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ISSUE BRIEF

The PACE Managed Care Program:
Its Purpose, Benefits, and Potential for Growth

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Executive Summary

Expanding the availability of the the Program of All-Inclusive Care for the Elderly (PACE) exemplifies the types of targeted reforms that can improve health outcomes for patients while reducing Medicare and Medicaid expenditures.

The PACE program provides medical and social care services to lower-income individuals 55 and older, typically living in underserved geographies or from underserved populations. These lower-income older adults are frail, chronically ill, and are living with potentially significant functional and cognitive impairments. While these individuals have complex medical needs that typically require costly services provided by nursing home facilities, they also have the capability of living in their own homes if they are provided with the requisite support. There are 186 PACE programs in the U.S. providing this support. They currently serve 84,000 participants in 33 states and the District of Columbia.

Since PACE centers can avoid more expensive nursing home care, it generates savings of around $2,800 per participant for the federal and state governments, or $33,600 annually. Relative to the current 84,000 participants, this equates to $2.8 billion in savings. Not only are there budgetary savings for the government, there is growing evidence that patients participating in the PACE program experience better health outcomes including lower rates of hospitalization, readmission, and potentially avoidable hospitalization than similar populations.

Starting a new center typically is costly, between $5 and $10 million. These costs include purchasing the,

- physical building where in center services are provided
- physical therapy equipment
- occupational therapy equipment
- recreational activity equipment
- food services, and
- health facilities capable of providing onsite nursing care, physician services, dental services, optometry, podiatrist, nutritional services, and pharmacy services.

It is also necessary to hire the professionals who will provide all these services before the center has received any compensation from the government. Due to these large upfront expenses, the 2015 expansion of the program to include for-profit providers was essential. The for-profit sector has greater access to capital, which is why these organizations are driving the current growth in the PACE program while providing the same high quality of care.

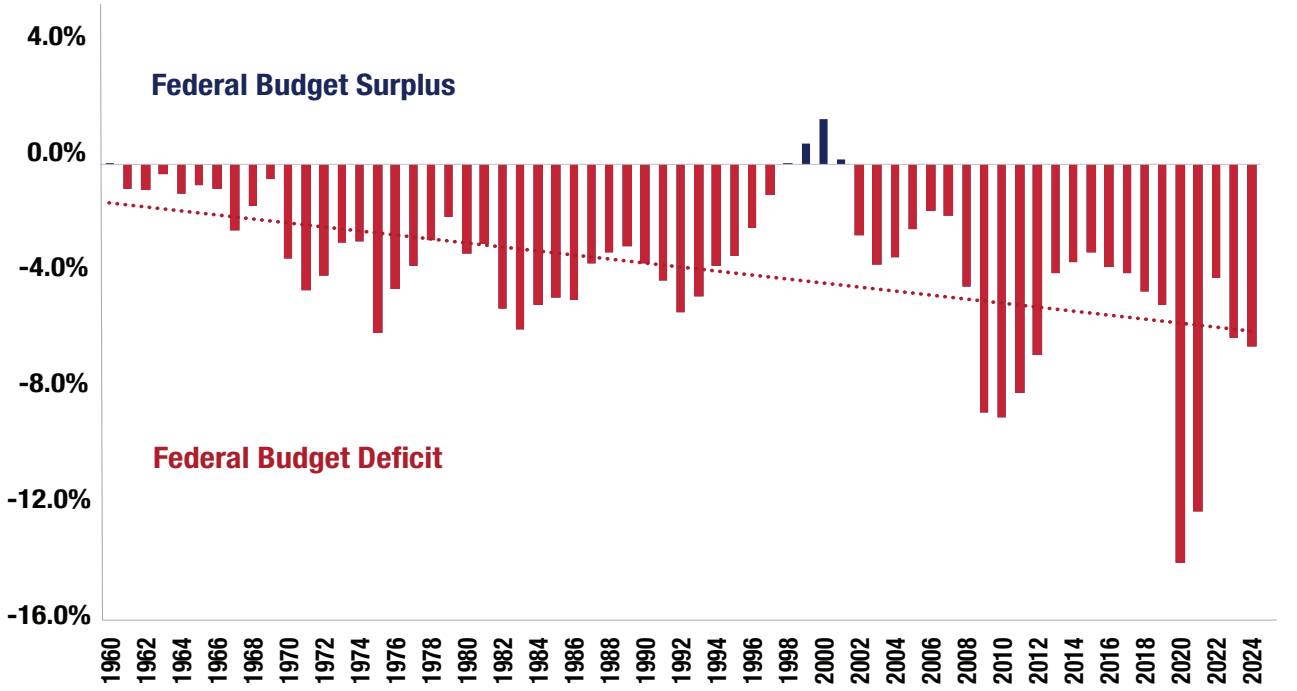
To expand the benefits of the PACE program to a wider population policymakers should support the ability of for-profit providers to participate in the PACE program, streamline the regulatory burden for starting and operating a PACE program, and expand the eligibility to incorporate a larger share of the high-need, high-cost patients that may currently have difficulties qualifying.

