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

Laura Skopec

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The Program of All-Inclusive Care for the Elderly (PACE) provides Medicare and Medicaid services for people aged 55 and older who require a nursing-home level of care but can safely live in the community with supports. Because PACE is a small program, enrolling about 56,000 Medicare beneficiaries in 32 states in 2023, relatively little research has focused on the PACE payment system. The DUALS Act, currently under consideration in the Senate Finance Committee, would expand access to the PACE program to enrollees under 55 and make it more broadly available across states. However, the current approach to paying PACE programs for the Medicare services they provide is based on the Medicare Advantage (MA) payment benchmarks that were in place before the Affordable Care Act (ACA), which were overly generous. In addition, since for-profit PACE organizations have entered the program in recent years, private equity has taken an increasing interest in acquiring PACE programs. These facts suggest that a closer look at Medicare payments to PACE programs is warranted to ensure that PACE expansion does not lead to unnecessary Medicare spending.

This brief compares Medicare payments to PACE programs across counties and assesses how PACE Medicare payments compare with payments to Dual Eligible Special Needs Plans (D-SNPs), a type of MA plan that enrolls beneficiaries with similar eligibility characteristics to those enrolled in PACE. We also explore state Medicaid payments to PACE programs, though publicly available data is lacking. We find the following:

- PACE programs differ from other care programs for beneficiaries dually enrolled in Medicare and Medicaid because they generally enroll a higher-need population, can fully blend Medicare and Medicaid payment to provide all-inclusive care, and focus on team-based care centered around a PACE day center (MedPAC 2012).
  - » Research suggests that PACE enrollment leads to fewer hospitalizations and better patient satisfaction than other models of care, including D-SNPs (Feng et al. 2021; MACPAC 2020; Smith, Waidmann, and Caswell 2021; Fretwell et al. 2015; Segelman et al. 2014; Ghosh, Orfield, and Schmitz 2014; Ghosh, Schmitz, and Brown 2015; Meunier 2016).
  - » However, PACE enrollment remains very low, covering about 56,000 Medicare beneficiaries in 2023. Low enrollment may be related to PACE start-up costs, state and federal restrictions on establishing new PACE programs or expanding existing programs, and the need for beneficiaries to switch to a primary care provider affiliated with the PACE program upon enrollment.
- The DUALS Act would expand access to PACE by making it a required Medicaid program in all states, removing the requirement that beneficiaries be 55 or older to enter, and removing several restrictions on PACE development and expansion.1 The DUALS Act does not include any changes to the PACE payment system, however.
- Medicare payments to PACE programs to provide Part A and B services vary widely nationwide and within states. For example, PACE programs in Miami-Dade County, Florida, were paid $1,831 per member per month (PMPM) to provide Medicare Part A and B services in 2021, compared with $1,356 in neighboring Broward County, a difference of 35 percent. Such large differences in payments are driven partly by large differences in traditional Medicare spending and service use across counties that do not appear to be related to differences in the underlying costs of providing care (MedPAC 2017).
  - » The ACA changed the MA benchmark system to reduce MA benchmarks across the country, but PACE was exempt from these changes.
- In 2011, before the implementation of ACA changes to MA benchmarks, Medicare payments to PACE programs were roughly equal to Medicare payments to D-SNPs in the 83 counties that had both options available. By 2021, Medicare paid PACE programs 20 percent more than D-SNPs in the same counties before risk adjustment. This suggests that PACE programs have benefited financially from being exempt from ACA reductions in MA benchmarks.
- Part D payments to PACE programs also exceed those to SNPs, but the gap narrowed between 2011 and 2021.
  - » Part D data shows that, while PACE enrollees have higher average risk scores than SNP enrollees, SNP and PACE enrollees look more similar in 2021 than in 2011.

Overall, our findings suggest that refinements to the PACE payment system are needed to align Medicare Parts A and B payments with other capitated programs like MA. Such payment changes

should be accompanied by additional research and data collection focused on the PACE program. Policy changes to consider based on the evidence include the following:

- align PACE Medicare payment benchmarks with the ACA-created benchmarks for MA plans (MedPAC 2012)
- apply medical loss ratio requirements to PACE programs and consider developing a PACE bidding system similar to the MA bidding system to promote high-value care
- assess state variations in PACE Medicaid payments to ensure payment accuracy and adequacy to support the PACE model
- collect and report data on PACE financial performance and care quality
- conduct further research to explore risk adjustment coding intensity in PACE programs to determine whether incentives to code as many diagnoses as possible that lead to overpayment in MA also affect PACE payment

What Is PACE and How Does It Differ from Other Medicare–Medicaid Integrated Care Programs?

PACE provides all-inclusive care, including medical, prescription drug, and long-term care for high-need beneficiaries enrolled in Medicare, Medicaid, or both. PACE programs must provide Medicare Parts A, B, and D benefits and Medicaid benefits, including home and community-based services and other long-term care supports. These provider-led programs receive capitated payments from Medicare and/or Medicaid and are at full risk for all Medicare Part A and B covered services. This payment structure allows them to provide items and services beneficiaries need that would not normally be covered by Medicare or Medicaid, including interventions intended to address health-related social needs.

Most PACE participants are dually enrolled in Medicare and Medicaid and receive all PACE services without any premiums, cost sharing, or deductibles. Although PACE is open to enrolling Medicaid- or Medicare-only beneficiaries, those beneficiaries must pay a high premium to cover the costs of the program they are not enrolled in, which is prohibitive for most (NPA 2023). Although many duals receive fragmented care because of their coverage through two separate programs, PACE programs integrate Medicare and Medicaid benefits into one package, including medical care and long-term care services and supports.

