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Growth of the Program of All-Inclusive Care for the Elderly and the role of for-profit programs

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Abstract

The Program of All-Inclusive Care for the Elderly (PACE) is a managed care program financed by capitated government payments that primarily serves adults aged 55 or older requiring nursing home level of care who are dual-eligible for Medicare and Medicaid. While PACE programs have historically been nonprofit entities, in 2016, a regulation change allowed for-profit PACE programs to help expand the program. We describe PACE program growth from 2010 to 2022. Both the number of PACE programs and enrollees grew from 2010 to 2022. Yet, after allowing for-profits to enter the market, the enrollment rate of growth slowed overall (13.4% vs 7.0%), though for-profit program enrollment grew more rapidly compared to nonprofit programs (13.2% vs 5.7%). Entry of new programs drove for-profit growth primarily. Despite the growth of for-profit programs, most enrollees continued to receive care from nonprofit programs (78%) by 2022. Allowing for-profit programs did not increase PACE enrollment rates overall. Given emerging evidence that for-profit ownership in other health care sectors may reduce quality compared to nonprofits, policymakers should carefully monitor care quality and patient outcomes in PACE as for-profit entities increase.

Key words: PACE; ownership; managed care; privatization; Medicaid; frail elderly; long-term care.

Introduction

Integrated care programs play a critical role in coordinating care for dual-eligible Medicare–Medicaid beneficiaries who may receive lower quality care and are among the costliest patients to insure. As a result, policymakers are increasingly focused on expanding integrated care programs to deliver high-quality care while stemming costs. The Program of All-Inclusive Care for the Elderly (PACE) is one category of integrated care programs that seek to align Medicare and Medicaid coverage. PACE programs manage care for community-dwelling adults aged 55 and older who require nursing home-level care and are mostly dual-eligible for Medicare and Medicaid. PACE programs receive capitated payments per person to deliver comprehensive medical and social services to enrollees primarily at home or in adult day health centers. Due to the fully integrated care, PACE is well suited to address the complex social and medical needs of eligible patients.[1-10] Evidence suggests PACE reduces long-term nursing home stays, but there is mixed evidence regarding mortality.[11] While PACE has grown over time, it remains one of the smallest Centers for Medicare & Medicaid Services (CMS) integrated care models and faces expansion challenges due, in part, to large upfront costs incurred by PACE, such as building space and employee salaries, as well as high premiums for Part D prescription drug coverage facing Medicare-only beneficiaries, which can be a disincentive to enroll in PACE.[10,12,13]

Since the inception of PACE in the 1970s, programs operated as nonprofit entities through waivers of federal Medicaid requirements that allowed a series of demonstration projects. The Balanced Budget Act of 1997 established PACE as a permanent Medicare program. The Act also allowed private, for-profit entities to participate in PACE as part of a separate demonstration program that began in 2007.[10,14] In 2016, based on an evaluation of this demonstration that suggested similar quality outcomes, CMS began allowing for-profit ownership of PACE programs.[10,14] However, concerns have remained about the quality and interpretation of the evaluation, such as generalizability of the results from 4 for-profit PACE programs with the same owner relative to 11 nonprofit PACE programs in Pennsylvania.[15] Yet, the role of for-profit ownership in PACE relative to nonprofit programs has been understudied and the consequences are unknown.

In recent years, for-profit firms, and specifically private equity, have been entering long-term care markets, particularly in home- and community-based settings.[16-19] Evidence from other health care settings suggests that compared to nonprofits, for-profit organizations, and especially those receiving private equity investments, may adversely impact quality of care.[16,18,20-22] Notably, this may be exacerbated if firms with short-term financial focus control a significant share of

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the market. However, for-profit entities may also help improve company efficiencies.[23] Moreover, for-profit entities and private equity can address challenges unique to PACE, such as the large upfront capital investments (eg, building and staffing costs) required to expand PACE. Thus, it is important to understand the role of for-profit entities in PACE programs, which serve vulnerable populations requiring long-term care in the community.

