Center for Health Care Strategies

Increasing Access to PACE: Stakeholder Perspectives on Key Barriers and Priority Actions

TAKEAWAYS

- The Program of All-Inclusive Care for the Elderly (PACE), an integrated Medicare and Medicaid care model for eligible older adults with complex care needs, currently serves a relatively small share of potentially eligible individuals nationwide.
- To identify opportunities to expand access to PACE, the Center for Health Care Strategies and the National PACE Association convened national experts, state regulators, PACE organizations, researchers, and funders in October 2025, with support from The John A. Hartford Foundation, West Health, and The Harry and Jeanette Weinberg Foundation.
- This meeting summary highlights four key areas of consensus that emerged during the convening and reflects participants' perspectives on the primary barriers to expanding access to PACE, along with priority actions identified by participants for states, policymakers, and other stakeholders.

As Medicaid budgets contract, states are seeking ways to better serve a particular subset of dually eligible individuals, such as people with dementia, whose complex needs and high care costs are not adequately addressed by more prevalent integrated care models. The Program of All-Inclusive Care for the Elderly (PACE) is one of the most highly integrated care models serving these high-need dually eligible populations, including individuals with dementia, rural residents, individuals who speak languages other than English, and those requiring integrated behavioral health care and long-term services and supports (LTSS). Compared with more prevalent integrated care models, PACE is associated with better outcomes and fewer emergency department visits and hospitalizations. Despite a 111 percent increase in enrollment between 2015 and 2025, PACE serves only one percent of the nation's 9.1 million full-benefit dually eligible individuals, leaving many of those with the greatest barriers and highest costs in models that may not meet their unique needs.

This meeting summary was co-authored by the Center for Health Care Strategies and the National PACE Association with support from The John A. Hartford Foundation.

To better understand opportunities for states to increase access to PACE — particularly for dually eligible individuals with complex needs, significant access challenges, and the highest care costs — the Center for Health Care Strategies and the National PACE Association, with support from The John A. Hartford Foundation, West Health, and The Harry and Jeanette Weinberg Foundation convened national experts, state regulators, PACE organizations (POs)*, researchers, and funders in October 2025. Through the convening, participants sought to identify key barriers to expanding access to PACE and actionable strategies to address them. This meeting summary highlights four key areas of consensus identified by participants during the convening and outlines meeting participants' priority actions for states, policymakers, and other stakeholders seeking to expand access to PACE for the highest-need older adults.

PACE At-a-Glance

- PACE is a community-based system of care that provides high-quality, interdisciplinary care for adults who are age 55 or older with complex medical, behavioral, and social needs. It is one of the few models that fully integrates medical care, long-term services and supports (LTSS), behavioral health care, and social support for older adults with high support needs, who may otherwise require nursing facility level of care.
- About 46 percent of PACE participants have some degree of dementia, and nearly 60 percent have at least one significant mental health disability. Enrollment in a fully integrated model improved outcomes for dually eligible individuals with dementia.
- PACE participants are less likely to be hospitalized and to visit the emergency department than dually eligible participants in Dual Eligible Special Needs Plans (D-SNPs) and fully integrated dual-eligible special needs plans (FIDE-SNPs).
- PACE is associated with reduced racial and ethnic disparities and improved outcomes for high-need dually eligible populations, including rural residents, individuals who speak languages other than English, and those requiring integrated behavioral health care and LTSS.
- Since 2015, PACE enrollment has increased by 111 percent, from 42,727 participants to 89,945 in 2025. Most dually eligible individuals are served outside of PACE, either in D-SNP plans, non–D-SNP Medicare Advantage (MA) plans, or fee-for-service arrangements.

* Throughout this paper, "PACE organization" (PO) is used as a general term encompassing both PACE organizations and PACE centers, except where a distinction is explicitly noted.

Key Barriers to PACE Access and Priority Actions to Address Them

Convening participants identified four areas of consensus and priorities for action to increase access to PACE for dually eligible individuals, particularly those with the most complex needs and highest care costs. These include: (1) reducing administrative and financial obstacles to starting or expanding POs; (2) expanding enrollment and eligibility; (3) advancing quality measurement and messaging; and (4) enhancing workforce and operational flexibility. Throughout the convening, participants emphasized the need to balance the highly localized and flexible nature of the PACE model with greater standardization, particularly in areas such as state oversight, quality measurement, and data collection, to support expansion to larger numbers of dually eligible individuals.

