Understanding the Economics Behind PACE

Supporting Access, Rate Integrity, and Financial Sustainability





MYERS AND STAUFFER LC

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The Program of All-Inclusive Care for the Elderly (PACE) is a fully integrated, capitated model that combines medical care, long-term services and supports (LTSS), and social services into a single delivery and financing arrangement. It is designed to allow seniors to remain safely in the community while receiving comprehensive, individualized care.

Although policy makers have traditionally focused on care delivery and compliance, its economic structure is just as critical. Economics drive sustainability, support participant outcomes, and directly influence not only the effectiveness of programs but also future decisions regarding growth and expansion.

This paper outlines a structured approach to understanding and managing PACE economics, with a focus on alignment between economics and care delivery. It also discusses internal cost structures, revenue dynamics, and operational considerations to offer programmatic insights necessary to oversee, evaluate, and manage risks. Understanding PACE economics is central to how the program is managed, how risks are identified, and how long-term sustainability is achieved. This requires moving beyond a compliance-based view of PACE to one that incorporates financial structure, performance dynamics, and the interaction between cost and quality. These elements function together, and effective oversight depends on understanding how they align in practice.

The Economic Complexity of PACE

PACE operates by balancing quality care, operations, and financing. It is one of the few models in government health care that integrates these components under a single capitated payment. This creates a unique dynamic. Revenue is based on a per member, per month basis. The participant population has high acuity and complex care needs. Service areas are limited by time and distance standards, which creates a limiting barrier to the size and construction of a PACE organization.

Furthermore, PACE organizations typically enroll between two and five participants per month, which means it can take years to reach the minimum number of participants to cover fixed costs. The result is a model where financial performance is directly tied to how, where, and to whom care is delivered. Decisions related to staffing, service delivery, care coordination, and expansion all have direct economic consequences. At the same time, financial constraints can influence how care is provided.



The PACE model consolidates funding streams into a single, fully at-risk structure, with primary revenue derived from Medicaid and Medicare capitation payments. Additional revenue may come from participant contributions such as partial premiums paid by participants eligible only for Medicare, full premiums paid by participants ineligible for both Medicare and Medicaid, or by participants in institutional care subject to post-eligibility treatment of income (PETI) rules. PACE relies on both Medicaid and Medicare funding. These funding streams are developed using different methodologies and are not inherently aligned.

The Medicaid Upper Payment Limit

The Medicaid upper payment limit, known as the Amount That Would Otherwise Have Been Paid (AWOP), is a major component of PACE financing, predicated on federal regulation at 42 CFR 460.182. The AWOP represents an analysis of what the population would have cost the Medicaid program in the absence of PACE. This analysis includes identifying a comparable population, analyzing historical claims data, and applying a series of adjustments to reflect expected future program conditions.

AWOP is an essential benchmark that establishes the upper bound of what a state could pay for PACE services under Medicaid managed care or fee-for-service. It is not designed to function as a rate-setting methodology. As a result, states must apply policy, financial, and programmatic decisions to translate that benchmark into a capitated payment structure. This distinction is important: AWOP defines the upper limit, but it does not determine where to set the payment rate. States typically establish rates as a percentage of AWOP driven by policy decisions and budgetary considerations.

AWOP defines the upper payment limit, but it does not determine where to set the capitation payment rate.





Medicare Revenue and Rate Alignment

PACE organizations operate within a uniquely complex financing structure that coordinates two fundamentally different payment systems. Although both Medicare and Medicaid support the same participant population, rate setting is developed using different methodologies, policy objectives, data structures, and timing mechanisms. These differences can create material misalignment between when costs occur and the timing of revenue recognition.