PACE allows participating providers and programs to blend capitated payments from Medicare and Medicaid to offer all-inclusive, integrated care to enrollees. The PACE model emphasizes the use of day care centers that offer primary care, therapy services, meals, social services, and transportation, among other services, to PACE enrollees. Beneficiaries' PACE center visit frequency depends on the recommendations of the comprehensive care team and each beneficiary's preferences.[2]

Other models of integrated Medicare and Medicaid services for duals do not necessarily fully integrate funding and benefits from both Medicare and Medicaid. Medicare D-SNPs generally offer only basic coordination with Medicaid benefits and do not cover Medicaid-only benefits like long-term care services and supports directly as part of the plan (MACPAC 2020). A specific type of D-SNP called a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) is required to have contracts with both Medicare and state Medicaid programs to offer Medicare and Medicaid benefits under a single managed care plan, including long-term care services and supports. However, FIDE-SNPs are only available in 12 states (MACPAC 2023), and enrollment is quite low compared with D-SNPs (MedPAC 2022). In contrast to PACE, D-SNPs and FIDE-SNPs also generally operate more like traditional managed care plans where patients select their providers from within their managed care plan's network.

Although the PACE model differs from the D-SNP model of care for duals, D-SNPs still offer an important point of comparison for PACE payment and outcomes since the programs have many similarities. Researchers and oversight bodies have frequently compared PACE outcomes to D-SNP outcomes and other state-led integrated care models (MACPAC 2020; Smith, Waidmann, and Caswell 2021). Additionally, D-SNPs and PACE draw from a similar population of dually enrolled Medicare and Medicaid beneficiaries and offer those beneficiaries an alternative to coordinating their Medicare and Medicaid benefits themselves.

Evaluations of PACE have generally found lower rates of hospitalization than in traditional Medicare or other integrated care programs like D-SNPs (Feng et al. 2021; MACPAC 2020; Smith, Waidmann, and Caswell 2021; Fretwell et al. 2015; Segelman et al. 2014). Findings on nursing home use and mortality are more mixed, but more recent studies tend to find lower nursing home use and lower mortality for PACE enrollees compared with enrollees in D-SNPs and other integrated care programs for duals (Segelman et al. 2017; MACPAC 2020; Smith, Waidmann, and Caswell 2021; Ghosh, Orfield, and Schmitz 2014; Ghosh, Schmitz, and Brown 2015; Feng et al. 2021). A study of patients disenrolled from PACE because of a PACE program closure found higher patient and caregiver satisfaction in PACE relative to non-PACE care after the closure (Meunier et al. 2016). However, these studies did not examine how payments to PACE plans compare with payments for other Medicare and Medicaid integrated care programs.

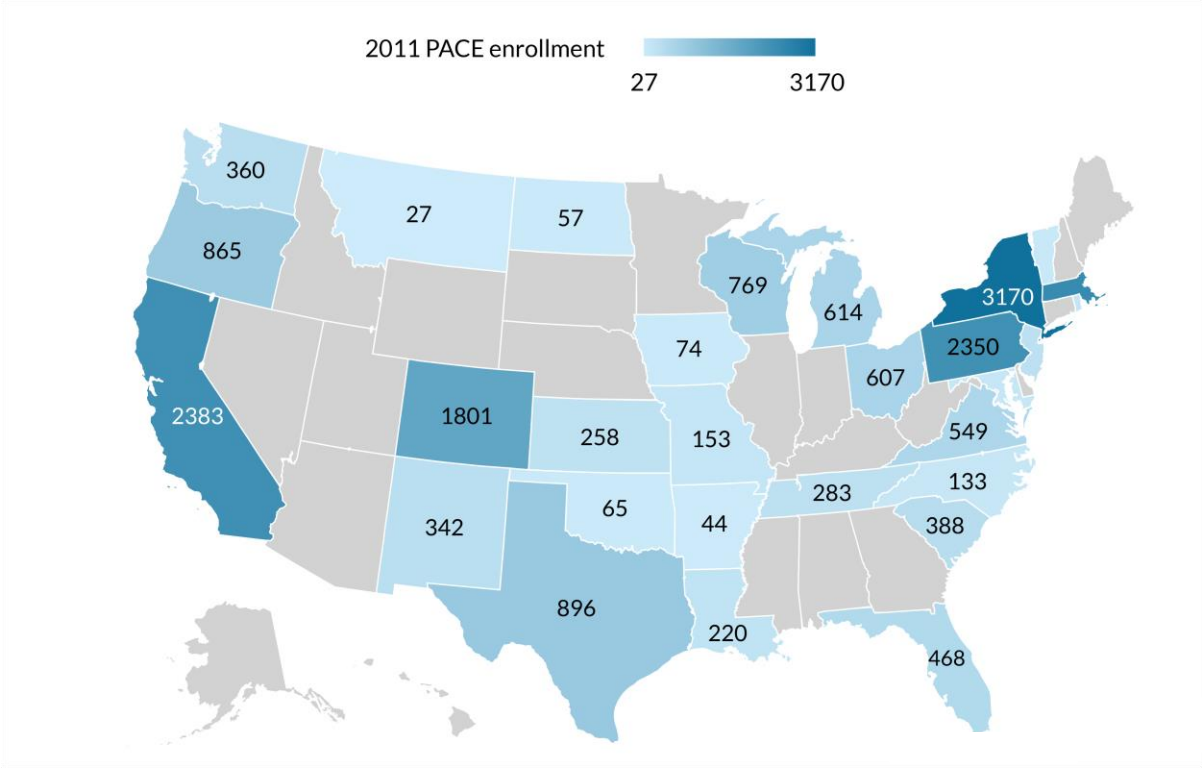
Where Is PACE Enrollment Concentrated, and How Has It Changed?

