require additional resources to complete administrative activities related to the application process, such as hiring more staff to review applications. Accordingly, this report recommends that Congress appropriate additional funding to CMS to support CMS’s increased administrative activities (see recommendation [IV.G.](#)).

B. Congress should modify HHS’s oversight of a new PACE program during the three-year trial period to require HHS, in coordination with the state administrating agency, to conduct at least one comprehensive review of the PACE program before the end of the trial period. The HHS secretary and state administering agency should continue to have the authority to conduct oversight, as appropriate, following the trial period.

Currently, under the Social Security Act, new PACE programs operate under a trial period during their first three contract years.¹⁰⁶ Under previous demonstration authority, the trial period established a grace period where PACE organizations operated without assuming full financial risk. The BBA removed this grace period and maintained the three-year trial period.¹⁰⁷

During the trial period, HHS, in coordination with the state administering agency, conducts annual oversight.¹⁰⁸ This oversight includes an on-site visit to the PACE site; comprehensive assessment of a

¹ The PACE Expanded Act ([S.3626](#)) is sponsored by Sen. Bob Casey (D-PA) and co-sponsored by Sen. Tim Scott (R-SC). It was introduced on March 10, 2022 and referred to the Committee on Finance. Sen. Casey also introduced the PACE Plus Act ([S.1162](#)) on April 15, 2021, which has no co-sponsors and was referred to the Committee of Finance. Reps. Debbie Dingell (D-MI-12) and Earl Blumenauer (D-OR-3) introduced a companion bill to the PACE Plus Act ([H.R.6770](#)) on February 2, 2022.

provider's fiscal soundness; comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants; detailed analysis of the entity's substantial compliance with all significant requirements of the Social Security Act and regulations; and any other elements HHS or the state administering agency considers necessary or appropriate.¹⁰⁹

Following the three-year trial period, current law establishes that HHS (in cooperation with the state administering agency) must continue oversight of PACE programs as appropriate.¹¹⁰

Although audits are important for ensuring that PACE enrollees receive appropriate and high-quality care, the annual audits during the three-year trial period pose significant administrative burdens for PACE organizations, states, and CMS. For example, some PACE organizations said it is time-intensive to coordinate with states and the federal government to submit audit materials and schedule on-site visits. This administrative burden can slow PACE organizations' growth as they allocate finite resources toward audits instead of expansion. The current process also requires significant federal and state resources. Some federal and state stakeholders expressed administrative and resource challenges, such as shortages of staff and funding to complete annual audits.

These challenges will likely worsen as PACE grows. Some stakeholders believe that the three-year trial period is unnecessary and should be replaced by HHS's current law authority to conduct continuing oversight, as appropriate. While HHS has continuing oversight authority following the trial period, these stakeholders suggest that the continuing oversight begin when a PACE program is established.¹¹¹

To balance the benefits of reducing barriers to PACE expansion with ensuring sufficient oversight to promote high-value care through PACE, BPC recommends that Congress amend Sections 1894(e)(4) and 1934(e)(4) of the Social Security Act to require at least one comprehensive review of the operation of the PACE program during the trial period. While current law requires annual, close oversight during the trial period, the revised law should require HHS, in coordination with the state administering agency, to conduct at least one comprehensive review of the PACE program before the end of the three-year trial period. With this recommendation, CMS would maintain the authority to conduct audits in addition to the one mandatory audit during the trial period. Following the trial period, HHS and the state administering agency should continue to have the authority to conduct continuing oversight, as appropriate, as established under current law.¹¹²

BPC's recommendation reduces the number of mandatory audits during a trial period but does not eliminate the trial period, and it still requires at least one mandatory audit. BPC believes new PACE organizations should undergo at least one audit before completing their trial phase and submitting any SAE applications. This policy change would reduce administrative burdens and costs for CMS and states, while preserving CMS's authority under current law to conduct continuing oversight of PACE programs, as appropriate. If HHS has reason to believe that conducting a review may be appropriate, HHS, in coordination with the state administering agency, should continue to conduct close oversight and review of the PACE organization after or during the trial period.

C. CMS should clarify in the Readiness Review Tool that PACE organizations may attest to the employment of staff for State Readiness Review purposes. CMS should also allow PACE organizations that have completed the trial period to submit multiple SAE applications (for geographic service area expansion and/or the addition of a new PACE center site) per application cycle and clarify the contract requirements so that only one contract per organization (legal entity and/or parent organization) is allowed per state.

The application process for establishing a new PACE program is essentially the same as the process for expanding a PACE program.¹¹³ This process includes submission of a notice of intent to apply (only for organizations establishing a new PACE program); submission and approval of the state administering agency and CMS's applications; submission and approval of the PACE Part D application; completion of a State Readiness Review; and completion of a three-way agreement between the state, CMS, and PACE organization. Although a rigorous process ensures an organization applying to become a PACE provider is prepared to deliver high value health services, many stakeholders believe that using the same process for PACE programs seeking to expand is unnecessarily stringent and delays the growth of comprehensive care for Americans with complex health care needs.

Established PACE programs in good standing that have operated for at least three years should have fewer barriers to expanding their geographic service area or increasing their number of PACE sites. BPC has identified three administrative actions that CMS should take to help streamline the PACE expansion process: **1) clarify that, for State Readiness Review purposes, states may accept attestations from the PACE organization that staff will be employed by the time the PACE center becomes operational; 2) allow PACE organizations that have completed the three-year trial period to submit multiple SAE applications (for geographic service area expansion and/or the**

addition of a new PACE sites) per application cycle; and 3) clarify the contract requirements so that only one contract per organization (legal entity or parent organization) is allowed per state.

1. Staffing Attestations: Under CMS policy, organizations submitting an application to establish a PACE program or submitting a particular SAE application that includes the addition of a new PACE center must submit a State Readiness Review report as part of the application process.¹¹⁴ Applicants may submit the State Readiness Review as part of the initial application submission or subsequently as a response to CMS's request for additional information.¹¹⁵ CMS policy outlines minimum federal criteria for the State Readiness Review, and states can establish additional or more stringent criteria. Currently, according to protocols in CMS's Readiness Findings and Compliance Report and Readiness Review [Tool](#), organizations applying to establish a PACE program or open an additional PACE site must have executed contracts with all contractors and contracted personnel by the time the PACE center becomes operational.¹¹⁶ The state must also ensure that the required members of the IDT are or will be employees or contractors of the PACE center by the time the center becomes operational.¹¹⁷

One challenge that PACE organizations often face is that some states require, as part of the State Readiness Review, that the organization has hired all staff. This is more stringent than current federal criteria. Also, there is no federal deadline for the state conducting the State Readiness Review, so PACE organizations often hire staff for extended periods of time without serving any participants. Several stakeholders have noted this as a significant financial barrier to establishing and expanding PACE programs.

To address any uncertainty around the federal criteria for personnel requirements and encourage states to accept personnel attestations, CMS should revise the State Readiness Review criteria for personnel requirements. Specifically, CMS should clarify that the criteria may be satisfied by an attestation from the organization that it will have hired all staff by the time the PACE center becomes operational and a description of how it plans to meet those requirements.