In contrast, Medicaid rates are developed using AWOP in conjunction with state-specific methodologies that are influenced by state policy decisions. These differences between rate calculation methodologies result in Medicare rates being more responsive to individual health risks, while Medicaid rates tend to remain stable year over year and prioritize LTSS, such as personal care or nursing facility services. Medicare and Medicaid financing approaches serve different but complementary purposes. Medicare uses risk adjustment to align payments with participant health needs, while Medicaid establishes a benchmark constraint through AWOP that requires state-driven policy decisions to translate into payment. For PACE programs, the challenge lies in harmonizing these two distinct funding streams, which operate on different timelines and design principles. Effective program management requires careful coordination to ensure sufficient funding is available to cover the comprehensive care needs of participants.

Oversight in this environment is often reactive instead of predictive. Addressing this gap is essential to strengthening the PACE program.

The Data and Oversight Gap

Most PACE participants are dually eligible for Medicare and Medicaid, yet the data and oversight infrastructure supporting these programs remains fragmented across federal and state systems. PACE organizations operate with near real-time visibility into participant enrollment, service utilization, clinical needs, interdisciplinary care planning, and revenue flows. States and CMS often do not have access to this same level of integrated operational and financial visibility.

Data relevant to program oversight is frequently dispersed across separate systems, delayed, incomplete, or designed primarily for administrative rather than predictive oversight purposes. Encounter data may be inconsistent or unavailable, financial reporting may occur retrospectively, and Medicare and Medicaid information often operate on different timelines and reporting platforms. This creates an information imbalance in which PACE organizations are managing participant care and financial operations continuously, while oversight entities are evaluating performance through lagged and fragmented sources.

In most cases, this environment functions appropriately because PACE organizations are operating as intended. However, when risks begin to emerge, they are frequently identified through complaints, audits, or retrospective review rather than through proactive monitoring. As PACE continues to expand nationally, strengthening integrated data solutions, financial transparency, and predictive oversight will become increasingly important to supporting program integrity, participant protection, and long-term sustainability.

CMS' Role in PACE Economics

CMS plays a foundational role in shaping the economic structure of PACE through federal policy, Medicare financing methodologies, regulatory oversight, and program design. While states are responsible for Medicaid rate setting and day-to-day program administration, CMS establishes the federal parameters that govern Medicare payment, and overall model integrity.

A central component of CMS' role is the development and administration of Medicare capitation payments. These payments are prospective and primarily informed by historical diagnostic and encounter data, creating a timing lag between changes in participant acuity and corresponding revenue adjustments. As a result, Medicare financing introduces important considerations related to participant mix, growth, and financial sustainability.

CMS also establishes the regulatory framework governing new applications, readiness reviews, ongoing oversight activities, service area expansions, and new center development, all of which influence the pace and structure of program growth.

In addition, CMS defines core program requirements related to benefit design, care delivery, participant protections, and service availability. These federal requirements establish a baseline operational cost structure that applies regardless of local market conditions. Consequently, PACE economics are influenced not only by state Medicaid capitation decisions, but also by the federally defined program expectations and Medicare financing methodologies.

Effective management of PACE economics therefore requires close alignment between federal and state components of the program. Medicare financing, Medicaid rate setting, regulatory oversight, and operational requirements are deeply interconnected, reinforcing the need for coordination between CMS and states to support financially sustainable and operationally viable PACE programs.

A State's Role in PACE Economics

States are the primary stewards of the PACE model at the local level, responsible not only for oversight but also for shaping the financial, operational, and quality framework that greatly influence whether the program succeeds or fails within their markets. This includes ensuring the integrity of AWOP development, designing rate setting approaches that are aligned with state objectives, and monitoring clinical, operational, and financial performance. States have responsibility for conducting readiness reviews, completing ongoing assessments, and establishing data and reporting requirements.

Beyond rate setting and oversight, states play a central role in evaluating and shaping the local PACE delivery system. This includes assessing market conditions to determine where PACE is viable, identifying gaps in access, and aligning program growth with broader LTSS strategies. States must assess financial and operational risks at both the program and system levels, including the potential impact of rapid expansion, enrollment concentration, or provider instability.

Moreover, states are responsible for vetting and onboarding PACE organizations through structured procurement and application processes. This includes evaluating provider readiness, financial capacity, operational experience, and alignment with state goals. Procurement processes are a critical control point, ensuring that new providers have the infrastructure and expertise necessary to deliver comprehensive care and manage financial risk.

