



Core Differences Between PACE and MA Plans

Programs of All-Inclusive Care for the Elderly (PACE®) and Medicare Advantage (MA) plans are both alternatives to the traditional fee-for-service Medicare benefit. While there are some similarities between PACE and MA, there are also fundamental differences. Understanding these differences is important for policy-makers and others so that changes intended for MA plans are not routinely applied to PACE, especially those that may be detrimental to the operational or financial viability of PACE.

The following are key distinctions between PACE and MA:

1. PACE and MA plans generally enroll different populations.

- PACE enrolls *only* the frailest Medicare beneficiaries, specifically those who meet state eligibility criteria for nursing home level of care and require comprehensive, ongoing and intensive services to meet their chronic health and long-term care needs. PACE organizations provide the frailest Medicare beneficiaries with access to a comprehensive and highly coordinated health care delivery system.
- MA plans typically enroll a general Medicare population. Within the MA program, Special Needs Plans (SNPs) focus on specific subsets of Medicare beneficiaries, including dual eligible beneficiaries with both Medicare and Medicaid, beneficiaries who meet institutional level-of-care requirements, and beneficiaries with specific types of chronic illness. Most SNPs are focused on dual eligibles, and – unlike PACE – most of these do not focus exclusively on beneficiaries with long-term care needs.

2. PACE and MA plans operate under separate statutory and regulatory authorities.

- Basic distinctions between PACE and MA are recognized in separate statutes and regulations governing the two plans. First and foremost, PACE organizations are health care providers, not large insurers like most MA plans. PACE organizations directly employ a broad range of health care providers – including physicians, nurses, therapists, health care aides and others – and must comply with extensive requirements related to the composition of the PACE interdisciplinary team and its role in assessment and care planning. A key element of these requirements is that the same providers are responsible for assessing program participants' care needs, developing and updating care plans, and providing care.
- MA plans generally consist of large networks of disparate providers. Plans process claims, collect information, make coverage determinations, and generally offer some level of care coordination. Decisions about coverage often are made by individuals who have no personal relationship with the beneficiary. Further, MA providers may be part of the same network but are not necessarily functioning in a coordinated system.
- For more than 30 years, the uniqueness of PACE has been recognized by Congress, both in legislation and extensive hearings. Initially, Congress authorized a demonstration program involving On Lok, a health care provider in San Francisco that became the prototype for the PACE model. The success of On Lok led to the authorization of a larger demonstration program involving multiple PACE sites and, eventually, Congressional recognition of PACE as a permanent Medicare and Medicaid provider.

3. PACE and MA plans do not provide the same benefit package.

- PACE is required to provide *all* Medicare and Medicaid covered benefits and additional medically necessary services. The explicit objective of PACE organizations is to develop patient-centered, comprehensive care plans that are not limited to Medicare services only but encompass the full range of medical and long-term care services required to maximize the health and well-being of program participants. PACE provides a comprehensive, interdisciplinary approach to care coordination and an effective use of outpatient and community-based services that lead to significant reductions in the utilization of inpatient care by participants. In turn, these inpatient savings are used to support care coordination and to expand both the range and intensity of community-based care.
- MA plans are only required to provide Medicare benefits. Since 2010, however, dual-eligible SNPs must contract with states to provide some Medicaid-covered services in addition to Medicare benefits.

4. PACE cannot respond to payment reductions by altering program benefits, raising premiums, or changing cost-sharing amounts.

- Federal regulation does not allow PACE to charge their participants premiums for Medicare-covered services or any deductible or cost-sharing amounts. This means that when payment reductions occur, PACE organizations must absorb the additional costs and cannot pass them on to PACE participants. PACE does not limit access to health care services in any way by the imposition of benefit limitations or cost-sharing requirements.
- MA plans can pass on costs and/or payment reductions to their enrollees by raising premiums and increasing cost-sharing amounts.

5. Payments to PACE and MA plans are set with different objectives.

- Because PACE benefits include all services covered by Medicare and Medicaid, including long-term services and supports, sites receive capitated payments from both Medicare and Medicaid. In general, PACE payments are based on what Medicare and Medicaid otherwise would spend on comparably frail individuals in the fee-for-service system.
- When capitated payments reach PACE organizations, they are no longer linked to a specific payer source and are used to provide services in the way that best meets each individual participant's medical and social needs. In PACE, care is provided without regard to fee-for-service reimbursement incentives or restrictions. This approach allows PACE organizations to provide services not traditionally covered by Medicare or Medicaid, such as care planning and care coordination activities. Medical need determines the care each participant receives.