2. Multiple SAE Applications (for Geographic Service Area Expansion and/or the Addition of a New PACE Center Site) for PACE Programs that have Completed their Trial Period:

Current CMS policy restricts the growth of PACE programs and may disincentivize investment in expansion by limiting the number of SAE applications (for geographic service area expansion and/or the addition of a new PACE sites) that a PACE organization may submit

per application cycle to one application. PACE organizations seeking SAEs (for geographic service area expansion and/or the addition of a new PACE center site) submit applications on the same quarterly schedule as organizations submitting initial PACE applications; under CMS policy, active PACE organizations may not submit a SAE application if the PACE organization has another application pending.¹¹⁸ PACE organizations seeking to submit another expansion application must wait until CMS has made a final determination on the pending application before they can submit another application as part of a subsequent quarterly cycle.¹¹⁹ As a result, some PACE organizations seeking large expansion must wait multiple cycles before they can submit applications for all desired growth.

An established PACE organization that is in good standing and has completed the trial period should be subject to less stringent application requirements for SAE applications. To encourage the growth of PACE, CMS should allow PACE organizations meeting those two criteria to submit multiple SAE applications (for geographic service area expansion and/or the addition of a new PACE center site) per application cycle. CMS should also allow PACE organizations to have multiple applications under review at the same time, so having one application under review does not preclude the PACE organization from submitting another application.

Because this recommendation will increase the volume of PACE applications, this report recommends that Congress appropriate additional resources to CMS to support CMS and states' increased administrative activities (see recommendation [IV.G.](#)).

3. One Contract per Organization (Legal Entity and/or Parent Organization) per State: Some PACE organizations circumvent the current policy limiting the number of SAE applications by applying as a new organization under a new contract. An organization may decide to operate under multiple contracts within one state because this practice allows the organization to expand more quickly. However, such a practice increases the administrative burdens and resources for states and the federal government, which have to audit new programs annually during the trial period. Some stakeholders said that having organizations operate under multiple contracts within a state is inefficient and unnecessary because the organization already operates an established PACE site within the state.

To streamline the SAE process, CMS should require an organization to operate under one PACE contract within a state. This change would

require PACE organizations to submit SAEs when seeking to expand in the state. CMS should also require a PACE organization operating under multiple contracts in a state to consolidate to one contract within three years of issuing this guidance.

As previously mentioned, BPC recommends that CMS revise its policy so that a PACE organization can submit, and have under review, multiple expansion applications after completing its trial period. This recommendation will also likely reduce, but may not eliminate, the number of PACE organizations applying under new contracts because PACE organizations will no longer need to circumvent the policy limiting the number of SAE applications.

D. Congress should reduce the time that CMS must approve, deny, or request more information from an applicant seeking to establish a PACE program from 90 days to 45 days.

CMS currently has up to two 90-day clocks to review PACE application materials, and this lengthy review period is a financial barrier to establishing PACE organizations. Under Sections 1894(e)(8) and 1934(e)(8) of the Social Security Act, CMS must respond to applications for new PACE programs within 90 days of submission.¹²⁰ In its first response, CMS must accept, deny, or request additional information for its review of the application. If CMS requests additional information and the PACE organization submits that additional information, then CMS has another 90 days to approve or deny the application. If CMS does not respond within 90 days after either submission, the application is deemed approved. PACE providers encounter financial and resource challenges associated with CMS's 90-day review periods. The providers applying to expand their service areas or add a new PACE center are required to submit generally the same application materials as new PACE provider applicants. However, CMS must review SAE applications in 45 days.

To mitigate application barriers to new PACE programs and promote PACE expansion, BPC recommends amending Sections 1894(e)(8) and 1934(e)(8) of the Social Security Act to reduce the number of days that CMS has to accept, deny, or request more information on an application to become a PACE provider from 90 days to 45 days.¹²¹ BPC also recommends further amending those sections of the Social Security Act by shortening CMS's window for reviewing additional information from 90 days to 45 days. With these changes, a PACE organization's application would be considered approved if CMS does not respond after 45 days of either the initial submission or, if applicable, submission of additional information. The suggested 45-day review window also aligns the length of review for new and SAE applicants; this alignment

would reduce the complexity of the application process. The proposed PACE Expanded Act ([S.3626](#)) and PACE Plus Act ([S.1162](#); [H.R.6770](#)) would similarly establish a 45-day timeframe for CMS's review of initial applications to become a PACE organization as well as the review of any additional information requested by CMS.

This recommendation will expedite CMS's review of PACE applications and, as a result, increase the administrative burden on the agency. To address this anticipated need for greater administrative resources, BPC recommends that Congress appropriate additional funding to CMS to support the agency's expedited review of PACE applications (see recommendation [IV.G.](#)).

E. Congress should establish a grant program resembling the 2006 Rural PACE Provider Grant Program and appropriate \$15 million to organizations to help establish nonprofit PACE sites in regions with low PACE penetration rates or disparate access to PACE. Grantees—up to 15 new, nonprofit PACE organizations—should be eligible to receive up to \$1 million under the grant. See [Appendix](#) for a breakdown of the cost estimate.

Individuals with nursing home level-of-care needs who live in regions outside of PACE service areas have reduced options for community-based, integrated care. As the older adult population continues to grow, and as more people desire to receive care in their communities, Congress should increase access to integrated HCBS programs such as PACE.

According to the National PACE Association, a medium estimate of the costs associated with initiating a new PACE program, adjusted for inflation between 2003 and 2022, is approximately \$5.83 million.¹²² Due in part to the large initial investment, PACE has expanded unevenly throughout the country. It has grown more slowly in rural areas due to barriers, such as provider shortages, low population density, and longer travel distances to the adult care centers. Rural communities also tend to have older and lower income populations who stand to benefit from access to PACE. To promote the development of PACE in rural service areas, Congress established the Rural PACE Provider Grant Program in Section 5302 of the Deficit Reduction Act of 2005.¹²³

Through CMS, this program provided a one-time grant of approximately \$535,000 each to grantees, launching 14 PACE pilot programs in rural areas across 12 states.^m Participating PACE programs cited the grant funding as instrumental to the success of their rural programs: 14 of the

^m The Rural PACE Provider Grant Program initially allowed 15 grantees. However, CMS ultimately funded 14 grantees because one grantee in West Virginia could not come to an agreement with the state and withdrew from the program before CMS distributed funds.

15 (93%) providers successfully launched PACE programs, and 11 of the 14 PACE programs (79%) that opened in 2006 remain in operation as of June 2022.¹²⁴ This undermines any perception that PACE programs in rural settings are not viable or capable of achieving similar outcomes as their urban peers.

To continue improving access, Congress should establish a grant program that builds on the success of the Rural PACE Provider Grant Program by focusing on nonprofit PACE programs in regions with low PACE penetration rates or disparate access to PACE, including but not limited to rural areas. Congress should appropriate \$15 million to CMS to award grants of up to \$1 million to no more than 15 nonprofit PACE organizations. BPC recommends 15 grantees to align with Congress's design of the previous Rural PACE Provider Grant Program and to encourage appropriate growth of PACE. As with the original grant program, the grants should remain available for two fiscal years after appropriation, and CMS should administer the grant. Grantees should be able to use the money for market research, provider network development, building or refurbishing a PACE center, and initial operating funds, as approved by the secretary of HHS. If CMS has awarded less than the total \$15 million within 1.5 fiscal years into the grant, due to lack of grant applications, CMS may use any remaining funds over the final six months to enhance technical assistance and peer-to-peer learning opportunities, such as on-site visits, between the grantees.

The proposed PACE Plus Act ([S.1162](#); [H.R.6770](#)) would similarly establish grants to PACE providers serving rural or underserved urban areas, but it would appropriate greater total funding for the grants than BPC's proposal. The proposed legislation includes \$30 million of funding for up to 30 new PACE programs; BPC, by contrast, recommends funding 15 new PACE programs. The \$1 million award amount within the PACE Plus Act ([S.1162](#); [H.R.6770](#)) is in line with the awards in the original Rural PACE Provider Grant Program of approximately \$535,000 when adjusted for inflation.