Introduction

The explosion in federal expenditures that began with the Covid-19 pandemic has hastened our impending budget crisis. Consider that between 1960 and 2019 (before the Covid-19 pandemic) total federal spending averaged around 20.9 percent of GDP. Federal spending then surged higher during the pandemic and never returned to its pre-crisis level. Instead, the additional federal spending became enshrined in the budget. As a result, 2024 federal spending was 2.9 percentage points higher relative to the historical average, reaching a new level of 23.8 percent of GDP. Without spending restraint, the private sector must finance this increased spending through either increased taxes or more debt.

In contrast to expenditures, total federal receipts have been stable relative to the size of the economy at around 17 to 18 percent of GDP. In 2024, total federal receipts equaled 17.4 percent of the economy. Figure 1 visualizes the inevitable result from these trends. The increased spending has been financed through rising federal deficits. Excluding the spending surges associated with the great recession and Covid-19 pandemic, federal deficits are now at their highest level relative to GDP since 1960.

Figure 1
Growing Deficits Are Undermining the Federal Budget's Sustainability



Source: Bureau of Economic Analysis

These trends indicate that the federal budget is on a fiscally unsustainable path that has not been caused by excessive tax cuts as some politicians allege. After all, federal revenues relative to the size of the economy are around their historical average. The same cannot be said for the level of federal spending. Making matters worse, without policy changes the amount of spending will continue to expand faster than the economy over the next several decades.

Growing health care expenditures are a large driver of this future acceleration due to the continued retirement of the baby boom generation and the proliferation of programmatic inefficiencies. Consequently, averting future fiscal crises require significant reforms to government health care programs.

Ultimately, averting the fiscal cliff requires fundamental reforms to Medicare and Medicaid. Such changes will be politically difficult and time-consuming to implement, however. Generating near-term savings via beneficial targeted reforms is essential, consequently.

Targeted reforms have the benefit of being quicker and easier to implement and are capable of improving the worsening federal fiscal position. While targeted reforms do not replace the need for fundamental changes, they can serve as essential stop-gap measures that provide near-term financial savings while also improving the quality of services for patients.

Expanding the availability of the PACE program (Program of All-Inclusive Care for the Elderly) exemplifies the potential benefits from targeted reforms. The PACE program, officially established in 1997, provides elderly participants with comprehensive community-based nursing care-type support services for extended periods of time, subject to an income limit.[1] These services include adult day care, medical care, physical and occupational therapy, dental care, nutrition counseling, and prescription medications. Services are fully covered by Medicare and Medicaid for eligible individuals, and the program is available to those who meet certain age, medical, and financial criteria.

“Expanding the reach of the PACE program and supporting the expansion of for-profit providers is a targeted reform that will provide important near-term benefits including improved outcomes for patients and reduced cost pressures on Medicare and Medicaid.

The PACE program has a strong track record of delivering high-quality cost-effective health care. Expanding the size and scope of the program offers the opportunity to improve nursing care services to the lower-income elderly population while also reducing total federal government expenditures.

Unfortunately, there are obstacles that increase the difficulty of expanding the program. Paramount among these, building a brick and mortar center and providing all of the services required by regulatory bodies requires significant capital investment on the part of the organizations delivering care. One of the major benefits from the recent expansion of the program to include for-profit organizations is their ability to more efficiently raise the large investment dollars necessary to operate the PACE programs. The outcomes of the for-profit PACE providers are also on par with the outcomes of the not-for-profit providers, indicating that for-profit organizations are well placed to expand the services of these higher-quality cost-effective programs to a wider population.