While it is generally known that PACE has been serving more dual-eligible Medicare–Medicaid beneficiaries over the past 15 years, trends in both the number of PACE programs and the number of beneficiaries served have not been examined in relation to the 2016 regulatory change to allow for-profit PACE programs. In this study, we examine PACE trends primarily by ownership status and secondarily by private equity investments.

Methods

First, we identified PACE programs and the year each program began using a publicly available list from the National PACE Association. Second, we identified PACE program enrollment counts and parent owners in the publicly available Medicare Advantage Plan Contract Directory from 2010 to 2022. If enrollment counts were suppressed due to small cell sizes, we imputed the missing enrollment to be 2, yielding a conservative approach to identify the number of PACE enrollees by ownership status. Third, we used the ProPublica Nonprofit Explorer to identify the years a program was nonprofit, as noted by 990 forms.[24] Fourth, we confirmed for-profit status using the S&P NetAdvantage database to identify and record the earliest year a program was listed as for-profit. Finally, we used the London Stock Exchange Group (LSEG), formerly known as Refinitiv, to identify private equity investments in PACE programs or the parent owner (as identified in the Medicare Advantage Plan Contract Directory). LSEG identifies private equity deals through direct reporting from private equity firms, venture capital firms, global banking and legal contributors, firm websites, news publications, and regulatory filings. We verified private equity investments in PACE via news outlets and press releases. Finally, we used KFF estimates of individuals eligible for both Medicaid and Medicare in 2021.

We described trends in the number of PACE programs and the number of enrollees over time. We calculated the rate of growth of for-profit and nonprofit PACE programs from 2010 to 2022, as well as of for-profit PACE programs receiving private equity investments. We calculated the average growth rate of all PACE enrollees and enrollees at nonprofit programs prior to the 2016 regulation change (2010-2015) and after the regulation change (2016-2022). We then calculated the average growth rate of the size of PACE programs by ownership status using the median number of enrollees per program for the years 2010-2015 and 2016-2022. By calculating the average growth rate of all PACE enrollees and by the size of PACE programs, we are able to disentangle whether growth is driven by increasing sizes of PACE programs or by entry of new programs (total growth – growth due to increasing size of programs). Notably, a small number of for-profit PACE programs existed prior to 2016 in a demonstration program that informed the 2016 policy change. All analyses were conducted using Stata SE Version 18.

Limitations

This study is subject to several limitations. First, while we used a systematic and multipronged approach to identify private equity investments in PACE, our analysis is subject to measurement error. It is possible a private equity deal is unobserved or misclassified as the definition and identification of private equity deals may differ across proprietary data sources (eg, Pitchbook vs LSEG vs PE Hub). Second, our analysis of private equity investments is descriptive only and does not elucidate why certain PACE programs received private equity investments while others did not. Relatedly, private equity penetration comprises a small number of programs which limits its generalizability. Third, due to cell suppression, we imputed values of enrollees that may introduce bias into estimates. However, analyses of the distribution of suppressed data do