A grant program would incentivize the creation of PACE programs by assisting with initial start-up costs, which pose a substantial barrier to PACE expansion. Additionally, PACE organizations participating in the grant program could form a network to share promising practices and strategies for expanding PACE in areas with high barriers to PACE development.

II. Increase PACE Enrollment

To increase the PACE population, Congress and CMS should implement changes to boost enrollment among current PACE-eligible populations and expand the PACE-eligible population. In addition to the PACE-specific recommendations included below, BPC continues to recommend broader legislative reforms that would indirectly support enrollment in PACE. Specifically, BPC recommends ensuring that full-benefit dually eligible beneficiaries have access to fully integrated care models, including PACE. BPC also recommends that Congress allow qualifying Medicare beneficiaries who are ineligible for Medicaid to purchase some HCBS through PACE and other fully integrated care models for an affordable premium, which would be federally subsidized for certain individuals with low to moderate incomes. An HCBS buy-in could reduce the cost of Medicare-only PACE beneficiaries' LTSS premiums for people with low or moderate incomes, as the federal government would partially or fully subsidize these costs.ⁿ

A. Congress should allow Medicare-only PACE participants the choice to enroll in either a qualifying, standalone Part D plan or the PACE Part D plan. The three-way PACE program agreement must describe how the PACE organization will coordinate care to the greatest extent practicable for Medicare-only PACE participants who enroll in a qualifying, standalone Part D plan.

One way to increase access to and enrollment in PACE is to address the high cost of monthly premiums for Medicare-only beneficiaries.

Although qualifying Medicare-only beneficiaries can enroll in PACE, only 212 were enrolled in PACE as of January 2022, and they constitute less than 1% of total PACE enrollees.^{125,126} The vast majority of PACE enrollees are dually eligible beneficiaries who have both Medicare and Medicaid coverage.¹²⁷

The average monthly premium for a Medicare-only beneficiary enrolled in PACE is \$4,781 per month—a major barrier to enrolling in the model.¹²⁸

To understand why PACE premiums are so high for Medicare-only beneficiaries, it is important to understand how PACE is financed and what the premium payments cover. PACE organizations receive a monthly capitation payment for each eligible enrollee and assume full financial risk for all medically necessary health care services. The

ⁿ For additional details on these recommendations, see the following BPC reports: [An Updated Policy Roadmap: Caring for Those With Complex Needs](#) (March 2022); [Guaranteeing Integrated Care for Dual Eligible Individuals](#) (November 2021); and [Bipartisan Solutions to Improve the Availability of Long-term Care](#) (September 2021). In an upcoming report, BPC plans to further explore its recommendation to allow qualifying Medicare beneficiaries who are ineligible for Medicaid to purchase some HCBS through fully integrated care models for an affordable premium.

monthly capitation payment is financed by combined Medicare and Medicaid prospective capitation payments and, in certain instances, supplemented through private premiums (if the participant is a Medicare-only beneficiary).

As PACE is both a Medicare program and a Medicaid state plan option, PACE organizations receive two capitation payments per month for dually eligible enrollees who have no out-of-pocket costs for participating in PACE. In comparison, Medicare-only beneficiaries pay monthly premiums equal to the Medicaid capitation amount—which generally covers the long-term care portion and Medicare Part D drugs—but Medicare-only enrollees do not pay deductibles, coinsurance, or any other type of Medicare or Medicaid cost-sharing for PACE services.

Under current law, PACE organizations must be Medicare Part D prescription drug plans, and all PACE enrollees must receive their prescription drug coverage through the PACE Part D plan. Moreover, if PACE participants enroll in a standalone Part D plan, they will be disenrolled from PACE.

The Part D portion of the total PACE capitation payment is significantly higher than the Part D premium cost for a standalone Part D plan. For example, in 2022, the national average PACE Part D plan premium was \$1,015 per month, while the national average for a standalone Part D plan was \$43 per month.¹²⁹

One contributing factor is that PACE enrollees are generally frail, older adults who require a nursing home-level of care to be eligible for the program. Accordingly, the PACE Part D plan serves a high-risk pool of HNHC enrollees. In contrast, standalone Part D plans can spread risk across a broader population that results in lower, more affordable premiums for enrollees.

Congress should allow Medicare-only PACE participants the choice to enroll in either a qualifying, standalone Part D plan or the PACE Part D plan to give these beneficiaries a more affordable pathway to PACE. Under this approach, a Medicare-only beneficiary who enrolls in a standalone Part D plan will be responsible for any deductibles, copayments, coinsurance, or any other cost-sharing under the Part D plan. Qualifying, standalone Part D plans would be those that have estimated out-of-pocket costs, including premiums and cost-sharing, which are equal to or less than the estimated out of pocket costs for PACE Part D plans.

A rough estimate suggests that allowing a Medicare-only PACE participant to select a standalone Part D plan at the average premium of \$43 per month could reduce their total PACE premiums from about

\$4,781 per month (\$1,015 is for the PACE Part D plan) to about \$3,809 per month (plus any deductible or cost-sharing expenses under the standalone Part D plan).^o This is equal to a reduction from \$57,372 per year for PACE premiums to about \$45,708 per year—an annual savings for Medicare-only PACE participants of \$11,664 per year minus any costs for deductibles, copayments, coinsurance, or other cost-sharing under the qualified, standalone Part D plan.^p For context, the median annual income for a household ages 65 to 69 in 2020 is \$57,992, which is about the same as current PACE premiums for Medicare-only enrollees.^{q, 130}

While reducing the total PACE premium for Medicare-only beneficiaries to roughly \$4,000 per month is an incremental improvement, about \$11,000 in annual savings could make PACE more affordable for some Medicare-only beneficiaries. Further, PACE includes access to LTSS that Medicare-only beneficiaries may not otherwise be able to affordably get. PACE also covers other services that the IDT deems necessary to improve and maintain the overall health of the PACE participant; for context, the median cost for 44 hours a week of home health aide services alone is about \$4,752 per month.^r Also, although this proposal may minimally increase Part D premiums for non-PACE enrollees, the current population of Medicare-only PACE enrollees is so low that their transition to standalone Part D plans is not likely to have any significant impact on Part D premiums. Similarly, the Medicare-only individuals who may enroll in PACE for the first time and select a standalone Part D plan are likely already in a Medicare Part D plan, so effects on the Part D risk pool and premiums would probably be minimal, if any.

This proposal would require Congress to make narrow exceptions to certain provisions in the Social Security Act, such as those that require PACE enrollees to receive benefits solely through the PACE program and that require PACE providers to assume full financial risk for enrollees. Anecdotally, some stakeholders historically held concerns that allowing Medicare-only beneficiaries to enroll in a standalone Part D plan would curtail the key factors that have allowed the PACE model to be

^o Numbers in this paragraph may not add up due to rounding.

^p Following enactment of the Inflation Reduction Act of 2022, Medicare-only PACE participants who select a qualified, standalone Part D plan may experience greater savings than they otherwise would have absent the legislation, due to the cap on out-of-pocket costs in the standalone Part D plan. Also, as detailed in the [Policy Landscape](#) section, the Inflation Reduction Act will reduce the baseline cost of Medicare Part D drugs and, thus, may result in some cost reductions for PACE Part D premiums, but additional legislation is needed to address the high Part D premiums that will remain a barrier to PACE participation for many Medicare-only beneficiaries.

^q Data are from the [2020 U.S. Census Bureau's and Bureau of Labor Statistics' Current Population Survey](#), which is the most recent data available.