In June 2011, there were 20,049 PACE enrollees in 119 counties in the US.[3] By June 2023, there were 56,114 enrollees in 315 counties, according to data published by the Centers for Medicare and Medicaid Services (CMS).[4] Over the 2011–2023 period, PACE enrollment grew from 2,383 in California to 13,295 (figures 1 and 2), and by 2023, Los Angeles had the largest PACE population of any county in the US with 3,387 enrollees. Only 13 states had more than 1,000 PACE enrollees in 2023, including

California, Colorado, Florida, Massachusetts, Michigan, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Texas, Virginia, and Washington.

FIGURE 1

PACE Enrollment by State, June 2011



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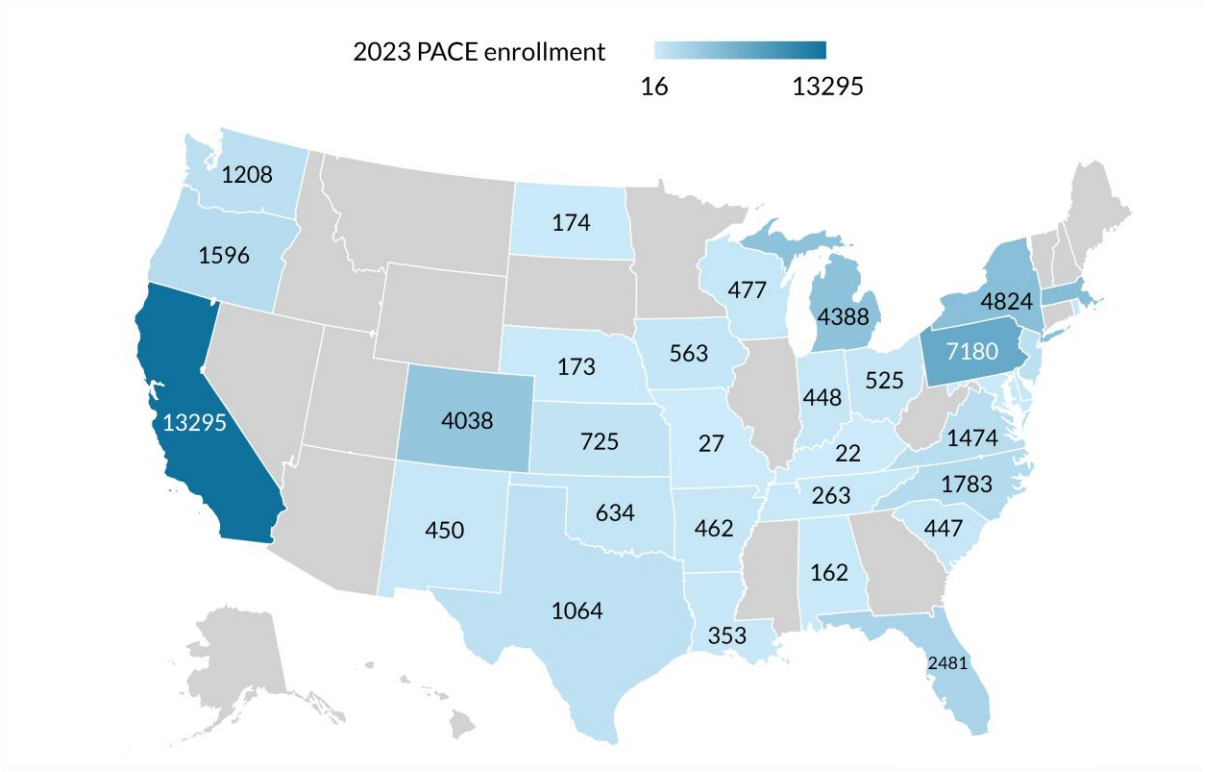
Source: Data are from CMS enrollment files by state, county, and contract for June 2023. Note that CMS suppresses county/contract observations with fewer than 12 enrollees. See "Medicare Advantage/Part D Contract and Enrollment Data," CMS.gov, accessed June 10, 2024.

Notes: PACE = Program of All-Inclusive Care for the Elderly.

FIGURE 2

PACE Enrollment by State, June 2023



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Source: Data from Centers for Medicare and Medicaid Services (CMS) state/county/contract enrollment files for June 2023. See "Medicare Advantage/Part D Contract and Enrollment Data," CMS.gov, accessed June 10, 2024.
Notes: PACE = Program of All-Inclusive Care for the Elderly.

The expansion of PACE availability and enrollment over the 2011–2023 period may be partly related to the growth of for-profit PACE organizations. In 2019, CMS finalized a rule removing the requirement that nonprofit organizations run PACE programs (CMS 2019). Before this rule change, for-profit plans in PACE were allowed as part of a demonstration program, and for-profit PACE participation grew after an evaluation commissioned by CMS showed very little difference in outcomes between nonprofit and for-profit PACE organizations (Jones et al. 2013). However, despite enrollment nearly tripling between 2011 and 2023, PACE remains a very small part of the Medicare program across all the areas in which it operates. For example, there were 5 million Medicare-only beneficiaries and 1.6 million duals in California in 2023,[5] but only about 13,000 PACE enrollees.

The need to establish a physician-staffed PACE center leads to high start-up costs for PACE programs (MACPAC 2023). Additionally, the focus on team-based care within the PACE center may be a limiting factor for PACE enrollment, as PACE enrollees must switch to a primary care provider associated with the PACE program (Foster, Schmitz, and Kemper 2007; Ghosh, Schmitz, and Brown

2015). The high start-up costs and low PACE enrollment may be self-reinforcing, making it difficult to develop economies of scale or greatly expand access.

How Does the PACE Payment System Work?