1. Reducing Administrative and Financial Obstacles to Starting or Expanding POs

Starting a PO requires the establishment of a three-way agreement between the state administering agency, the Centers for Medicare & Medicaid Services (CMS), and the PO, as well as completion of state procurement processes and applications to CMS and Medicare Part D. Convening participants identified several barriers in this process, including the inability to submit applications to CMS outside of one day per quarter, the inability to submit multiple applications at a time, and extended CMS review timelines. Participants also noted that new POs undergo several audits during the first three years of operation, which are sometimes duplicative and increase startup administrative costs. Variation in state oversight processes and data collection and reporting procedures, as well as a lack of coordination between federal and state PACE oversight activities were also noted as challenges for most stakeholders.

Participants also noted that the significant cost of launching a PO — generally around $8 million before Medicare and Medicaid reimbursement begins — can be a significant barrier. Due to the sizable upfront investment required to build and staff the PO without the opportunity to bill for services prior to CMS approval, new POs must carefully plan to secure financing, achieve reimbursement, and garner community support. In addition to startup costs, participants noted that reimbursement amounts via capitation rates vary based on state calculations of the amount that would have otherwise been paid (AWOP). Although states use different methods to determine the AWOP, it is generally based on the cost of care in nursing homes and other populations similar to PACE participants in the state. While states generally set a percentage of AWOP for reimbursement, some conduct a risk and utilization adjustment process, which may be subject to lags in data submission.

Action Items: Reduce Administrative and Financial Obstacles to Starting or Expanding POs

Convening participants identified the following priority actions:

Streamlining the PACE Application and Audit Processes

- ✓ **Develop a model PACE application process** that aligns requirements across states (to the extent possible) and streamlines state and CMS requirements.
- ✓ **Streamline CMS/state application cycles** for PACE, expand the CMS application windows, and implement more frequent CMS application cycles.
- ✓ **Reduce administrative burden associated with PACE audits** — particularly during trial periods — and refocus audits to prioritize outcomes, access to care, and participant experience.
  - Of note, the Medicaid and CHIP Payment and Access Commission (MACPAC) recently recommended that CMS "update audit protocols and three-way program agreements to facilitate joint audits of PACE organizations with state administering agencies."
- ✓ **Streamline PACE expansion processes** by creating an expedited process for existing POs with proven results.

Facilitating Payment, Financing, and Capital Access

- ✓ **Expand access to grants, low-cost capital, technical assistance, and education** on financing sources for nonprofit POs looking to develop or expand PACE.
  - Of note, $50 billion in funding is being provided to states through the Rural Health Transformation Program over five years. In each of their applications, Virginia, Pennsylvania, and Wisconsin indicated an interest in expanding integrated care options for dually eligible populations, and Pennsylvania specifically noted interest in expanding the PACE program.
- ✓ **Incentivize potential PACE investors** through tax credits to support expansion of PACE into new communities.
- ✓ **Expand transparency models** already used in some states to improve clarity in AWOP calculations and reduce financial uncertainty for new POs.
- ✓ **Implement risk adjustment** in all PACE programs to avoid penalizing programs serving higher-acuity or lower-income populations, and to accurately capture outcomes of PACE services and care relative to PACE enrollees' baseline status.

2. Expanding PACE Enrollment and Eligibility

To be eligible for PACE, individuals must be at least 55 years old, meet their state's nursing facility level of care (NFLOC) criteria, live within a PACE service area, and be able to "live safely" in the community at the time of enrollment. Eligibility is not limited to Medicare or Medicaid beneficiaries — individuals may qualify for either, both, or neither. Convening attendees noted that PACE enrollees with only Medicare coverage, or moderate-income older adults, may pay more for their PACE Part D plan due to high

Medicare Part D premiums. Participants also noted that while several state and federal mechanisms exist to facilitate enrollment of dually eligible individuals into D-SNPs, no comparable mechanisms exist for PACE. While private pay is an option, the cost and the NFLOC eligibility requirement can prevent POs from serving a growing population of older adults in the "forgotten middle" — those with care and support needs but who earn too much to qualify for government-subsidized services yet not enough to afford private options.