^r Estimate is based on the national, median, hourly cost for a home health aide in 2021, which was \$27.00 per hour according to Genworth. Available at: <https://www.genworth.com/aging-and-you/finances/cost-of-care/cost-of-care-trends-and-insights.html>.

successful, but those concerns have generally subsided. This may be because the current model is simply not accessible to Medicare-only beneficiaries, as demonstrated by average PACE premiums that are equal to median income levels for individuals ages 65 to 69 and the fact that less than 1% of PACE enrollees are Medicare-only beneficiaries. Also, a comprehensive, home and community-based model that is highly integrated may be more valuable than a fully integrated model that is unaffordable and inaccessible to most Medicare-only beneficiaries. Nonetheless, this proposal aims to address any concerns about the Part D benefit not being fully integrated for Medicare-only PACE participants. It does so by establishing a requirement that providers describe in their PACE program agreement how they will integrate and coordinate care for Medicare-only beneficiaries to the greatest extent practicable. CMS should work with states and PACE organizations to create an amendment to existing PACE program agreements if necessary. It is also important to note that this proposal would preserve current law for dually eligible and Medicaid beneficiaries, as they would still be required to receive their prescription drug benefits through the PACE Part D plan.

Approaches to making the PACE premium more affordable for Medicare-only participants have received some bipartisan support. For example, both the PACE Expanded Act ([S.3626](#)) and the PACE Part D Choice Act of 2021 ([H.R.4941](#)) have bipartisan support.^s However, as discussed in this [Policy Landscape](#), these bills take different approaches to making the PACE premium more affordable for Medicare-only participants. Notably, the PACE Expanded Act goes further than BPC's recommendation, as it would permit greater flexibility in setting premiums by allowing PACE programs to charge a capitation rate consistent with the Medicare-only beneficiary's health status.

^s The PACE Part D Choice Act of 2021 ([H.R.4941](#)) is sponsored by Rep. Earl Blumenauer (D-OR-3) and co-sponsored by Reps. Jackie Walorski (R-IN-2), Debbie Dingell (D-MI-12), and Christopher H. Smith (R-NJ-4). It was introduced on August 6, 2021 and referred to the Committees on Energy and Commerce and Ways and Means. Ways and Means referred it to the Subcommittee on Health.

As also discussed in the report's [Policy Landscape](#) section above, the IRA implements a \$2,000 out-of-pocket spending cap for Medicare beneficiaries enrolled in Part D Plans, but this does not make PACE more affordable for Medicare-only beneficiaries. PACE participants are protected against out-of-pocket costs, such as copayments or deductibles, but they have high premiums that may be reduced only slightly by the IRA's likely decrease to the baseline cost of Medicare Part D drugs. In addition, the cost of the PACE Part D plan relative to other Part D coverage options is increased by the IRA's out-of-pocket cost protections. Additional legislation is needed to address the high Part D premiums for Medicare-only beneficiaries.

B. The Center for Medicare & Medicaid Innovation (CMMI) should test a model for expanded PACE eligibility that targets HNHC, full-benefit dually eligible populations. This demonstration project should include data collection, transparency, and quality improvement requirements (see recommendations [IV.A-IV.C](#)).

In addition to those currently eligible for PACE, several HNHC populations—who receive full Medicare and Medicaid benefits but are ineligible for PACE based on age—would benefit from receiving integrated medical and nonmedical care. Through the PACE Innovation Act of 2015, Congress has already authorized CMS to waive certain PACE requirements in the Social Security Act so it can conduct a PACE demonstration project through CMMI.¹³¹ Following enactment of the 2015 legislation, CMS issued an RFI to explore expanding PACE to additional populations, but it never moved forward with the demonstration project.¹³²

To expand PACE to Medicare and Medicaid populations that are likely to benefit from the integrated model, CMMI should use its existing authority to conduct a demonstration project that tests the application of PACE to full-benefit dually eligible beneficiaries who are currently ineligible for PACE due to age but have similar care needs to the PACE-eligible population. Many of the proposed populations are ineligible for PACE because they are under the age of 55. For example, CMMI should consider testing the expansion of PACE to certain full-benefit dually eligible populations between the ages of 21 and 54, including adults with developmental disabilities and comorbidities; adults with physical disabilities and comorbidities; and adults with behavioral health conditions and comorbidities.¹³³

Assuming the additional PACE population has different needs than the original PACE population, CMMI should work with providers and researchers to determine programmatic and service differences. For

example, the IDT may require additional specialty providers so it can better meet the needs of the newly eligible HNHC populations.

Either new organizations or existing PACE organizations could apply to participate in the demonstration project. To participate, organizations would need to create or modify an existing three-way contract with the state administering agency and CMS.

Under that approach, the demonstration would ultimately make PACE available to full-benefit dually eligible beneficiaries between the ages of 21 and 54 with disabilities and comorbidities. BPC estimates that in 2019, there were approximately 700,000 full-benefit dually eligible beneficiaries under the age of 65 with comorbidities.^{t, 134, 135} Because not all full-benefit dually eligible beneficiaries under the age of 65 with comorbidities have disabilities, BPC estimates there are less than 700,000 full-benefit dually eligible beneficiaries who could qualify for this model of expanded PACE eligibility. BPC recommends that CMS make this demonstration available through a limited number of PACE programs evenly distributed across the regions nationally. Accordingly, only a small proportion of the less than 700,000 potentially eligible beneficiaries would enroll in this demonstration.

Members of Congress have similarly sought to test the expansion of PACE to new populations. The proposed PACE Expanded Act ([S.3626](#)) would require the HHS secretary to design a model for expanded PACE eligibility targeting HNHC populations. Although CMMI currently has the authority to do this absent congressional intervention, the proposed legislation would require the agency to use its authority and target the application of PACE to HNHC populations.

Some stakeholders, however, have suggested that the federal government first optimize PACE for the currently eligible population before expanding it to new populations. Because providing quality care for individuals with complex care needs who are ineligible for PACE is a pressing and costly challenge for the U.S. health care system, BPC recommends that the federal government test a model of expanded PACE eligibility while also optimizing PACE for the currently eligible population. When designing the demonstration project, CMMI should include data collection, quality improvement, and transparency

^t Estimate is based on the Congressional Budget Office's report, which found around 8% of full-benefit dually eligible beneficiaries were under the age of 65 and were diagnosed with three or more chronic conditions in 2009. In 2019, there were around 8.7 million full-benefit dually eligible beneficiaries. BPC's estimate assumes the same percentage of full-benefit dually eligible beneficiaries under the age of 65 with diagnoses with three or more chronic conditions in 2009 and 2019. BPC did not find recent data on the number of full-benefit dually eligible beneficiaries under the age of 65 with disabilities, so BPC's estimate likely over projects the number of full-benefit dually eligible beneficiaries under the age of 65 with comorbidities and disabilities.

requirements, as outlined in recommendation [IV](#), to build evidence for the model and learn from the demonstration project. This approach aims to ensure a timely response to the need for innovative models for individuals with complex needs while also ensuring the HHS secretary has sufficient data and monitoring capabilities to evaluate the demonstration project and report the results.

III. Raise Consumer Awareness of PACE

To raise consumer awareness of PACE, this section recommends that CMS modify marketing guidance for PACE organizations seeking to expand their programs and implement changes to the Medicare.gov website to improve consumer education.

A. CMS should allow established PACE organizations that are expanding their geographic service areas or adding a new PACE site to market their program earlier in the application process; this change would enable them to inform potential enrollees that the organization is working to bring a new PACE program or site to the service area.