PACE programs receive a blend of capitated payments from Medicare Parts A, B, and D, and state Medicaid agencies. PACE programs can use these payments to cover the services beneficiaries need, including services that may not be generally covered under Medicare. Under the capitation model, PACE programs are at risk for meeting beneficiaries' needs within the amounts set by Medicare and Medicaid, though Medicare payments are risk adjusted to reflect the population's health care needs. In many states, Medicaid payments are not risk adjusted and instead are based on a share of the average amount the Medicaid program would have otherwise spent on a patient in a nursing home.[6]

For Medicare Part A and B services, PACE programs are paid based on a benchmark system similar to that for MA plans. CMS sets a PACE benchmark for each county based on traditional Medicare spending in that county. However, there are two major differences between PACE and MA payments. First, PACE programs do not need to submit a bid to CMS that reflects an estimate of their expected costs of providing care. Instead, all PACE programs receive the benchmark amount in the counties where they operate. Second, the benchmark calculations differ between PACE and MA. PACE was not subject to the benchmark changes included in the ACA, which generally reduced MA benchmarks while providing bonus opportunities for high-quality MA plans. Instead, PACE continues to rely on the pre-ACA benchmarking system, and PACE programs are not eligible for quality bonuses made to MA plans.

The benchmark amounts paid to PACE programs are risk adjusted using CMS' diagnosis-based risk adjustment system, which also applies to MA plans. However, PACE risk scores also receive a frailty adjustment, which generally increases them beyond the scores that would have been achieved based only on diagnoses. This frailty adjustment is intended to capture the greater functional limitations and higher severity of health care needs in the PACE population.[7]

Unlike Medicare Parts A and B, PACE plans must submit a bid to provide Part D benefits to their enrollees. Because PACE programs may not charge any cost sharing for prescription drugs, PACE Part D bids tend to be much higher than standard Part D bids or bids for Part D coverage integrated into SNP plans. For dually enrolled beneficiaries, PACE programs receive supplemental payments beyond those available to other Part D plans that cover duals to account for higher premiums and no cost sharing in PACE Part D plans.

Currently, PACE enrollees must use their PACE program's Part D plan. PACE Part D bids tend to be much higher than typical Part D plans because PACE programs cannot charge any cost sharing for Part D. For most beneficiaries, Medicaid covers the Part D premium, so the higher PACE Part D bids do not directly affect them. However, for PACE users who are not Medicaid-eligible, the requirement to enroll only in their PACE programs' Part D plan leads to significantly increased costs over enrolling in a typical Part D plan with cost sharing. The DUALS Act would change this approach, allowing PACE enrollees

who are not eligible for Medicaid the option to maintain a standard Part D plan as an alternative to the PACE Part D plan.

Finally, PACE programs also receive capitated payments from Medicaid. State Medicaid agencies contract with PACE programs to provide Medicaid services to dual enrollees for a lump sum capitation payment. States must set PACE capitation rates that are less than what the state would have otherwise paid for nursing homes and other care (CMS 2015). These state Medicaid payments vary widely, and many states do not provide public data on them. It is also unclear how comparable payment data are across states. From the states with readily available public data, we found that payments varied from a high of a $8,279 lower-bound PMPM payment for a full dual in San Francisco in 2022[8] to a low of $2,737 PMPM for a full dual in Oklahoma in 2023/2024 (table 1).[9] Because of a lack of comparable public data across states, we focus most of our analysis on Medicare payments rather than Medicaid payments.

TABLE 1

Publicly Reported State Medicaid Payments to PACE Organizations, 2022–2024

State	County	PACE PMPM Medicaid Payment	Notes
California	Alameda	$6,238	Lower-bound dual rate for 2022
California	Contra Costa	$6,027	Lower-bound dual rate for 2022
California	El Dorado	$5,143	Lower-bound dual rate for 2022
California	Fresno	$4,126	Lower-bound dual rate for 2022
California	Humboldt	$5,528	Lower-bound dual rate for 2022
California	Kern	$4,690	Lower-bound dual rate for 2022
California	Kings	$4,583	Lower-bound dual rate for 2022
California	Los Angeles	$4,685	Lower-bound dual rate for 2022
California	Madera	$4,583	Lower-bound dual rate for 2022
California	Orange	$4,201	Lower-bound dual rate for 2022
California	Placer	$5,143	Lower-bound dual rate for 2022
California	Riverside	$4,106	Lower-bound dual rate for 2022
California	Sacramento	$5,421	Lower-bound dual rate for 2022
California	San Bernardino	$4,106	Lower-bound dual rate for 2022
California	San Diego	$4,301	Lower-bound dual rate for 2022
California	San Francisco	$8,218	Lower-bound dual rate for 2022
California	San Joaquin	$5,422	Lower-bound dual rate for 2022
California	Santa Clara	$6,289	Lower-bound dual rate for 2022
California	Stanislaus	$5,562	Lower-bound dual rate for 2022
California	Sutter	$5,143	Lower-bound dual rate for 2022
California	Tulare	$4,636	Lower-bound dual rate for 2022
California	Yuba	$5,143	Lower-bound dual rate for 2022
Maryland	Baltimore	$3,832	Duals 65+ rate for 2021
New Jersey	Statewide	$4,689	Dual rate for 2022
Oklahoma	Statewide	$2,737	Dual rate for 2023/2024
Texas	El Paso	$2,882	Dual rate for 2021
Texas	Lubbock	$3,144	Dual rate for 2021
Texas	Potter	$2,916	Dual rate for 2021
Texas	Randall	$2,916	Dual rate for 2021
Virginia	Central	$4,760	Dual rate for 2022
Virginia	Charlottesville/Western	$4,597	Dual rate for 2022
Virginia	Northern/Winchester	$5,846	Dual rate for 2022

State	County	PACE PMPM Medicaid Payment	Notes
Virginia	Roanoke/Alleghany	$4,854	Dual rate for 2022
Virginia	Southwest	$4,662	Dual rate for 2022
Virginia	Tidewater	$4,839	Dual rate for 2022
Wisconsin	Statewide	$4,501	PACE capitation rate for 2024