Ongoing state-based assessments are essential to maintaining program integrity over time. States conduct periodic reviews of financial performance, service utilization, and quality outcomes to identify emerging risks and ensure programs remain sustainable. These assessments often complement, but are distinct from, federal oversight activities.

States must align Medicaid rate setting, program monitoring, and expansion decisions with federal requirements, while navigating differences in timing, data availability, and oversight structures between Medicaid and Medicare.

Furthermore, effective administration of PACE requires coordination with CMS. States must align program monitoring and expansion decisions with federal requirements, while navigating differences in timing, data availability, and oversight structures between Medicaid and Medicare. This coordination is critical to ensuring that the combined financing streams support the full scope of care and that program growth occurs in controlled and sustainable ways.

Balancing access, sustainability, and budget constraints is a core part of the state's role. States are economic and quality stewards responsible for ensuring that the program operates effectively and continues to meet the needs of participants over time.

Financial Monitoring and Early Warning Measures

Effective oversight requires monitoring a comprehensive set of indicators that provide insight into financial performance, care delivery, and overall program stability. Monitoring should not rely on any single dataset but instead be based on a balanced set of data resources and key performance indicators, as well as early warning measures across financial, operational, and quality domains.

Financial indicators such as total cost of care, margins, cash reserves, and medical expenditures provide insight into financial stability. Quality and utilization indicators help assess whether care delivery is aligned with program goals. Operational indicators, including transportation efficiency, workforce stability, and access to services, further inform how effectively the model is functioning in practice.

Enrollment trends are also an important indicator. Monitoring enrollment growth, disenrollment patterns, and participant mix over time provides insight into demand, market saturation, and the potential for adverse selection. Sudden shifts in enrollment or acuity can be signs of emerging financial or operational risks that should be evaluated with other performance data.

Integrating financial, quality, operational, and enrollment data helps identify patterns, understand risk drivers, and differentiate between short-term variation and emerging issues that require intervention. This comprehensive approach supports proactive risk assessment by allowing states to implement predefined response strategies such as targeted oversight or technical assistance before challenges escalate. By linking key indicators to actionable thresholds, states can transition seamlessly from monitoring to intervention when necessary.



Core Economic Drivers in PACE

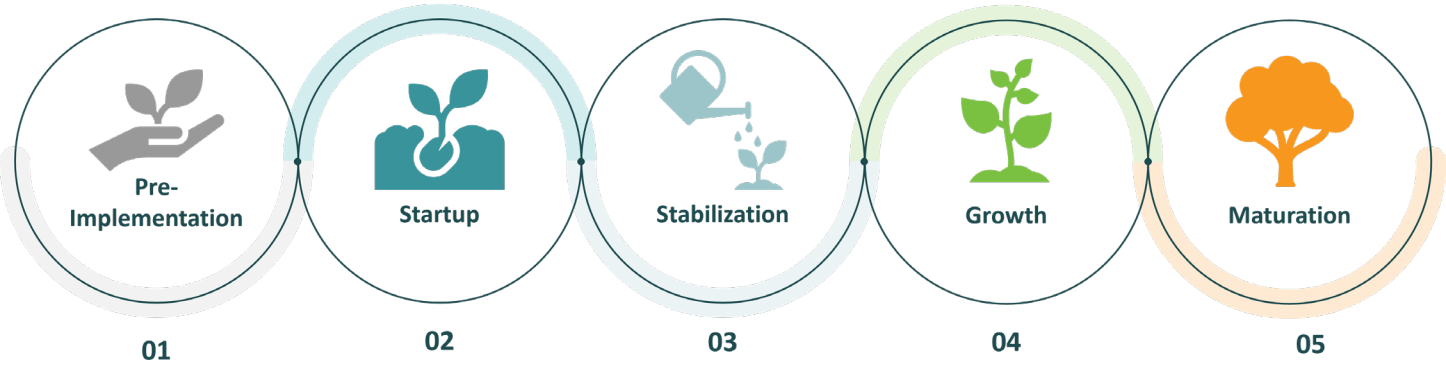
PACE economics are influenced by a combination of internal decisions and external conditions. Key internal drivers include enrollment volume and participant mix; acuity and functional status; service utilization patterns; staffing models; and the balance between center-based and community-based services. Transportation logistics, institutional care, and pharmacy costs also represent significant internal cost drivers.