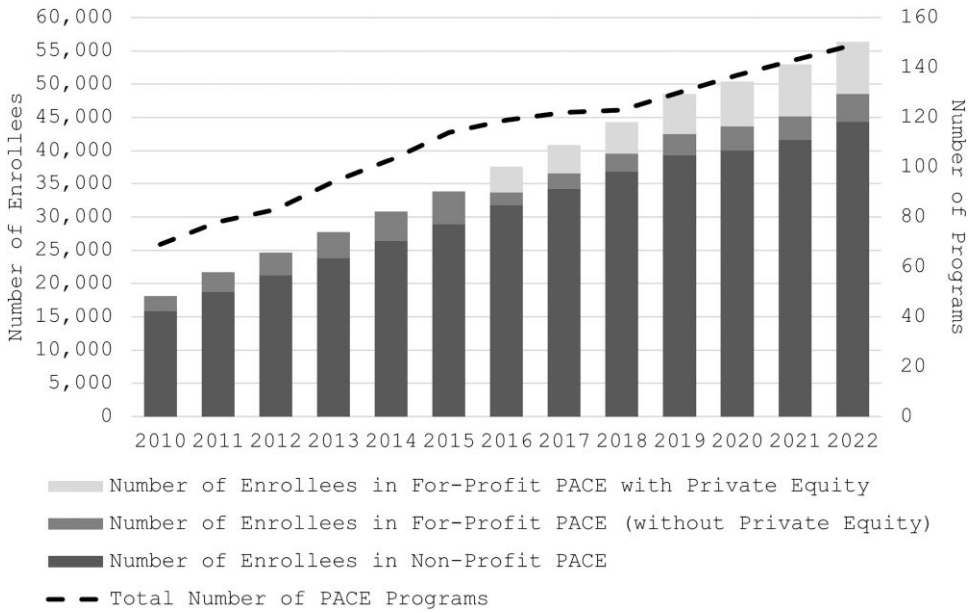

Figure 1. Growth of Program of All-Inclusive Care for the Elderly (PACE) programs and enrollees by ownership status. Source: author calculations.

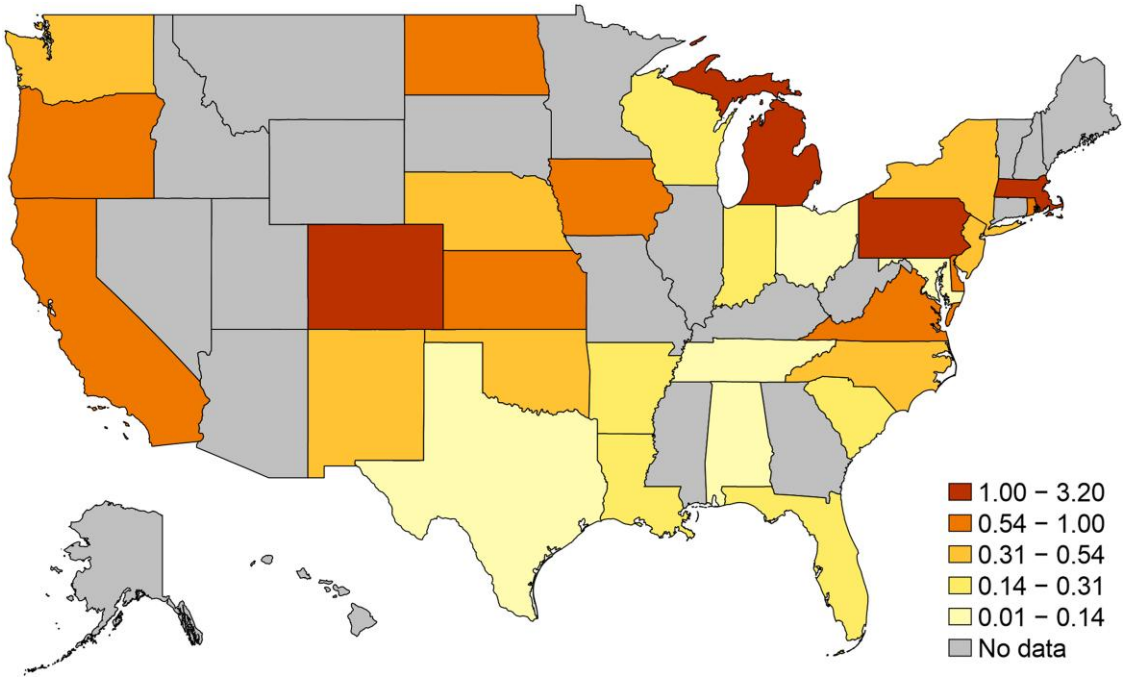

Figure 2. Geographic distribution of Program of All-Inclusive Care for the Elderly (PACE) enrollees as a share of Medicaid and Medicare enrollees. Source: author calculations.

not suggest significant patterns by profit status (see Appendix S1 for additional details). Finally, we do not examine patient outcomes across different ownership types.

Results

From 2010 to 2022, the number of PACE programs increased by 116% from 69 to 149 (Figure 1) with an annual average of 10%. The number of PACE enrollees increased by 211% from approximately 18 100 to 56 350. PACE enrollment grew across the United States, though the penetration of PACE varied geographically. In 2010, PACE existed in 26 states spanning multiple census regions. By 2021, we found that PACE enrollees as a share of the total number of dual enrollees were less prevalent in the Midwest and were concentrated in Massachusetts, Pennsylvania, Colorado, and Michigan (Figure 2).