Source: California: "Program of All-Inclusive Care for the Elderly (PACE) Rates," HealthData.gov, accessed June 13, 2024; Maryland: "PACE Expansion Data Book—September 2021," Maryland Department of Health, accessed June 13, 2024; New Jersey: "New Jersey Department of Human Services—Division of Aging Services Programs of All-Inclusive Care for the Elderly (PACE) Application for New PACE Programs," NJ.gov, accessed June 13, 2024; Oklahoma: "Program of All-Inclusive Care for the Elderly (PACE) Fast Facts, September 2023," Oklahoma Health Care Authority, accessed June 10, 2024; Texas: Cecile Erwin Young, *Texas PACE Rating Report*, Texas Health and Human Services, July 9, 2021; Virginia: Mercer, *Fiscal Year 2022 Program of All-Inclusive Care for the Elderly Upper Payment Limits and Capitation Rate Report*, Commonwealth of Virginia, May 27, 2021; and Wisconsin Michael Cook and Briana Botros, *State of Wisconsin: Department of Health Services Calendar Year 2024 Capitation Rate Development PACE Program*, (Brookfield, WI: Milliman, November 14, 2023).
Notes: PACE = Program of All-Inclusive Care for the Elderly; PMPM = per member per month. Payment amounts across states may not be directly comparable because of differences in risk adjustment, data years, and other state policy differences. Except for Wisconsin, all state capitation rates are for full duals.

Research has generally shown that PACE has no net effect on Medicare spending, though this work was conducted before the ACA (Ghosh, Schmitz, and Brown 2015). Research on the effects of PACE on Medicaid spending finds mixed results, with some studies showing increased Medicaid spending under PACE (Ghosh, Schmitz, and Brown 2015; Foster, Schmitz, and Kemper 2007), while other studies find net Medicaid savings from PACE programs (Wieland et al. 2013). These differences in results appear to be at least partially related to how the comparison population is defined. The portion of the comparison group receiving full-time nursing-home care in Medicaid versus home and community-based waiver services substantially affects savings estimates for PACE. For example, researchers developed a matched comparison group that was 56 percent home and community-based services and 44 percent nursing home and found substantial savings for PACE (Wieland et al. 2013). Others found that at least 27 percent of PACE enrollees would have to go directly to a nursing home for PACE to produce Medicaid savings (Foster, Schmitz, and Kemper 2007). Medicaid savings also may vary by state, as state Medicaid payments to PACE programs and nursing home costs can vary substantially (Ghosh, Schmitz, and Brown 2015).

How Would the DUALS Act Change PACE?

The DUALS Act was introduced in the Senate on March 14, 2024, and referred to the Senate Finance Committee for consideration.[10] If enacted, the DUALS Act would make several changes to the PACE program to expand the model, including the following:

- removing the requirement that beneficiaries be aged 55 or over to enroll, allowing younger beneficiaries to access PACE programs
- making PACE a required Medicaid benefit for all states and requiring states to remove restrictions on PACE program development and enrollment

- allowing beneficiaries to enroll in PACE at any time and establish payment amounts for partial-month enrollees
- removing enrollment limits and quarterly and geographic limits on PACE organization applications
- allowing Medicare-only PACE enrollees to choose their own Part D plan rather than be required to enroll in the PACE Part D plan

The proposed DUALS Act does not currently include changes to the Medicare and Medicaid payment systems for PACE. It remains an open question whether expansion of PACE would cost or save the Medicare and Medicaid programs money, and the Congressional Budget Act has not provided a cost estimate for the legislation. In the next section, we explore how PACE Medicare payment compares to that for D-SNPs as a first step toward examining whether the PACE payment system updates may be needed to support PACE expansion.

How Do Medicare Payments to PACE Differ from Those to D-SNPs?

Data and Methods

We compare Medicare Part A and B payments to PACE programs with Medicare Part A and B payments to D-SNP plans in the same local areas. We focus our comparison on D-SNPs because they serve a similar lower-income, high-need population of dual-enrollees but were subject to ACA changes to benchmarks. We note that D-SNP enrollees do not need to meet the PACE eligibility standards and are likely healthier, on average, than PACE enrollees. Although PACE enrollees may have higher health care needs or use more Medicare services than D-SNP enrollees, such additional costs would be expected to be covered by risk adjustment payments. We therefore focus our analysis on payments before risk adjustment to ensure comparability across the two plan types.

To compare Part A and B payments, we use data on plan payments for D-SNPs from CMS, including rebates and CMS-published PACE benchmarks in each county.[11] We compare PACE and D-SNP payments in 2021, the most recent year of D-SNP payment data available, and we also assess changes in payment over the 2011–2021 period. In 2011, both PACE programs and D-SNPs were subject to the pre-ACA payment benchmarks, while by 2021, the benchmark changes for D-SNPs were fully phased in. For comparisons, we focus on the 83 counties with both PACE and D-SNPs in 2011 and 2021 to reduce the effects of rapid PACE and D-SNP growth on our analysis. These 83 counties enrolled about 20 percent of all Medicare beneficiaries in 2011 and 2021.

Finally, we compare CMS data on Part D payments and risk scores between PACE programs and SNPs. [12] The Part D data does not allow differentiation between D-SNPs and other types of SNPs.

However, we note that D-SNPs are the most popular SNPs, covering 5.2 million of the 5.7 million SNP enrollees in 2023.[13]

Part A and B Payments

Between 2011 and 2021, Medicare Part A and B PMPM payments to PACE programs grew 34.5 percent in the 83 counties that had both PACE and D-SNP enrollment in the study years (table 2 and table A.1).[14] In comparison, D-SNP payments, including rebates, grew 14.5 percent over this same period. In 2011, PACE programs were paid about 2 percent more than D-SNPs across the 83 study counties ($868.50 for PACE versus $848.55 for D-SNPs). By 2021, PACE programs were paid 20 percent more than D-SNPs in the same areas ($1,168.15 for PACE versus $971.91 for D-SNPs).