Currently, PACE organizations applying to expand their geographic services areas or open a new PACE site must follow the same marketing restrictions as entities seeking to become a new PACE organization.¹³⁶ Federal regulations prohibit applicants from marketing until CMS approves the applications.¹³⁷ Under these requirements, PACE organizations must have finished building new, additional centers or have them operational, but they cannot market their expansion until CMS's approval of the application is complete. A similar restriction applies to PACE organizations expanding their geographic service area. They cannot advertise until CMS approves the SAE and the PACE organization has received the amended program agreement.¹³⁸

Expanding PACE is resource-intensive, and the application process takes several months. The process, as described in recommendation [I.C.](#), includes up to two 90-day clocks for CMS's review but with no deadline for states to submit the State Readiness Review. For some PACE organizations, particularly nonprofits, the existing marketing requirements that restrict advertising before completion of the application process pose a barrier to expansion. PACE-eligible populations and other stakeholders serving potential PACE participants receive no notice that a PACE program is coming to the area, further delaying program enrollment and solvency once CMS approves the expansion.

To address that challenge, CMS should allow established PACE organizations that have successfully completed their trial period to market their expansion during the application process. PACE

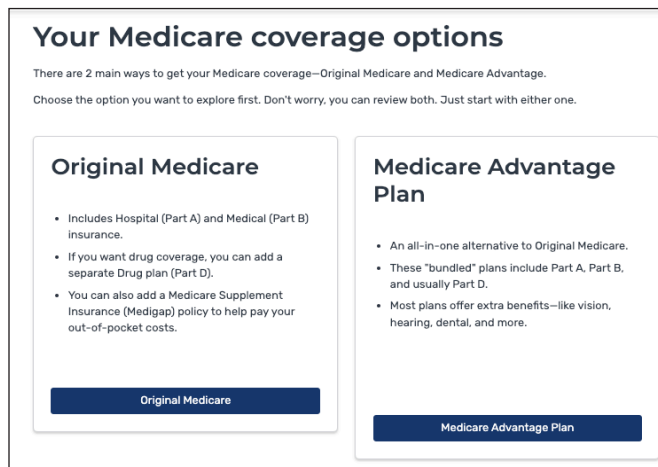
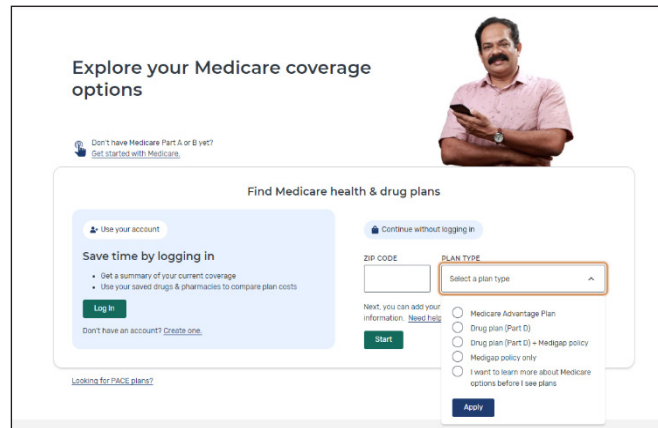
organizations seeking to expand are distinct from organizations applying to become first-time PACE providers. For example, PACE organizations applying to open an additional PACE site are already providing services and have experience developing marketing materials compliant with federal regulations. Thus, they should be allowed to market their anticipated expansion earlier in the application process. To support consumer protections, CMS should provide standard language to PACE organizations that clearly indicates the organization's expansion is pending state and federal approval. This proposal would help PACE providers generate interest from potential participants earlier and enroll more individuals as soon as the center is open.

B. CMS should improve the Medicare.gov website to make it easier for users to navigate and to access information on PACE. This should include better integrating PACE in CMS's existing "Find Plans" coverage tool.

One barrier to increasing PACE enrollment is consumer awareness of PACE. Medicare.gov is a central location that many older adults and their families use to understand Medicare's coverage options. There is opportunity to improve the promotion of PACE on Medicare.gov to better ensure all PACE-eligible individuals know their coverage options and have the information necessary to choose the most appropriate coverage option.

Despite recent updates to the CMS website, users must navigate multiple pages to receive information on PACE services and eligibility. CMS recently redesigned the "[Get started with Medicare](#)" page to include updated information comparing coverage options. CMS also revamped the "[Find Plans](#)" tool that guides users through questions to gather personalized information and directs users to Medicare options unique to their situations.^{139,140} The "Find Plans" tool, which is promoted on the Medicare.gov homepage, does not include PACE organizations in its results. Instead, users must locate the "Looking for PACE plans?" hyperlink at the bottom of the search tool. This hyperlink brings users to the "[PACE plans in your area](#)" tool on Medicare.gov.¹⁴¹ Additionally, the "Coverage Options" resource page promoted on Medicare.gov contains no information on PACE.

Figure 3: Screenshots of the “Find Plans” and “Coverage Options” Webpages on Medicare.gov



Sources: Centers for Medicare & Medicaid Services, [Explore your Medicare Coverage Options](#) and [Your Coverage Options](#)

CMS should streamline information on PACE on Medicare.gov and better integrate PACE in its existing “Find Plans” tool. CMS should also add information on PACE alongside the listings for original Medicare and Medicare Advantage directly on its “Coverage Options” webpage. Additionally, CMS should update its “Find Plans” tool to notify users if they reside in a PACE service area and display the “Looking for PACE Plans?” hyperlink more prominently on the “Find Plans” tool. Improving access to information of PACE on Medicare.gov will provide users with information to compare PACE to other coverage options.

IV. Ensure and Demonstrate the Continued Value of PACE

To ensure and demonstrate the continued value of PACE, BPC recommends in this section that Congress and CMS strengthen transparency, quality improvement, and data collection for PACE programs. Providing quality care for individuals with complex health care needs is one of the most pressing challenges facing the U.S. health care system, and research suggests that expanding PACE has the potential to improve care for these individuals. However, as with all health care delivery systems, data collection and transparency are fundamental to making evidence-based policy and practice decisions. These recommendations are especially important because the PACE landscape is shifting, as the number of private equity-funded for-profit PACE organizations will likely increase. BPC also recommends reforms to improve alignment across programs serving dually eligible beneficiaries.

A. To improve transparency and support quality improvement, CMS should require PACE organizations to publicly post quality improvement plans, including a date when the PACE organization last reviewed and posted its plan. CMS should also require PACE organizations to publicly indicate their entity status (e.g., for-profit or nonprofit) on the homepage of their websites.

Data and quality improvement transparency are essential components to demonstrating the value of health programs. Currently, under federal law and regulations, PACE organizations must have a written quality improvement plan that its governing body (e.g., the board of directors) reviews annually.^{142, 143} Federal regulations require that the quality improvement plan, at a minimum, specify how the PACE organization proposes to identify areas to improve or maintain the delivery of services and patient care; develop and implement plans of action to improve or maintain quality of care; and document and disseminate to PACE staff and contractors the results from the quality improvement activities.¹⁴⁴ Also, the quality improvement program must include, at a minimum, use of objective measures to demonstrate improved performance across several areas detailed in regulation, such as utilization of PACE services; caregiver and participant satisfaction; outcome measures derived from data collected from assessments, such as data on functional status; effectiveness, and safety of services; and nonclinical areas.¹⁴⁵ Although CMS requires that PACE organizations disseminate the quality improvement plans to PACE staff and contractors, many organizations' plans are not accessible to stakeholders, such as prospective and current PACE participants and states.¹⁴⁶

There is also opportunity to improve transparency around PACE organizations' entity type (e.g., for-profit or nonprofit). As for-profit PACE organizations increase, researchers, policymakers, and consumers stand to benefit from improved transparency of a PACE organization's entity

type. For example, researchers could compare quality improvement plans between for-profit and nonprofit PACE organizations to monitor practice differences. Although some for-profit PACE organizations post information on their entity status, this information is often unclear or difficult to locate.