Expanding the reach of the PACE program and supporting the expansion of for-profit providers is a targeted reform that will provide important near-term benefits including improved outcomes for patients and reduced cost pressures on Medicare and Medicaid.

This *Issue Brief* evaluates the benefits from expanding the reach of the PACE program beginning with an overview of the history of the program and documenting its ability to provide elderly patients with higher-quality lower-cost nursing-care type services. Next, the analysis illustrates how Congress's bipartisan decision to enable private sector, for-profit organizations to support programs has expanded PACE to a wider population while still providing the same high-quality services. The analysis concludes with a discussion of beneficial policy reforms that can help accelerate the expansion of the PACE program.

How Patients, Taxpayers and the Community Benefit from PACE

PACE's purpose is to provide medical and social care services to lower-income individuals 55 and older, typically living in underserved geographies or from underserved populations. These lower-income older adults are frail, have chronic diagnoses, and are living with potentially significant functional and cognitive impairments. While these individuals have complex medical needs that typically require costly services that are provided by nursing home facilities, they also have the capability of living in their own homes if they are provided with the requisite support.

The PACE program provides this requisite support. It delivers the core medical and social care services that this complex population requires while allowing them to remain in their homes. Keeping these individuals in their homes and communities is not only the preferred option for many of these patients, but the PACE program also creates net cost savings compared to the costs of care at more expensive nursing homes. Essentially, the program is a compelling model for seniors that provides coordinated care for patients with complex issues and needs, helps patients remain at home (out of nursing homes) and in their community, and provides important socialization benefits for patients beyond the health services.

"PACE's purpose is to provide medical and social care services to lower-income individuals 55 and older, typically living in underserved geographies or from underserved populations.

To qualify, beneficiaries must be "certified by their state to need a nursing-home level of care, reside in the service area of a PACE organization, and be able to live safely at home with PACE support. Nationwide, most PACE participants (87 percent) are dually enrolled in Medicare and full Medicaid. About 13 percent are enrolled in full Medicaid but not in Medicare. Fewer than 1 percent have Medicare without Medicaid or neither Medicare nor Medicaid coverage."[2]

The PACE program was officially established in 1997, but the program's antecedents reach back to the 1970s. According to *Stateline,*

> In the early 1970s, community leaders in San Francisco's Chinatown-North Beach neighborhood were looking for a way to care for elders who had mainly emigrated from China, Italy and the Philippines. They determined nursing homes were cost-prohibitive and culturally inappropriate in their community, so they formed a nonprofit to provide long-term elder care. They named it On Lok, a Cantonese term meaning "peaceful, happy abode."
>
> The On Lok adult day center eventually became the first PACE center.[3]

During the 1970s and 1980s, the On Lok day center started receiving Medicaid funds, expanding its services to include a broad array of medical and social services, and adopted a capitated payment method that paid the center a fixed amount for each person who is served.[4] The PACE model was permanently recognized as a provider for Medicare and Medicaid in the Balanced Budget Act of 1997.[5] Following this recognition, the program started expanding at a much faster rate. According to Miller, Gupta, and Polsky (2025), the number of PACE programs grew 116 percent between 2010 and 2022, and the number of enrollees grew 211 percent.[6] Despite this growth, PACE's availability is still quite limited. There are currently "186 PACE programs serving more than 84,000 participants in 33 states and the District of Columbia," according to the National PACE Association.[7]

Improving Care While Decreasing Costs

The limited availability of the program is troubling as PACE is widely regarded as a success. By avoiding the need for costlier nursing home care when patients can be treated via home-based care, PACE creates significant savings. According to California Mobility, the average cost of a nursing home is between $6,800 and $7,800 per month.[8] According to the American Council on Aging, while the fees vary based on the PACE program the average costs generally range between $4,000 and $5,000/month.[9] Based on these average prices, the per participant PACE program savings for the federal and state governments are around $2,800 a month on average, or $33,600 annually. Relative to the current 84,000 participants, this equates to $2.8 billion in savings, see Table 1. Expanding the population served by the PACE program will increase these savings.