TABLE 2

Average Medicare Parts A and B Per Member, Per Month Payments to PACE Programs and D-SNP Plans, 2011–2021

	2011	2021	Percent change, 2011–2021
PACE PMPM payment before risk adjustment	$868.50	$1,168.15	34.5%
D-SNP PMPM payment before risk adjustment	$848.55	$971.91	14.5%
PACE to D-SNP Payment Ratio	1.02	1.20	

Source: PACE payments are from CMS ratebooks, 2011 and 2021, see "Plan Payment Data," CMS.gov, accessed June 10, 2024. D-SNP payment data are from CMS plan payment data for 2011 and 2021 and include both A and B payments and rebates, see "Ratebooks & Supporting Data," CMS.gov, accessed June 10, 2024.
Notes: PACE = Program of All-Inclusive Care for the Elderly; D-SNP = Dual Eligible Special Needs Plans; PMPM = per member, per month. Estimates include only the 83 counties for which PACE and D-SNP data were available in 2011 and 2021. Estimates are unweighted across those 83 counties. For a full list of counties, see online appendix table 1. These counties represented about 20 percent of Medicare enrollees in 2011 and 2021 (21.1 percent in 2011 and 20.5 percent in 2021).

In 2021, PACE payments for Medicare Parts A and B services varied substantially across the country, including within states (table A.2). For example, PACE programs in Miami-Dade County, Florida, were paid $1,831 PMPM before risk adjustment in 2021, compared with $1,356 in neighboring Broward County, a difference of 35 percent. In contrast, D-SNP payments were quite similar between Miami-Dade and Broward Counties in 2021 ($1,039.09 and $1,019.34, respectively), as were the maximum D-SNP benchmarks ($1,096.79 and $1,068.02, respectively). Across the 267 counties with PACE enrollment in 2021, the PACE-to-D-SNP payment ratio varied from a low of 1.0 in McPherson, Kansas, to 1.76 in Miami-Dade, Florida. Overall, in the 267 counties with PACE, PACE PMPM payments for Parts A and B services ranged from a low of $892.35 in Isabella County, Michigan, to a high of $1,820.66 in Miami-Dade, a nearly $1,000 difference. In contrast, D-SNP payments ranged from a low of $838.87 in Valencia, New Mexico, to a high of $1,211.95 in Baltimore City, Maryland, a difference of about $400.

Overall, in the 267 counties with both PACE and D-SNP enrollment in 2021, average payments to PACE programs were $1,162.88, compared with $985.24 for D-SNPs (both weighted by county-level

enrollment in the respective program, see table 4). As noted above, these averages obscure significant variation in PACE payments relative to D-SNP payments across the country. Because the ACA changes to MA benchmarks generally served to lower MA benchmarks across the country (Guterman, Skopec, and Zuckerman 2018), excluding PACE from those changes has allowed PACE payment to grow more quickly than D-SNP payment. In addition, the ACA changes to MA benchmarks reduced variation in MA payment across the country (Guterman, Skopec, and Zuckerman 2018), but large variations in PACE payments persist. Research on regional variation in traditional Medicare spending suggests that these large differences in payment by county are unlikely to be related to underlying cost differences (MedPAC 2017).

TABLE 4

Average Medicare Parts A and B Payments to PACE and D-SNPs in 2021

	PACE payments	D-SNP payments (including rebates)
Weighted Average Spending, 2021	$1,162.88	$985.24
Unweighted Average Spending, 2021	$1,102.88	$957.86

Source: PACE payments are from CMS ratebooks, 2021 see "Plan Payment Data," CMS.gov, accessed June 10, 2024. PACE and SNP enrollment data are from CMS State-County-Contract enrollment files for June 2021, see "Medicare Advantage/Part D Contract and Enrollment Data," CMS.gov, accessed June 10, 2024. D-SNP payment data are from CMS plan payment data for 2021 and include both A and B payments and rebates, see "Ratebooks & Supporting Data," CMS.gov, accessed June 10, 2024.
Notes: PACE = Program of All-Inclusive Care for the Elderly; D-SNP = Dual Eligible Special Needs Plans. Includes only the 267 counties with nonzero PACE and D-SNP enrollment in 2021. All payments are per member per month. Weighted rows are weighted by county-level PACE enrollment. Unweighted rows show a straight average across the 267 counties. For a complete list of counties, see table A.2.

Part D Payments

PACE programs are required to submit a bid to provide Part D coverage to enrollees. PACE Part D coverage differs from Part D coverage in MA and SNP plans because PACE must cover all prescription drugs without copayments, even for nonduals (though nonduals must pay premiums). PACE programs receive extra low-income subsidy payments to cover their premiums and the additional costs of not charging copayments or deductibles for prescription drugs. Because PACE enrollees do not pay cost sharing for services, PACE Part D plans are not eligible for drug discounts designed to reduce consumer cost sharing in the Part D coverage gap.

In 2011, for the 87 counties with PACE and SNP Part D payment data, Part D payments to PACE programs were about 60 percent higher than Part D payments to SNP plans with integrated drug coverage (table 5). PACE Part D payments were higher across all federal payment categories, including direct subsidies, reinsurance, and payments for low-income cost-sharing support. By 2021, Part D payments to PACE programs were 48 percent higher than payments to SNPs. Over the 2011 to 2021 period, Part D direct subsidy payments to SNPs fell substantially because of falling premiums. Still, reinsurance and low-income cost-sharing payments grew faster in SNPs than in PACE, offsetting the reductions in direct subsidies.