For-profit and nonprofit entities operating PACE programs underwent differential growth patterns. From 2010 to 2022, the number of nonprofit PACE programs grew from 64 to 117 (83% increase), as did the number of enrollees (15 868 to 44 368; 180% increase) (Figure 1) with a 10% annual average growth in number of enrollees (Figure 3A). While the absolute number of enrollees increased, the percentage of PACE enrollees served at nonprofit PACE programs decreased over time from 88% in 2010 to 79% in 2022. Moreover, the rate of growth in nonprofit PACE programs changed after the 2016 regulation change allowing for-profit entities. Prior to 2016, nonprofit PACE programs grew by an annual average of 12.9% compared to 5.7% in the years 2016-2022. This decrease in the rate of growth was mirrored in the overall average growth rate of all PACE programs (7% in 2016-2022 vs 13.4% in 2010-2015).

From 2016 to 2022, the number of for-profit PACE programs grew from 17 to 32 (88% increase) and the number of participants enrolled in for-profit PACE programs grew from 2275 to 11 982 (109% increase) by a 13.2% annual average growth rate. While the number of enrollees in for-profit PACE remained relatively low, the percentage of PACE enrollees served at for-profit PACE programs increased over time from 15.3% in 2016 to 21.0% in 2022. Notably, only 4 programs during the study period switched from nonprofit to for-profit. Three of the 4 programs switched after 2020.

Both the entry of new programs and expansion of existing programs played key, but contrasting, roles in driving the differential growth patterns of for-profit and nonprofit entities. Pre-2016, the expansion of existing nonprofit PACE programs yielded an average growth rate of 3%, which suggests expansion did not explain most of the total enrollment growth of 12%, but instead was driven by the entrance of new programs (Figure 3B). However, after the policy change in 2016, growth in nonprofit PACE programs was driven by expansion of existing programs. Of the total 13% annual growth of for-profit programs, almost 5% was attributable to the expansion of existing programs while nearly 9% was attributable to new programs. Thus, growth of for-profit PACE was driven primarily by the entry of new programs and secondarily by growing the size of existing programs.

The first for-profit PACE program received private equity investments in 2015. From 2016 to 2022, the number of PACE programs with private equity grew from 8 to 15 (88% increase). Among all PACE programs, the percentage of for-profit PACE programs receiving private equity investments in 2015, 2016, and 2022 was 0.9%, 6.7%, and 10.1%, respectively. However, the percentage of for-profit PACE programs receiving private equity investments in 2015, 2016, and 2022 was 6.3%, 47.1%, and 46.9%, respectively. The growth in the number of enrollees in for-profit PACE programs was driven by for-profit programs receiving private equity investments, with an average growth rate of 12.6%. During the same time period, the average growth rate of for-profit PACE programs without private equity was 14.9%. This growth was primarily