To demonstrate the continued value of PACE and improve consumer transparency, CMS should require PACE organizations to publicly post their most recent quality improvement plans on their websites in an accessible manner. CMS should also require that PACE organizations include the date of the latest review of the improvement plan. To strengthen transparency of PACE organizations' entity types, CMS should require PACE organizations to publicly indicate their entity type on their websites. PACE organizations should post this information clearly and prominently on the homepage of their websites. BPC also recommends that CMS provide standard language for PACE organizations to use.

B. To identify disparities, CMS should require PACE organizations to disaggregate their reported health outcomes and any standardized quality measures by race, ethnicity, sexual orientation, gender identity, primary language, and disability status.

As the older adult population continues to become more racially and ethnically diverse, some researchers believe that PACE is well positioned to align with the needs of PACE-eligible minorities.^{147,148} Disaggregated data are necessary to comprehensively assess the value of PACE, including its ability to care for diverse populations. Currently, CMS requires that PACE organizations have a quality improvement program that includes, at a minimum, use of objective measures to demonstrate improved performance in several areas, including certain outcome measures.¹⁴⁹ As part of the quality improvement, PACE organizations must also meet or exceed minimum levels of performance established by CMS and the state on standardized quality measures, such as influenza immunization rates, specified in the PACE program agreement.¹⁵⁰ CMS, however, does not require PACE organizations to submit the data disaggregated by race, ethnicity, sexual orientation, gender identity, primary language, and disability status. PACE's current aggregated data submission limits CMS's ability to identify and address disparities within the program.

To identify disparities, CMS should require, to the extent feasible, that PACE organizations submit required health outcomes and any standardized quality measures disaggregated by race, ethnicity, sexual orientation, gender identity, primary language, and disability status. CMS should also encourage PACE organizations to include culturally competent strategies for addressing identified disparities in their quality improvement plan.

C. Congress should direct the HHS secretary to develop—in coordination with states, stakeholders, and policy experts—a voluntary set of procedure codes for frequently administered nonclinical PACE services. States would have the option of requiring PACE organizations to report on the set of procedure codes.

As a fully capitated model, PACE providers are incentivized to provide services that address social determinants of health, which may include food, housing, and transportation. For example, a PACE organization might provide an air conditioner to help support a participant's health. These nonclinical PACE services play an important role in enrollees' care and are currently not captured by national procedure codes.^u

Research suggests the role of nonclinical services might continue to grow in response to the COVID-19 pandemic. State Medicaid directors indicated an increasing focus on addressing social determinants of health, including among PACE-eligible populations.¹⁵¹ Although some states, such as Colorado, have started developing procedure codes for these nonclinical services, no comprehensive standardized procedure codes for nonclinical PACE services exist.¹⁵²

Congress should direct the HHS secretary to develop—in coordination with states, stakeholders, and policy experts—a voluntary set of procedure codes that captures a limited set of frequently administered nonclinical services delivered by PACE organizations. This would serve as an initial step toward exploring the value of a potential, longer-term effort to develop a more comprehensive set of procedure codes for nonclinical PACE services.

The procedure codes for the limited set of frequently administered, nonclinical PACE services should be broad enough to capture a wide range of activities. For example, if the HHS secretary develops a procedure code for transportation services, then PACE organizations would use this code for the nonemergency transportation of PACE participants regardless of duration, distance, or vehicle type. States would have the option of requiring PACE organizations to report on the set of procedure codes. Capturing these nonclinical services would further demonstrate PACE's value and inform quality improvement initiatives. Additionally, standardizing procedure codes for nonclinical services would improve the consistency of PACE data reporting across states and allow for data comparisons. Encouraging consistency across states is particularly important at a time when some states are beginning to develop their own sets of procedure codes for PACE.

^u Procedure codes are a uniform language used by health care providers and professionals to report services, procedures, supplies, and products they render to patients. Procedure codes inform claims, billing, and payments processes and help track public health.

D. To demonstrate and improve PACE's value, Congress should allow CMS to use encounter data for oversight purposes and require that PACE organizations submit enrollee encounter data to CMS. Congress should also appropriate \$20 million to CMS to award competitive grants to states to establish loan programs for PACE providers; the loans would fund the purchase or upgrade of EHR technology, the training of personnel on the use of EHR, and the improvement of the electronic exchange of health information. (See [Appendix](#) for a breakdown of the cost estimate.)

Some states may already require PACE organizations to submit encounter data, but there is no federal requirement for PACE organizations to collect or submit encounter data with one exception: PACE organizations must collect and submit encounter data to CMS to help the agency calculate risk-adjusted payments to the organizations. CMS generally does not receive PACE organizations' encounter data since there is no standardized automatic collection process. Encounter data, which require health IT, are essential for measuring and monitoring Medicare and Medicaid finances, service utilization, and quality.¹⁵³ Although CMS does not require PACE organizations to submit encounter data, CMS requires many other Medicare and Medicaid programs to do so. For example, Section 4753(a)(1) of the BBA requires states to submit Medicaid managed care encounter data as well as fee-for-service claims information to CMS.¹⁵⁴ CMS, through federal guidance, and Congress, through Section 6504(b) of the Affordable Care Act, have strengthened these reporting requirements.¹⁵⁵ Similarly, Medicare Advantage plans and the Financial Alignment Initiative demonstration's Medicare-Medicaid Plans are required to submit encounter data to CMS.^{156, 157}

To demonstrate and improve the value of PACE, Congress should require states to submit accurate, complete, and timely enrollee encounter data to CMS. As PACE grows, the need to measure and improve its value grows as well. Submission of encounter data will allow CMS to evaluate the effectiveness of PACE. To continue to measure PACE's value, Congress also should allow CMS to use encounter data for audit and oversight purposes, as that is not clearly established as part of CMS's regulatory authority to monitor PACE.¹⁵⁸ Some stakeholders have indicated that PACE organizations' health IT could require updates to comply with this requirement; Congress should therefore allow a grace period for PACE organizations to update their technology.

Additionally, Congress should provide \$20 million to CMS to create state loan programs for PACE providers, similar to state loan programs under the Health Information Technology for Economic and Clinical Health Act (HITECH).¹⁵⁹ To be eligible for the grants, states must establish a health IT loan fund, submit a written plan describing how the state

intends to use the federal funds, and provide at least \$1 for every \$5 of federal funding. Under the state loan program, states would use the federal grants to loan money to PACE providers for enhancing their health IT. The Health IT loans would help PACE providers purchase or upgrade EHR systems that meet federal certification, train personnel on the use of EHRs, and improve the electronic exchange of information.

E. CMS should publicly post Medicare and Medicaid spending data on PACE and disaggregate data by payer type and consumer demographics.

Policymakers and researchers need data on Medicare and Medicaid's spending on PACE to measure the value of the model as it grows. This federal and state data allow researchers and policymakers to learn how spending on the PACE population compares to the amount that would have been spent if this population received care through another program or plan, such as a D-SNP. Data are especially helpful when broken down by payer type (e.g., state or federal) and consumer demographic (e.g., race, ethnicity, or disability status). Although there is some public federal and state spending data on PACE, much of the data are difficult to locate, outdated, or incomplete (e.g., does not disaggregate by payer type or consumer demographic). For example, the annual [CMS Medicaid Financial Management Report](#) indicates the total federal and state Medicaid spending on PACE, but this data present only a partial picture of total federal spending on PACE, because the model is also financed by Medicare payments.¹⁶⁰ BPC did not find public data on Medicare spending for PACE.