TABLE 5

Part D Payments to PACE and SNP Plans in 87 Counties, 2011–2021

	2011				2021			
	Direct subsidy	Reinsurance payment	Low-income cost-sharing payment	Total	Direct subsidy	Reinsurance payment	Part D low-income cost-sharing payment	Total
PACE	$96.58	$ 107.64	$231.48	$435.70	$97.84	$ 196.88	$288.55	$583.27
SNP	$62.34	$68.82	$141.03	$272.19	$22.62	$ 182.65	$190.06	$395.33
PACE-to-SNP ratio	1.55	1.56	1.64	1.60	4.33	1.08	1.52	1.48

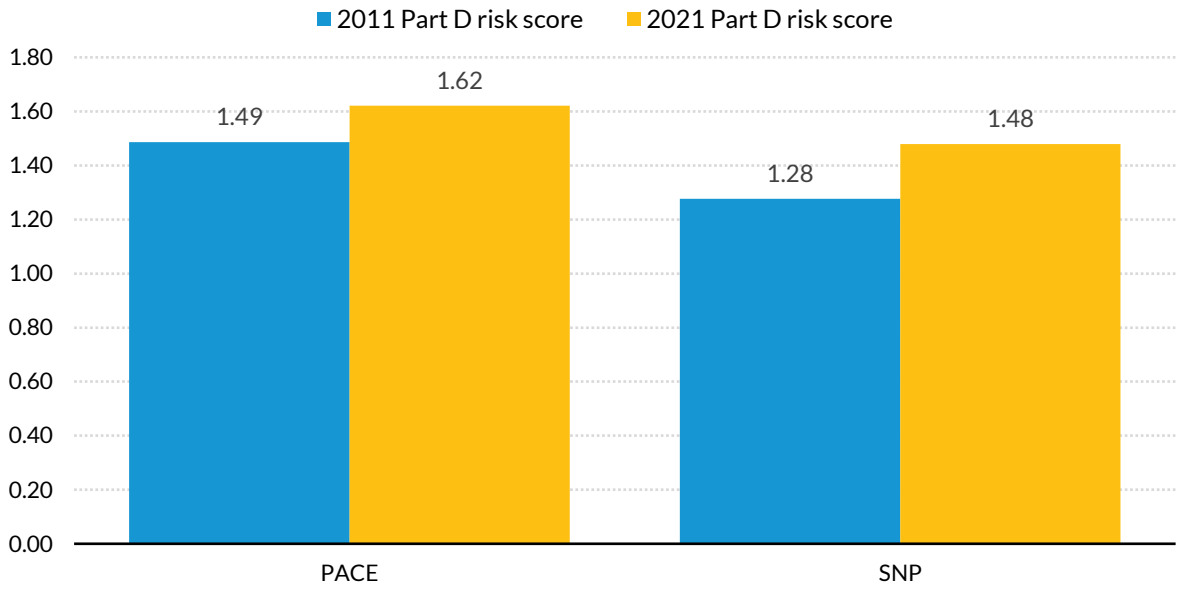
Source: CMS Part D payment data for 2011 and 2021, see "Ratebooks & Supporting Data," CMS.gov, accessed June 10, 2024.
Notes: PACE = Program of All-Inclusive Care for the Elderly; SNP = Special Needs Plans. The CMS data does not allow for differentiation between D-SNPs and other SNP plans. Estimates are limited to the 87 counties for which SNP and PACE data were available in 2011 and 2021. Within counties, estimates are weighted by enrollment. Across counties, estimates are unweighted.

Figure 2 shows changes in Part D risk scores between 2011 and 2021 for PACE and SNP plans. Part A and B risk score data are not available for PACE programs, so Part D risk scores provide important insight into how the health status of PACE enrollees differs from that of SNP enrollees. However, Part D risk scores are limited to the conditions for which enrollees take prescription medication, which may not offer a full picture of patient risk.

In 2011, the average risk score for PACE Part D enrollees was 1.49, compared with 1.28 for SNP Part D plans, a difference of 0.21 (figure 2). Risk scores for PACE and SNP Part D plans grew over 2011–2021, potentially reflecting broader enrollment. By 2021, the average PACE Part D risk score was 1.62, compared with 1.48 for SNPs, a difference of 0.14. These differences in Part D risk scores indicate that PACE enrollees likely have higher health care needs—and utilization—than SNP enrollees, but the gap has narrowed. However, such differences should be accounted for in risk adjustment and, therefore, should not affect the Part A, B, and D payments examined here, which do not include risk adjustment payments.

FIGURE 2

Part D Risk Scores for PACE Programs versus SNP Plans, 2011–2021



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Source: CMS Part D payment data, 2011 and 2021, see "Ratebooks & Supporting Data," CMS.gov, accessed June 10, 2024.
Notes: PACE = Program of All-Inclusive Care for the Elderly; SNP = Special Needs Plan. Estimates only include the 87 counties for which PACE and SNP data were available in 2011 and 2021. Across counties, estimates are unweighted. Within counties, estimates are weighted by plan enrollment. Part D data does not allow the separation of D-SNPs from other SNP plan types.

Considerations for the PACE Payment System

The PACE program has been widely praised as a strong integrated care model that successfully reduces hospitalizations and potentially undesirable health care use among its enrollees. However, little attention has been paid to the PACE payment system, likely because PACE has remained a small program. However, private equity has shown increasing interest in acquiring PACE programs (Gonzalez 2020),[15] suggesting that payment is more than adequate to support profitability. Additionally, the DUALS Act seeks to significantly expand PACE enrollment. The MA experience shows that it is very difficult to claw back overpayment once a program becomes popular, so it is critical to identify potential issues in PACE payment and address them to prevent payment problems from becoming entrenched as the program expands. We, therefore, explored how Medicare payments to PACE differ from Medicare payments to D-SNPs, another managed care program focused on serving duals.