External factors play an equally important role. Workforce availability directly impacts the ability to deliver services and manage costs. In many markets, staffing shortages lead to higher labor costs and increased reliance on contract labor. General economic conditions also affect the model. Inflation, provider pricing, and broader health care market dynamics can increase costs and create pressure on margins. Effective evaluation of PACE financial performance requires distinguishing between controllable operational factors and broader external economic pressures.

Financial Risk and Margin Dynamics

PACE organizations operate on margins that are sensitive to changes in cost and utilization. Financial risk can arise from rate inadequacy, enrollment volatility, and labor cost pressures. In addition, cost exposure is driven by several key areas, including nursing facility utilization, post-acute skilled nursing care, hospital utilization, and high-cost pharmaceuticals. A small number of participants with complex needs can have a significant impact on overall financial performance. Even small changes in utilization patterns or costs can greatly influence margins, especially during the early start-up phases of operations.

Because PACE organizations operate under fully capitated financing structures, sustained financial performance depends on the ability to manage uncertainty over time rather than within isolated reporting periods. Margin stability is influenced heavily by scale, operational maturity, reserve capacity, and ability to adapt to changing participant needs and market conditions. Newer and low census programs are often more vulnerable to financial risk because a limited participant base can magnify the impact of high-cost cases or temporary shifts in utilization patterns. As programs mature and enrollment stabilizes, financial performance generally becomes more predictable, although exposure to market-based pressures such as inflation and wages remains significant.



The PACE Economic Continuum

States are the primary stewards of the PACE model at the local level, responsible for overseeing programs as they move through different phases of economic and operational maturity. Programs move through distinct phases that each carry different financial and operational characteristics. These phases generally include pre-implementation, startup with negative margins, stabilization, and growth. As programs mature, they may pursue expansion with a state through new service areas or alternative care settings. This introduces additional capital requirements and operational complexity. Mature programs can then focus on optimization before encountering periods of stress or realignment driven by economic or operational pressures.

New centers, expanded service areas, or alternative care settings require careful planning and sufficient infrastructure by both the PACE organization and the state. Long-term success depends on achieving operational and financial maturity before pursuing expansion. CMS typically requires a waiting period before organizations can pursue additional service areas or a second center, usually tied to the completion of Initial Operations Review and the first Initial Comprehensive Review and Corrective Action Required (ICR/CAR) cycle – usually around 18 months. However, this milestone does not necessarily indicate that a program has reached financial stability. Growth that occurs before a program is fully stabilized can create deeper and more challenging risks.

Programs that approach expansion as a managed phase of the PACE lifecycle rather than simple growth are better positioned to achieve long-term sustainability.

Market Expansion and Economic Sustainability

Expansion requires careful consideration of both financial and non-financial factors. Geographic variation, enrollment density, and market dynamics all influence the feasibility of expansion. In addition, social determinants of health, housing stability, and cultural factors affect participant outcomes and program performance. Programs that align with the communities they serve are most likely to succeed.

Sustainable expansion is not just a function of demand for PACE. It depends on reaching a level of operational and financial maturity before entering new markets or adding service capacity. Expansion that is not grounded in demonstrated financial and operational stability introduces avoidable risk at both the program and system levels. As a result, expansion decisions for a given PACE organization should be a function of demonstrated performance, stable margins, and availability of adequate infrastructure.

Market conditions must also be evaluated in terms of provider networks, workforce availability, and referral pathways. Limited access to necessary services, such as home care or specialists, can significantly impact cost and quality. An assessment should be made as to whether the necessary ecosystem exists to support PACE delivery in a new service area.

