NATIONAL PACE ASSOCIATION
Issue Brief
February 2022

Enable More Older Americans to Age in Place: Cosponsor the PACE Plus Act, S. 1162/H.R. 6770

Programs of All-Inclusive Care for the Elderly (PACE®) face many systemic challenges and obstacles to growth and expansion. If these barriers were eliminated, PACE organizations could serve many more of the 10 million people age 55 and over needing long-term care services and supports, rather than just the nearly 60,000, or 0.001 percent, currently enrolled. The PACE Plus Act not only would eradicate most federal impediments but encourage the expansion of existing PACE programs and the establishment of new ones. The National PACE Association (NPA), on behalf of our 144 PACE programs, requests your support of the PACE Plus Act.

Background

PACE programs enable people age 55 and over with chronic, complex medical conditions to live at home safely, despite needing a nursing home level of care. Through the innovative and integrated PACE model of care, program participants receive the entire continuum of Medicare services, Medicaid services, and any other services or supports determined to be medically necessary to maintain or improve their health status from 138 organizations in 30 states. PACE meets the needs of each individual participant through a personalized care plan that is developed and delivered by an interdisciplinary team of health care providers 24 hours a day, seven days a week, 365 days a year. Most participants (90 percent) are dually eligible for Medicare and Medicaid, but less than 1 percent are just Medicare eligible.

U.S. Census Bureau projections show the population of older Americans (age 65 and over) will continue to swell to 77 million by 2034, when for the first time it will surpass the number of Americans under age 18 (76.5 million).[i] By 2029, approximately 14.4 million middle-income adults, representing 43 percent of all aging adults,[ii] will be seeking ways to obtain the care they need outside of Medicaid since an estimated 20 percent will have high health care and functional needs, while 60 percent will experience mobility limitations.

According to the Commonwealth Fund, 83 percent of adults with high needs have public health insurance, 20 percent are dually eligible for Medicare and Medicaid, 50 percent are Medicare beneficiaries,[iii] and 13 percent are Medicaid beneficiaries. Considering this significant reliance on Medicare and/or Medicaid among those with high health care needs, it is critical for our nation to encourage increased use of evidence-based, proven, cost-effective care models such as PACE.

PACE is well suited to meet the needs of dually eligible beneficiaries, Medicaid-only beneficiaries and Medicare-only beneficiaries. However, there are several barriers that impede Medicare beneficiaries from readily accessing PACE. A recent report from the Milken Institute states, "67 percent of adults 55 and older with complex care needs cannot access a PACE program due to geographic, financial and regulatory barriers."[iv] The PACE Plus Act, if enacted, would eliminate many of the identified barriers and facilitate increased access by Medicare beneficiaries to this proven model of care. The bill also streamlines some of the administrative challenges experienced by PACE organizations as they seek to grow and expand to serve more aging adults and people with disabilities.

Summary

Allow Medicare Beneficiaries to Access PACE Organizations in States Not Exercising the Option to Establish PACE in Their Medicaid State Plan

Currently, PACE organizations can operate only in states that have added the PACE program to their Medicaid plans and agree to enter into three-way PACE program agreements with PACE organizations and the Centers for Medicare & Medicaid Services (CMS). To date, 18 states have not elected PACE as a state option, so Medicare beneficiaries do not have access to the program in those states. Allowing for two-way agreements would enable Medicare beneficiaries to enroll in PACE and

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have their long-term services and support needs met and coordinated with their medical care and other recommended services without spending down to Medicaid. (See Section 3.)

Make PACE More Affordable to Medicare Beneficiaries by Permitting PACE Organizations Flexibility in Setting Their Premiums

Existing regulations limit the ability of PACE organizations to establish the monthly premiums charged to Medicare-only beneficiaries since the amounts must be set in accordance with their Medicaid rates for dually eligible beneficiaries. Paying an average rate may make sense for Medicaid, which funds care for many, but tying the cost charged to an average does not make sense for individual Medicare beneficiaries. Since they are paying out of pocket for PACE, Medicare beneficiaries should be able to pay a rate reflecting their individual health status and corresponding level of need. Allowing Medicare beneficiaries to pay a capitation rate consistent with their health status will better align their needs with their costs and result in improved affordability of PACE services. Additionally, giving PACE organizations the flexibility to set Medicare-only premiums according to a beneficiary's needs allows for greater alignment with consumer demand. (See Section 5.)

Enable PACE Enrollment at Any Time

Currently, PACE programs may enroll beneficiaries only on the first of the month. The bill would enable PACE programs to enroll a Medicare-only beneficiary on the date the signed enrollment agreement is received. In addition, dually eligible beneficiaries would be able to enroll in PACE any time if permitted by their state. Payments by Medicare and/or Medicaid would be prorated in accordance with the date of enrollment. Allowing enrollment at any time would shorten the waiting time before enrollment and make PACE a viable option for more older adults and their families. (See Section 4.)

Streamline PACE Applications and Approvals

CMS accepts applications just once a quarter for new PACE programs and for existing programs seeking to establish a new center within its current service area or to expand into a new service area. The PACE Plus Act would eliminate this arbitrary requirement so applications of all types could be submitted faster. It also reduces the time CMS has to approve, deny, or request more information on an application to 45 days, after which an application is deemed approved. If further clarification is sought, the application will be deemed approved within 45 days of CMS receiving the material, unless the CMS secretary denies the application (See Section 6).

Facilitate Expansion of PACE Through Grants

Thirty grants of up to $1 million each would be awarded to establish new PACE programs or expand existing ones in rural or urban undeserved areas. Twenty grants of up to $100,000 each would be made to states so they may establish PACE programs (See Section 2).

Test the PACE Model of Care with New Populations

The bill allows pilots to test the PACE model of care with new high-need and high-cost populations not currently eligible to participate. Interested entities must perform an assessment of their service area to identify which new populations would be most appropriate to serve.

Enable States to Serve Expanded Populations with 90 Percent FMAP

Finally, the bill gives states offering PACE as a benefit under Medicaid the opportunity to expand their eligibility definition for PACE programs beyond those requiring a nursing home level of care. Potential participants must still be age 55 or over and live within the service area of the PACE program but may include those with incomes no greater than 150 percent of the poverty level and unable to perform at least two activities of daily living or whatever threshold a state may set. The costs of serving such expansion populations would be covered primarily through a 90 percent Federal Medical Assistance Percentage (FMAP) (See Section 8).

Endnotes

i U.S. Census Bureau. (2018). **Older People Projected to Outnumber Children for First Time in U.S. History**. March 13.

ii Pearson, C.F., Quinn, C.C., Loganathan, S., Datta, A.R., Mace, B.B., Grabowski, D.C. (2019). **The Forgotten Middle: Many Middle-Income Seniors Will Have Insufficient Resources for Housing and Health Care**, *Health Affairs,* 38 (5): 851-859.

iii Hayes, S.L., Salzberg, C.A., McCarthy, D., Radley, D.C., Abrams, M.K., Shah, R., Anderson, G.F. (2016). **High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care? A Population-Based Comparison of Demographics, Health Care Use, and Expenditures. The Commonwealth Fund. Issue Brief,** Appendix 1a, August.

iv Davis, D., Servat, C. (2021). **New Approaches to Long-Term Care Access for Middle-Income Households.**

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