Action Items: Expand PACE Enrollment and Eligibility

Convening participants identified the following priority actions:

- ✓ **Increase access to standalone medication coverage plans** to enhance affordability of PACE for individuals with only Medicare coverage, or moderate-income older adults. Convening participants noted that Congress could do this by allowing individuals the choice of enrolling in a standalone Part D plan or participating in the PACE Part D plan.
- ✓ **Align PACE enrollment processes with features used in some D-SNP models**, such as expedited or presumptive clinical and functional eligibility and default enrollment, to facilitate access for dually eligible individuals with complex needs and high costs.
- ✓ **Expand the authority in Section 71121 of Public Law 119-21 (H.R. 1)**, which provides home- and community-based services (HCBS) to individuals who do not meet NFLOC requirements under Section 1915(c) of the Social Security Act, to include PACE programs.

3. Advancing Quality Measurement and Messaging

Research demonstrates that PACE is associated with reduced disparities for dually eligible populations. While evidence on PACE cost savings is mixed, some studies show that PACE can reduce higher-cost care, and generate potential savings of approximately $2,800 per month per enrollee compared to average nursing home costs. Research also shows high participant satisfaction, reflecting the model's holistic approach to care and flexibility in responding to enrollees' needs and preferences and its role in reducing isolation and loneliness among PACE-eligible populations.

Comparisons between PACE and other integrated models (including FIDE-SNPs and D-SNP/managed long-term services and supports (MLTSS) plans) could support PACE expansion, but convening participants agreed that this is challenging since PACE lacks a standardized, national quality measurement strategy, including risk stratification and alignment with other highly integrated models. Attendees representing state regulatory departments expressed a strong interest in accessing more encounter data for comparison purposes, POs noted the potential burden of collecting encounter data for comparison purposes without a claims-based encounter data system, and researchers noted they are pursuing hybrid solutions to enhance data reliability and validity. POs also expressed a desire to be measured on quality with metrics that reflect the holistic, interdisciplinary, and long-term nature of the model and not simply transactional, encounter-based processes.

Participants also discussed challenges in communicating the long-term value of PACE. As an integrated payment and care model that delivers medical, behavioral health, LTSS, and social support to older adults with complex needs, evidence more readily captures short-term outcomes, while longer-term impacts, such as supporting individuals to age in place over long periods of time, are more difficult to measure and track.

Action Items: Advance Quality Measurement and Messaging

Convening participants identified the following priority actions:

Investing in PACE Quality Measurement and Oversight

- ✓ **Develop a focused, meaningful set of nationally standardized PACE quality measures** with strong risk stratification and detailed measure specifications.
  - Measures could address, at a minimum: access and timeliness; functional status; participant experience; dementia care; caregiver benefit and burden; ability to age in place and/or rebalancing measures to indicate the shift in resource use from facilities toward HCBS; and end-of-life preferences and care.
  - Relatedly, MACPAC recently recommended development of "a standardized, national quality measure set for PACE organizations" along with publicly accessible performance data on this measure set, and "existing PACE program performance data, including data PACE organizations submit through the CMS Health Plan Management System (HPMS) as well as enrollee satisfaction data collected as part of PACE organization quality improvement programs pursuant to *42 CFR 460.134(a)(2).*"
- ✓ **Build a common national assessment dataset** to support outcome measurement and improvement over time and invest in enhanced PO data infrastructure.
- ✓ **Establish a clear set of accurate and reliable encounter data reporting requirements** aligned across states that require encounter data.