From an economic perspective, expansion introduces both opportunity and risk. While increased enrollment improves scale, it introduces variability in participant case mix and utilization patterns. Because of this, states should play a central role in guiding market expansion, selecting service areas based on data-informed assessments rather than simply responding to provider requests. Without this approach, there is a risk of adverse selection, as providers may target populations that optimize financial performance.

Ultimately, successful expansion requires disciplined planning and a clear understanding of how market, financial, and operational factors interact. Programs that approach expansion as a managed phase of the PACE lifecycle rather than simple growth are better positioned to achieve long-term sustainability.

Common Economic Pitfalls in PACE

Common challenges in PACE often stem from underestimating implementation timelines, overestimating potential enrollment, and failing to fully account for the cost structure of the model. The PACE program requires significant upfront investment, time to scale, and disciplined operational execution. Across stakeholders, there can also be gaps in understanding how financial, operational, and clinical components interact within a fully capitated model. When these dynamics are not fully understood, they can create avoidable pressures early in the program lifecycle.

For state administering agencies, a primary challenge is relying too heavily on rate setting alone to ensure program sustainability. While AWOP development and rate setting are key functions, they do not, by themselves, ensure that a program will perform as intended. States may also face limitations in data availability, making it difficult to monitor performance proactively. Insufficient investment in oversight infrastructure, including staffing, analytics, and defined response protocols, can limit the ability to identify and address emerging risks. Without a structured framework that integrates financial, operational, and quality monitoring, states may find themselves reacting to issues rather than actively managing them.

For CMS, a growing challenge is managing the increasing complexity and scale of the PACE model as more organizations enter the program across additional states and service areas. As the volume of PACE activity grows, maintaining the staffing, operational infrastructure, and specialized expertise necessary to oversee the program effectively becomes increasingly difficult. CMS also faces increasing challenges associated with



fragmented data systems, varying levels of state oversight capacity, and the operational complexity of coordinating Medicare and Medicaid financing structures across multiple stakeholders. Many oversight activities remain retrospective in nature or rely on delayed reporting. Without continued investment in infrastructure, analytics, standardization, and coordinated oversight strategies, CMS may face increasing difficulty identifying emerging operational, financial, or quality risks proactively as the PACE landscape continues to evolve.

For PACE organizations, common pitfalls include underestimating the capital and time required to reach operational stability, as well as challenges in managing the balance between cost and care delivery under a capitation payment model. Early-stage programs may experience financial pressure due to low enrollment and high fixed costs, while more mature programs may face risks related to expansion, workforce constraints, and high-cost utilization. Furthermore, organizations that do not effectively integrate clinical and financial management may find it difficult to align participant outcomes with financial performance. Successful programs require disciplined growth, strong infrastructure, and a clear understanding of how operational decisions impact cost and quality.

Building a Sustainable Economic Framework

States are responsible for establishing and maintaining a sustainable economic framework for PACE that balances financial viability, participant protection, and high-quality care. Although AWOP development and rate setting are foundational, they are not sufficient on their own. Long-term sustainability depends on a broader framework that balances financial design with the protection of participants and the maintenance of high-quality care, all grounded by the operational realities of local economics. This requires reliable, actionable data to support informed decision-making over time.

Robust data infrastructure is essential to support this framework. States and CMS must have access to timely, reliable financial, operational, and quality data to evaluate performance, identify emerging risks, and guide strategic decisions. This includes not only traditional financial metrics, but also utilization patterns, enrollment trends, participant acuity, and outcomes data.

PACE Multi-State Learning Collaborative
By Myers and Stauffer

Peer Collaboration through the PACE Multi-State Learning Collaborative

State agencies overseeing the PACE program can benefit from participating in national peer networks that allow them to share experiences, emerging challenges, and oversight strategies. The PACE Multi-State Learning Collaborative (PMLC) is a forum designed to support collaboration among state Medicaid and partner agencies responsible for administering PACE programs. The PMLC allows states to exchange operational insights, discuss emerging policy issues, and learn from the experiences of other state agency peers. By maintaining connections to the national conversation, states can strengthen their own oversight frameworks while benefiting from lessons learned across other programs. To learn more about the PMLC, visit our PACE page.