CMS should publicly post Medicare and Medicaid spending data on PACE, disaggregating the data at the payer type and consumer demographic level. CMS collects the data necessary to publish a resource consolidating federal and state spending on PACE. As noted above, CMS already publishes federal and state Medicaid spending on PACE, but it does not publish federal Medicare spending on the program. States submit their PACE Medicaid spending data via CMS-64 forms to the CMS Data Center and the Medicaid database. Through this process, CMS has data on federal and state Medicaid spending on PACE. Additionally, CMS has information on federal Medicare spending on PACE since Medicare pays for PACE. By publishing a resource that consolidates Medicare and Medicaid spending on PACE and disaggregating data by payer type and consumer demographic, CMS would provide policymakers and researchers with the data necessary to assess the value of PACE more easily as it grows.

F. Congress should ensure the inclusion of diagnoses obtained through audio-only telehealth when determining risk adjustment for PACE participants who have established relationships with PACE providers during the COVID-19 PHE.

PACE participants have a greater risk of morbidity and mortality related to communicable diseases, including COVID-19, and PACE organizations can utilize audio-video or audio-only (telephone visits without video) telehealth to reduce PACE participants' risk of infection. During the COVID-19 PHE, CMS expanded Medicare coverage for audio-only services, but it has not allowed PACE organizations to use diagnostic information obtained via audio-only telehealth visits in determining risk adjustments. Notably, the Center for Consumer Information and Insurance Oversight allows plans on the federal health insurance marketplace to use data obtained via audio-only visits when determining risk adjustments.

By excluding diagnostic information obtained from audio-only telehealth visits, CMS relies on incomplete data to calculate PACE organizations' monthly payments. Payment miscalculations can have a significant impact on PACE programs because many programs enroll a small number of participants.

Any reform allowing PACE organizations to use diagnostic information obtained through audio-only telehealth in determining risk adjustment, however, may negatively affect care quality and should thus include certain limitations to balance access to care and quality.

One concern that policymakers, payers, and providers have raised is that audio-only visits are of lower quality than audio-video telehealth or in-person visits and present risks of overuse and fraud for the Medicare program.^{v,161} If data ultimately suggest those concerns are valid and audio-only diagnoses are included in determining risk adjustment, then PACE programs could have an incentive to conduct more audio-only telehealth visits. Lower quality care could then result.

A competing concern is that the exclusion of audio-only diagnostic information may encourage PACE organizations to underutilize telehealth services for PACE participants and thus serve as a barrier to accessing care. PACE participants generally include frail, older adults who may have functional limitations or cognitive impairment, and many of these individuals may not have access to or the ability to use technology that allows both audio and visual communication. For example, PACE participants with cognitive limitations may only

^v BPC plans to release a digital health report in the fall of 2022. This report will include additional evidence-based federal recommendations for the effective use of telehealth beyond the COVID-19 PHE.

have access to audio-only telehealth visits. Older, rural, poorer, and minority populations are also disproportionately affected by barriers to technology that requires audio-visual communication.¹⁶² Also, promoting telehealth has been particularly important during the pandemic, as older adult populations, such as the PACE population, are at the highest risk of COVID-19 infection and mortality.

To ensure accurate monthly payments while balancing the quality of and access to care, Congress should allow CMS to utilize diagnostic information obtained via audio-only telehealth for risk adjustment purposes throughout the COVID-19 PHE. Under this policy, PACE providers should only utilize audio-only telehealth when the provider has an established relationship with the PACE participant and it is clinically appropriate to utilize audio-only services. BPC's recommendation underlies the importance of using complete diagnostic information to calculate PACE organizations' risk adjustments while also reducing the risk of overusing audio-only telehealth. A similar policy proposal is included in the bipartisan Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021 ([H.R.2166](#)).^w

G. Congress should appropriate \$15 million in additional resources to CMS to support CMS and states' administrative activities related to the appropriate growth of PACE; these resources could include hiring additional staff, improving operations, and providing technical assistance. (See below and [Appendix](#) for specific activities and a breakdown of the cost estimate.)

To account for an expected increase in CMS and states' administrative activities resulting from the growth of PACE, BPC recommends that Congress appropriate \$15 million in additional resources to CMS for federal and state administrative activities, as follows:

- **\$2 million for hiring additional CMS staff for processing and reviewing PACE applications:** BPC's recommendations to improve the PACE application process will increase the volume and frequency of applications and decrease CMS's time to review these applications.
- **\$7 million for hiring additional CMS staff for PACE audits and oversight:** As the number of PACE programs increases, CMS will also experience an increase in audit and oversight responsibilities, which will require additional staff and dedicated staff time.

^w The Ensuring Parity in MA and PACE for Audio Only Telehealth Act of 2021 ([H.R.2166](#)) is sponsored by Rep. Terri A. Sewell (D-AL-7). It is co-sponsored by 27 Democrats and 24 Republicans. It was introduced on March 24, 2022 and referred to the House Ways and Means Subcommittee on Health; and the Energy and Commerce Subcommittee on Health.

- **\$2 million for improving federal program operations:** The growth of PACE will increase federal costs related to program operations, such as training personnel, systems updates, and other operating costs.
- **\$3 million in additional resources to states to hire staff responsible for PACE applications and oversight:** Some states might need additional resources to hire more staff or dedicate greater staff time to PACE applications and oversight. To receive funding, states must submit a plan describing how they plan to use the money to support administrative activities related to growing PACE. In reviewing the applications, CMS should consider each state’s current PACE landscape and opportunities for PACE expansion within the state. For example, a state close to reaching its PACE enrollment cap will likely consider fewer applications and require less additional, administrative resources than a state rapidly expanding its PACE program.
- **\$1 million to provide technical assistance to states on the following topics:**

Reviewing, administering, and evaluating PACE programs—With the expansion of PACE and recommended efforts to collect more PACE organizations’ encounter data, CMS should strengthen its technical assistance to support states implementing and evaluating PACE. It is important to increase federal technical assistance efforts to help state policymakers better understand the value of PACE and identify opportunities for their PACE programs. CMS’s technical assistance would help states, for example, utilize the encounter data to inform the state’s Medicaid risk adjustment, study disenrollment in PACE, and establish quality improvement initiatives that may include capitation bonuses to PACE organizations meeting quality improvement benchmarks.

Establishing or growing PACE programs—Although CMS provides some technical assistance to PACE providers and states interested in establishing or growing programs, this technical assistance can be streamlined and improved. For example, CMS currently posts different application information across Medicaid.gov, CMS.gov, and the Division of Medicare Advantage Operations portal; as a result, applicants cannot locate all application information in one location. Additionally, information on PACE applications is scattered across separate guidance documents. This fragmented technical assistance poses a barrier for PACE applicants and states reviewing applications. PACE applicants often hire consultants to navigate the application process, which can be particularly costly for a new, nonprofit PACE organization. States

and PACE providers also expressed some difficulty identifying a standard CMS contact for application questions. Since PACE applications are submitted on a quarterly timeframe, challenges navigating the process could result in delayed submissions, which would require the applicant to restart the application process the next quarter.

CMS should streamline its PACE application guidance by creating a PACE application toolkit and checklist to help applicants successfully navigate the process in a timely manner. Additionally, to ensure PACE organizations and states can easily locate comprehensive guidance, federal websites containing PACE information should consistently include references to other federal websites that contain PACE information. CMS should also clearly post contact information for PACE questions from applicants and states.