Messaging and Demonstrating the Value of PACE

- ✓ **Develop and disseminate comparative analyses of PACE and other integrated models,** including FIDE-SNP and D-SNP/MLTSS HCBS programs, using standardized quality metrics (such as Integrated Satisfaction Measurement for PACE, National Core Indicators – Aging and Disabilities, and HCBS-Consumer Assessment of Healthcare Providers and Systems data) and comparisons of administrative costs across models. Existing reports compare PACE, FIDE-SNPs, and D-SNPs to MA plans. Additional analyses can compare integrated models with each other and with MLTSS HCBS programs and assess long-term quality and cost outcomes.
- ✓ **Estimate long-term cost and outcome trajectories for PACE-eligible populations**, including both PACE-eligible individuals who are enrolled and those who are not, mapping AWOP and comparing long-term PACE costs and outcomes with FIDE-SNP and D-SNP/MLTSS programs.
- ✓ **Strengthen existing quantitative analyses with qualitative data** illustrating participant experience, quality of life, community integration, care integration that supports

participant well-being, reduced caregiver burden and increased benefit, and sustained, stable care for participants with complex medical, functional, and social needs.

4. Enhancing PACE Workforce and Operational Flexibility

POs must employ a full interdisciplinary team, including a primary care physician, 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 representative, and driver or representative. Workforce shortages across health care staff, particularly personal care staff and nurses, were identified as a significant barrier to PACE expansion. Convening participants also noted that challenges in attracting and retaining staff and serving a sufficient volume of program participants can particularly limit the viability of rural POs. Participants also discussed the greater costs associated with having to maintain full staffing prior to receiving final program approval due to the lack of federal deadlines for state readiness review and additional processes for state approvals.

Action Items: Enhance PACE Workforce and Operational Flexibility

Convening participants identified the following priority actions:

- ✓ **Develop a national PACE staffing rotation program** based on the model provided by some POs wherein clinical staff agree to work in a PO for a certain amount of time (e.g., one to three years) to gain exposure to the PACE model and provide care aligned with their licensure and scope of practice. Rotational programs support staffing of rural PACE centers while allowing staff to remain mobile.
- ✓ **Develop targeted incentives** for health care workers to relocate to rural areas.
- ✓ **Expand regulatory flexibility to adapt enrollment processes** and consider reinstating certain flexibilities introduced during the COVID-19 pandemic, such as telehealth and mobile service delivery.

Looking Ahead

As stakeholders seek opportunities to improve outcomes for dually eligible individuals, expanding access to PACE may offer a meaningful approach, particularly for serving those with the most complex needs and highest care costs. The four areas of consensus identified through the convening — reducing administrative and financial obstacles to starting or expanding POs and centers, expanding enrollment and eligibility, advancing quality measurement and messaging, and enhancing workforce and operational flexibility — offer a set of targeted actions that participants identified as having the potential to support PACE expansion. Participants emphasized that collaboration across stakeholders will be important to assess the feasibility and implementation of these strategies and to understand any potential impacts on access to care for dually eligible populations with complex needs.

Acknowledgements

Thank you to the following individuals who participated in the convening and helped inform this meeting summary:

- Shawn Bloom, National PACE Association
- Esiquio Casillas, MD, AltaMed Health Services
- Preston Choctaw, West Health
- Tyler Cromer, ATI Advisory
- Peter Fitzgerald, National PACE Association
- Jed Geyerhahn, Cambridge Health Alliance PACE
- Anita Gibson, National PACE Association
- Lisa Harootunian, Bipartisan Policy Center
- Jennie Chin Hansen, Hirsch and Associates, former CEO of On Lok
- Jennifer Heidmann, MD, Redwood Coast PACE
- Amy Sandy Herr, West Health
- Priscilla Ko, The Harry and Jeanette Weinberg Foundation
- Katherine Miller, Johns Hopkins Bloomberg School of Public Health
- Kevin Murphy, Division of Aging Services, New Jersey
- Mary Naber, PACE Southeast Michigan
- Francesca O'Reilly, National PACE Association
- Matt Patterson, MD, WelbeHealth
- Susan Philip, Health Care Delivery Systems, California Department of Health Care Services
- Eric Roberts, University of Pennsylvania Perelman School of Medicine
- Ramon Royster, National Cooperative Bank
- Tonya Saffer, National PACE Association
- Lisa Shugarman, NORC at the University of Chicago
- Erin Slabonik, Department of Human Services, Pennsylvania
- Lauren Solis, Office of Medicare Innovation and Integration, California
- Phyllis Sosa, Department for Aging and Independent Living, Kentucky
- Terrell Taylor, National Cooperative Bank
- Nancy Wexler, The John A. Hartford Foundation

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.