Overall, in 2021, PACE plans were paid 20 percent more than D-SNPs for a risk-neutral Medicare enrollee to cover Part A and B services. This ratio has grown as D-SNP benchmarks were reduced under the ACA. The exemption of PACE from those benchmark reductions, which also made MA payment less variable across the country, has led to extreme variation in PACE payment that does not appear to have any relationship to underlying differences in health care costs.

MedPAC has recommended paying PACE programs the current post-ACA MA benchmarks and incorporating a quality bonus payment system to mirror that in MA (MedPAC 2012). Our results show that such an approach could substantially lower Part A and B payments to PACE programs and rationalize payment across the counties. Other MA policies designed to improve the value of the Medicare program could also be applied to PACE. For example, MA plans are required to have a medical loss ratio of 85 percent or more, meaning plans must spend at least 85 percent of their premium and Medicare revenue on health care claims and related expenses. PACE programs are currently exempt from this requirement, but as the program expands, medical loss ratio requirements could be an important tool to ensure growth benefits beneficiaries and the Medicare program. Similarly, PACE is currently exempt from the MA bidding system, meaning PACE programs do not have to develop a bid to offer coverage and instead are just paid the full benchmark amount. Future research should explore whether a bidding system in PACE could lead to better value for enrollees and taxpayers.

An expanded PACE program would also benefit from more transparency. PACE programs must submit financial data to the National Association of Insurance Commissioners and CMS, but that data is not made publicly available. CMS also does not publish PACE risk scores for Parts A and B, making it difficult to assess how much PACE programs may be paid through the risk-adjustment system. States also do not consistently make PACE payment data publicly available, so it is currently impossible to provide a complete picture of PACE payment. More transparent reporting from PACE programs, CMS, and states would allow stakeholders and researchers to track PACE payments and profitability and help CMS ensure payments are adequate to meet the unique costs of the PACE program.

Finally, additional research on utilization and outcomes in PACE programs could also help policymakers assess PACE expansion. PACE programs must submit claims and encounter data for Parts A, B, and D, but few studies have examined PACE utilization and outcomes, likely because of the program's small size. Investing in this research could help CMS and policymakers track the effects of PACE expansion and further assess the value of PACE relative to other integrated care programs for duals.

Notes

[1] US Congress, Senate, *DUALS Act of 2024*, S 3950, 118th Cong., 2nd sess., introduced in Senate March 14, 2024, https://www.congress.gov/bill/118th-congress/senate-bill/3950/text.

[2] "Chapter IV—Centers for Medicare & Medicaid Services, Department of Health and Human Services" *Code of Federal Regulations*, title 42, § 460.98 (2024), https://www.ecfr.gov/current/title-42/section-460.98.

[3] Data are from CMS enrollment files by state, county, and contract and plan for June 2011. Note that CMS suppresses county/contract observations with fewer than 12 enrollees. "Medicare Advantage/Part D Contract and Enrollment Data," CMS.gov, accessed June 10, 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data.

[4] Data are from CMS enrollment files by state, county, and contract for June 2023. Note that CMS suppresses county/contract observations with fewer than 12 enrollees. See "Medicare Advantage/Part D Contract and Enrollment Data," CMS.gov.

[5] "Office of Medicare Innovation and Integration," DHCS.CA.gov, accessed June 10, 2024, https://www.dhcs.ca.gov/services/Pages/OMII.aspx.

[6] Tom Stitt and Colin Higgins, "Understanding PACE Capitation and Funding Sources," *HDG Insights* (blog), July 14, 2021, https://healthdimensionsgroup.com/insights/blog/pace-funding/.

[7] FIDE-SNPs are also eligible to receive the frailty adjustment in the MA risk adjustment system.

[8] "Program of All-Inclusive Care for the Elderly (PACE) Rates," HealthData.gov, accessed June 10, 2024, https://healthdata.gov/State/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/3qny-sm35.

[9] "Program of All-Inclusive Care for the Elderly (PACE) Fast Facts, September 2023," Oklahoma Health Care Authority, accessed June 10, 2024.

[10] US Congress, Senate, *DUALS Act of 2024*, S 3950, 118th Cong., 2nd sess., introduced in Senate March 14, 2024, https://www.congress.gov/bill/118th-congress/senate-bill/3950/all-info

[11] "Ratebooks & Supporting Data," CMS.gov, accessed June 10, 2024, https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/ratebooks-supporting-data.

[12] Plan Payment Data," CMS.gov.

[13] "Medicare Advantage: Special Needs Plan (SNP) Enrollment, by SNP Type," *KFF*, accessed June 10, 2024, https://www.kff.org/medicare/state-indicator/snp-enrollment-by-snp-type/?currentTimeframe=0.

[14] Appendix tables are available online; see https://www.urban.org/research/publication/program-all-inclusive-care-elderly-pace-payment-system.

[15] Sarah Varney, "Private Equity Pursues Profits in Keeping the Elderly at Home," *The New York Times*, August 20, 2016, https://www.nytimes.com/2016/08/21/business/as-the-for-profit-world-moves-into-an-elder-care-program-some-worry.html.

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About the Author

Laura Skopec is a senior research associate in the Health Policy Center at the Urban Institute, where her research focuses on health insurance coverage, health care access, and health equity. Before joining Urban, she worked on Affordable Care Act implementation at the Office of the Assistant Secretary for Planning and Evaluation in the US Department of Health and Human Services and on transparency in health insurance and health care at the American Cancer Society Cancer Action Network. Skopec holds a BS in biopsychology and cognitive science from the University of Michigan and an MS in public policy and management from Carnegie Mellon University.

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500 L'Enfant Plaza SW
Washington, DC 20024
www.urban.org

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