Clarifying marketing requirements—The review process for a PACE organization’s marketing includes a review by the state’s administering agency and the CMS regional office to ensure marketing materials comply with federal regulations at 42 CFR § 460.82. Although CMS released revised marketing guidance in March 2022, stakeholders noted receiving inconsistent feedback and approval on marketing materials and outreach activities.¹⁶³ PACE organizations cited a need for clearer guidance on the content that can be included in marketing materials. CMS should provide example or template marketing materials to demonstrate compliant marketing materials.

H. Congress should provide MMCO with funding and regulatory authority to establish and oversee full integration in all programs serving dually eligible beneficiaries, including PACE.

Under the 2018 Bipartisan Budget Act, Congress established that MMCO is responsible, subject to the final approval of the secretary of HHS, for developing regulations and guidance related to (i) implementation of a unified grievance and appeals process for D-SNPs and (ii) the integration or alignment of policy and oversight under the Medicare and Medicaid programs regarding D-SNPs. Although CMS develops PACE regulations with input from MMCO, Congress did not provide the office with regulatory authority related to PACE. Also, the lack of staffing and resources requires MMCO to rely on other offices within CMS for many functions. Without full authority to establish and oversee integration in

all programs serving dually eligible individuals, including PACE, these offices can hinder the full integration of services and create differing requirements for the various integration models, potentially leading to unintended consequences.

Congress should provide authority to MMCO, subject to the final approval of the secretary of HHS, to issue regulations and guidance related to all dual eligible programs, including PACE; to serve as a full partner with states seeking to integrate care; and to implement the federal fallback program proposed by BPC in previous [reports](#). This transfer of authority will require a strong commitment from the HHS secretary and the CMS administrator. Congress should also appropriate additional resources to CMS to support MMCO's staffing needs related to its increased responsibilities.^x

Conclusion

PACE is a comprehensive, home and community-based care model that has long received bipartisan support in Congress. While PACE currently serves a relatively small number of Medicare and Medicaid beneficiaries, the program has demonstrated its value as a fully integrated, flexible model with potential to improve health outcomes and reduce costs. Policymakers should work together to advance bipartisan policy solutions that will address barriers to the appropriate spread and scale of PACE. To that end, we hope that policymakers will consider the bipartisan set of federal policy reforms in this report to improve access to and enrollment in PACE to better meet the LTSS needs of the rapidly aging U.S. population, and to improve care for populations with high rates of chronic illness, including the dually eligible population.

^x The amount should be sufficient to ensure MMCO has adequate staffing and resources to meet its increased responsibilities, but BPC does not have enough data to estimate the specific amount that may be necessary.

Appendix

BPC's Report Recommendations and Estimated Federal Costs*

Description	Cost Rationale	Estimated Cost in Millions (Frequency of Cost)
Recommendation I.E.		
<p>Congress should establish a grant program similar to the 2006 Rural PACE Provider Grant Program and appropriate \$15 million to organizations to help establish new nonprofit PACE sites in regions with low PACE penetration rates or disparate access to PACE. Grantees—up to 15 new, nonprofit PACE organizations—should be eligible to receive up to \$1 million under the grant.</p>	<p>The PACE Plus Act (S. 1162) includes \$30 million of funding for up to 30 new PACE programs, which aligns with the 2006 Rural PACE Provider Grant Program when adjusted for inflation. BPC recommends half the number of new PACE programs, so BPC recommends Congress appropriate \$15 million.</p>	<p>\$15 (one-time cost)</p>
Recommendation IV.D.		
<p>To demonstrate and ensure the continued value of PACE, Congress should allow CMS to use encounter data for oversight purposes and require that PACE organizations submit enrollee encounter data to CMS. Congress should also appropriate \$20 million to CMS to award competitive grants to states to establish loan programs for PACE providers to purchase or upgrade EHR technology, train personnel on the use of EHR technology, and improve the electronic exchange of health information.</p>	<p>BPC estimates the cost of purchasing and installing an EHR technology in 2022 is around \$64,500 per provider. This estimate is based on the Office of the National Coordinator for Health Information Technology's estimates between 2003-2007; the median value for providers to purchase and install an EHR was around \$42,500 in 2005.¹⁶⁴ BPC did not find more recent EHR purchase and installation prices per provider, so this report uses this estimate and adjusts for inflation between 2005 and 2022. BPC estimates the total cost of purchasing and installing EHR technology for all PACE sites is around \$18 million. This estimate is based on the total number of PACE sites in 2022.¹⁶⁵</p> <p>To account for assumptions, such as one PACE provider at a PACE site, BPC recommends Congress allocate \$20 million.</p>	<p>\$20 (one-time cost)</p>
Recommendation IV.G.		
<p>Congress should appropriate \$15 million in additional resources to CMS to support CMS and states' administrative activities related to the appropriate growth of PACE, as follows:</p>		
<p>Congress should appropriate \$2 million for hiring additional CMS staff for processing and reviewing PACE applications.</p>	<p>BPC's estimate is based on CMS's request to hire additional full-time equivalent staff in which the estimated cost of hiring one FTE is \$200,000.¹⁶⁶ BPC's estimate assumes CMS would need to hire an additional FTE in each of its 10 HHS regional offices.</p> <p>For FY2023, CMS requested Congress allocate \$844.1 million to CMS for hiring 4,518 direct FTEs. Accordingly, BPC assumes that one FTE would cost roughly \$200,000, but we recognize that the cost for an FTE to process and review PACE applications may be notably less than that estimated average cost for an FTE.</p>	<p>\$2 (annual cost)</p>
<p>Congress should appropriate \$8 million for hiring additional CMS staff for PACE audits and oversight.</p>	<p>CMS requested \$6.6 million to improve oversight of PACE in FY2023.¹⁶⁷ BPC's recommendations would expand PACE, so we estimate that CMS will require additional funds above that amount to reach roughly \$8 million.</p>	<p>\$8 (annual cost)</p>

Description	Cost Rationale	Estimated Cost in Millions (Frequency of Cost)
Congress should appropriate \$1 million for improving federal program operations.	BPC's calculation is based on the estimated cost of modifying federal operations for other Medicare programs.	\$1 (annual cost)
Congress should appropriate \$3 million in additional resources to states to hire staff responsible for PACE applications and oversight.	BPC's estimate assumes each of the 32 states operating PACE as of August 2022 will require one additional FTE to review and implement PACE. BPC's estimate is based on the average salary of state employees in 2020, which was around \$66,000. BPC's estimate allocates a significant amount of money to account for assumptions and variations between states.	\$3 (one-time cost)
Congress should appropriate \$1 million to provide technical assistance to states on the topics outlined in this report.	BPC's calculation is based on the estimated cost of enhancing technical assistance to states for similar Medicaid programs.	\$1 (annual cost)
		TOTAL (ONE-TIME): \$38 TOTAL** (ANNUAL): \$12

*The estimates in this table are rough approximations of potential federal costs that may be associated with federal policy recommendations in this report. BPC does not suggest that the estimates in this table will be the actual costs of each federal policy recommendation. A more detailed cost analysis should be performed to determine the appropriate federal cost of each recommendation. The purpose of these rough estimates is to provide a starting point for such an analysis.

**BPC has not included in this table its recommendation to provide MMCO with funding and regulatory authority to establish and oversee full integration in all programs, including PACE, serving dually eligible beneficiaries. Any funding that Congress appropriates for this purpose would add to the total costs outlined in this table.

Endnotes

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