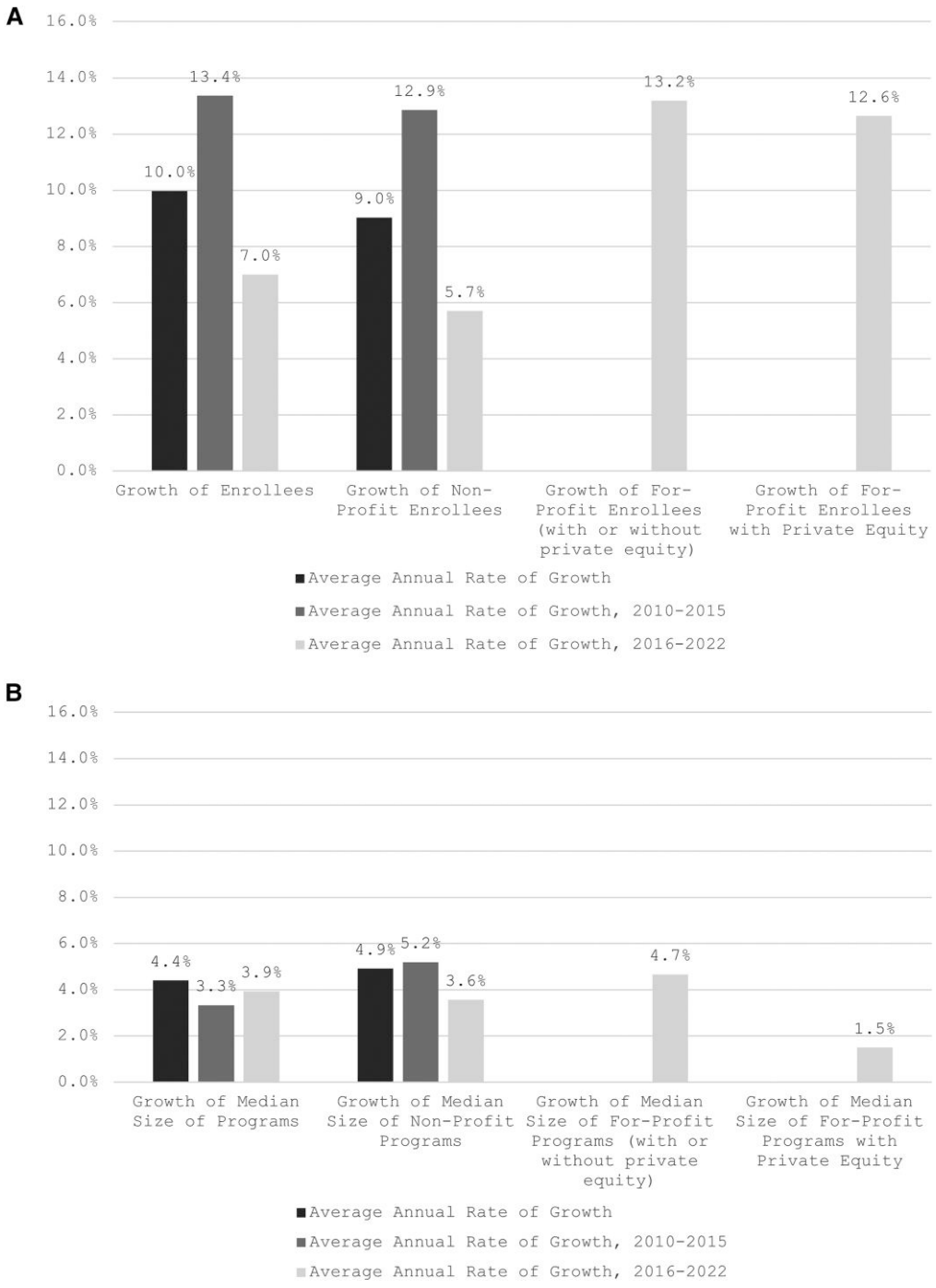

Figure 3. Average annual rates of growth of Program of All-Inclusive Care for the Elderly (PACE) programs and enrollees by ownership status. (A) Total number of PACE enrollees. (B) Size of PACE by median number of enrollees per program. Source: author calculations.

attributed to the entry of new programs rather than expansion of existing programs (Figure 3). Among enrollees receiving care at for-profit programs in 2022, 79% received care at programs with private equity investments.

Discussion

Our study examines the growth of both nonprofit and for-profit PACE programs over the last 2 decades. Both the number of PACE programs and number of enrollees in PACE programs grew from 2010 to 2022. We also observed differing trends across ownership types after the 2016 regulatory change. While nonprofit PACE programs served the majority of PACE enrollees, programs with private equity investments comprised a notable share of the growing market of for-profit PACE programs. Despite the increasing number of PACE enrollees, PACE's rate of growth slowed after for-profit entities were allowed to enter the market, suggesting that for-profit entry did not expand the program at a faster rate than before the rule change when only nonprofit programs existed. Instead, one possible explanation is that a "crowding-out" effect of nonprofit programs may have occurred. However, further analysis is required to examine the drivers and alternative factors impacting PACE growth rates

(eg, Medicaid expansion under the Affordable Care Act). Yet these findings have implications for policy efforts to expand PACE and inform the broader trend of for-profit entities entering health care markets.