Sustainability depends on establishing clear expectations for performance and accountability. This includes defining key performance indicators, monitoring early warning signals, and implementing structured oversight processes that allow for timely intervention when issues emerge. States play a critical role in setting these expectations and ensuring they are consistently applied.

Finally, sustainable PACE programs must be designed with adaptability in mind. The health care environment, regulatory landscape, and participant needs will continue to evolve. Programs that are structured to scale, adjust to changing conditions, and incorporate innovation are more likely to achieve long-term success. Without this type of structured framework, states risk reacting to issues rather than actively managing them, limiting their ability to guide the program toward long-term sustainability.

Strengthening data, improving alignment, and applying disciplined economic management practices are not optional. They are essential to ensuring that the model can grow responsibly and continue to meet the needs of a complex and vulnerable population.

Conclusion

The efficacy of PACE as a service is well established. However, its long-term success depends on the strength of its economic foundation. Sustainable growth requires more than funding. It requires alignment across Medicare and Medicaid financing, disciplined program management, and a commitment to data-informed decision-making.

States have a central role in strengthening this foundation. This includes investing in data infrastructure that allows for timely and accurate insight into financial performance, utilization, and participant outcomes. States should also establish clear expectations for performance monitoring, including the use of key performance indicators and early warning measures to identify emerging risks. In addition, oversight and expansion decisions should be grounded in a thorough understanding of market conditions, provider capacity, and program readiness. There are opportunities to strengthen the rate setting approach, as well as to better recognize economic realities and provider innovation.

At the federal level, there are opportunities to improve transparency and alignment across funding streams. Enhancing the availability and usability of Medicare data as well as strengthening coordination with state oversight activities would support more effective program management. Greater alignment between Medicare and Medicaid financing structures would reduce administrative complexity.

For states and CMS, the path forward requires a more disciplined, data-driven, and economically informed approach to oversight. This includes strengthening data infrastructure, refining rate setting approaches, and implementing proactive monitoring frameworks that identify risks before they materialize. These actions are necessary to ensure that the program can be effectively managed at scale.

PACE organizations should invest in the capabilities needed to succeed within a capitated model. This includes integrating clinical and financial management, building strong data analytics functions, and developing strategies to manage risk across changing enrollment and acuity patterns. Organizations that proactively manage these dynamics will be better positioned to deliver high-quality care while maintaining financial stability. PACE organizations should also continue to focus on innovative solutions that improve quality while reducing cost, including the potential of revenue diversification and creative community partnerships.

The future value of PACE depends on the collective actions of states, CMS, and PACE organizations. Strengthening data, improving alignment, and applying disciplined economic management practices are not optional. They are essential to ensuring that the model can grow responsibly and continue to meet the needs of a complex and vulnerable population.

Why Myers and Stauffer?

Established in 1977, Myers and Stauffer is a nationally based consulting and certified public accounting firm. For nearly 50 years, we have worked exclusively with government health and human services agencies to help them accomplish their most critical goals for the nation's most vulnerable people.

Backed by disciplined professionals who meet the highest ethical and compliance standards, we continue to forge strong partnerships with our clients, built on trust earned through a long history of strong performance and exacting execution. We help clients, including state agencies and CMS, meet their goals one engagement at a time. Each is a rewarding chapter in our ongoing effort to support health and human services programs nationwide.

To create a consistent opportunity for a national conversation, we created the PACE Multi-State Learning Collaborative from the ground up to drive high-level thought leadership and sharing among state agency leadership. This dynamic and state-focused program, the only one of its kind in the country, now includes participants from more than 30 states, addressing more than 85 percent of all PACE participants nationally.

Why Myers and Stauffer? We are purposeful and mission-driven. The values that inspire us inform everything we do in support of government programs and the clients who administer them.

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