In the last decade, PACE has experienced an evolution in market structure. While PACE was originally composed of nonprofit programs existing in a limited number of US states, the program currently exists in more than half of the states, though notably with limited penetration in the Mountain and West North Central census divisions.[25] Our findings suggest that while most PACE enrollees receive care from a nonprofit PACE program, the number of PACE enrollees receiving care from for-profit programs, often with private equity investment, has increased, primarily due to entry of new programs. Despite these increases, the rate of growth did not increase after for-profit PACE programs entered the market, suggesting that for-profit investment did not grow PACE more than when only nonprofit programs existed. However, these findings must be considered in the broader context of additional rules and regulations impacting market structure and competitiveness, such as Certificate of Need laws that vary across states and require health care facilities to establish community need before opening a facility or offering a service.[26] Relatedly, states must submit a state plan amendment to allow the entry of PACE to a state and the CMS must approve any proposed expansion of existing PACE programs. As a result, such policies and regulations may limit access to and uptake of PACE programs. Additionally, the PACE program is fundamentally a high-risk financial model as it requires PACE organizations to undertake full financial risk for a historically high-cost, high-need population. Therefore, additional incentives to entice new entrants into the market or to expand existing programs in order to grow the PACE program may be necessary. Further research into how policies restricting market entrants and local market characteristics (eg, rurality, competition) may be driving the growth rate, or lack thereof, is needed to inform policy recommendations to accelerate the rate of growth of PACE.

The growth of for-profit entities in PACE mirrors the rise of for-profit programs in other health care sectors, such as nursing homes, hospitals, and home health. The entry of for-profit entities may lead to more standardized practices in organizations, while also having the ability to withstand the high startup capital investments (eg, day center building, transportation, staffing requirements), an often-cited barrier to expanding PACE. Alternatively, the entry of for-profit entities may result in practices that maximize profits at the expense of quality of care. While PACE models are highly regulated by CMS, the National PACE Association estimates notable variation in the processes and outcomes of care in PACE models, yet little evidence exists regarding whether program processes and outcomes vary by ownership.[10] In other sectors, evidence suggests for-profit and private equity investments have had harmful impacts on quality of care and patient outcomes.[21,27-37] However, evidence from the assisted living industry suggests that private equity may be beneficial and improve access to and quality of care. For example, when attempting to establish a brand identity as a high-quality long-term care option, providers are incentivized to deliver high-quality care to achieve sufficient volume to maximize profits, particularly in the context of private payers.[38] Notably, in PACE, relatively few programs have private equity investments. However, the trends of private equity investments since 2016 illustrate the need for monitoring entry of private equity in the future. Additionally, while we cannot determine whether the entry of for-profit programs improved access to care, given the existing evidence for other long-term care industries, careful monitoring of access to and quality of care in PACE is critical.

Though this study is specific to PACE, our findings inform the increasing reliance on private investments rather than public investments in the health care sector. Reliance on private vs public investments may offer opportunities for innovation and operational efficiencies, but potentially at the expense of access to high-quality care. These concerns are amplified for vulnerable populations, such as PACE enrollees, who are predominately Medicaid enrollees requiring a nursing home level of care. As the population ages, the number of older adults incurring age-related disabilities will grow. However, the expansion of PACE is constrained by the large capital investments initially required, lack of awareness of the program, and insufficient concentration of enrollees in a service area to achieve economies of scale. Relying on private instead of public investments to meet the care needs of vulnerable, ageing populations raises significant concerns about the potential for inequitable access and lower quality of care.

Conclusion

To meet the care needs of dual-eligible Medicare–Medicaid beneficiaries, integrated care models like PACE will serve an increasingly important role in health care delivery. Our findings suggest that after the 2016 regulation change allowing for-profits, PACE program growth slowed and differing trends of growth occurred by ownership status. The present study highlights the evolving market structure of PACE programs in light of regulation changes and is an important step to understanding how access to and quality of PACE has changed over time. Future work examining heterogenous effects of PACE by ownership status on patient outcomes is necessary to inform policy discussions of integrated care models to meet the increasingly complex care needs of ageing populations.

Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

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Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

Notes

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