Table 1
Home-based Care Through the PACE Program Saves Billions Annually

	MONTHLY SAVINGS	ANNUAL SAVINGS
Average Savings	$2,800	$33,600
Number of Current Participants	84,000	84,000
Total PACE Savings Relative to Average Nursing Care	$235,200,000	$2,822,400,000

Source: Author calculations based on data from California Mobility, American Council on Aging, and National Pace Association

Not only are there budgetary savings for the government, but there is also growing evidence that patients participating in the PACE program experience better health outcomes. For example, a study in the *Journal of the American Geriatrics Society* found that "PACE enrollees experienced lower rates of hospitalization, readmission, and PAH [potentially avoidable hospitalization] than similar populations."[10] After reviewing studies that have examined the impact of PACE, the Commonwealth Fund concluded that the program is one of the

> most successful models of integrating services for high-need people with acute and LTSS [long-term support services] needs. Several studies and evaluations have demonstrated the positive effects of enrolling in PACE. Such benefits include reductions in hospitalization, rehospitalization, and emergency department use; reductions in long-term nursing facility placements; reductions in mortality; and lower rates of functional decline and better reported health status and quality of life.[11]

PACE's payment model increases the program's potential for simultaneously delivering budgetary savings and higher quality health care for patients. PACE is based on a capitated coordinated care model that compensates providers on a fixed per person (or "capitated") basis. The fixed payment covers all health care services the provider is responsible for delivering over a defined period. Typically, the payments are adjusted according to each patient's expected needs and providers are held accountable for the quality of the outcomes.

One advantage of this payment model is that, by better aligning the payment incentives, capitated payment models discourage waste and encourage innovation in care. As described in a 2016 *Harvard Business Review* analysis:

> It's the only payment system that fully aligns providers' financial incentives with the goal of eliminating all major categories of waste. It fundamentally shifts the role of managing the amount, form, and cost of care from insurers to medical practitioners. It also ensures that providers receive enough of the savings that they can afford to fund the changes needed to bring down costs." [12]

Experience demonstrates that how health programs implement the capitated payment system matters; however, as applied to the PACE program, the capitated model has lived up to its potential. The response of PACE providers to the pandemic exemplifies these outcomes. As a Bipartisan Center analysis documented, "PACE sites were able to respond quickly to the pandemic, and many programs adapted by delivering care creatively in the home. For example, PACE programs increased their reliance on technology for telehealth, home monitoring, combating social isolation, and other activities. They also repurposed transportation vehicles to deliver meals, groceries, medications, durable medical equipment, and other items such as brain games for cognitive stimulation."[13]

For-Profit Providers Have a Comparative Advantage Raising Capital

For-profit service providers have been eligible to participate in the program since 2015. Critics of these for-profit organizations worry that they will provide lower quality services to participants, but the evidence does not support these accusations. If acted upon, there are consequences from these unfounded concerns because for-profit PACE providers have been essential contributors enabling PACE's recent growth.

A 2025 Health Affairs Scholar piece on the PACE program (Miller et al. (2025)) tracked the different growth rates of for-profit and nonprofit PACE providers.[14] The authors found that for-profit programs have been expanding at more than twice the rate of nonprofits. A March 2025 evaluation of the for-profit expansion of PACE by NORC at the University of Chicago concluded that since the regulatory changes enabled for-profit entities to participate, their growth has

> substantially outpaced their nonprofit counterparts in both the number of contracts and participant enrollment. Specifically, for-profit entities expanded their contract base by 182% and increased enrollment by 173%, compared to a modest 6% and 44% growth among nonprofit organizations.[15]

For-profit entities are driving growth in the program because there is a large necessary infrastructure that must be purchased before a PACE center can serve a single participant. The Health Dimensions Group breaks down these large expenditures citing,

> the most significant part of the capital investment is the brick-and-mortar component of developing a PACE center. A PACE center is the hub of a PACE program's operation and is a required element of becoming a PACE organization. The cost of the PACE center will vary depending on many factors including the square footage; whether the building will be built, bought, or leased; the condition of the building; and the construction market landscape. This is typically a multimillion-dollar investment.[16]

In addition to the physical center, the centers need the equipment to provide physical therapy, occupational therapy, recreational activities, and food services. The centers also need to establish health facilities capable of providing onsite nursing care, physician services, dental services, optometry, podiatrist, nutritional services, and pharmacy services. It is also necessary to hire the professionals who will provide all these services before the center has received any compensation from the government.

Covering all these expenditures requires substantial resources that must be available to the potential center upfront. According to the Health Dimensions Group, covering all these expenditures requires between $5 and $10 million on average depending on the specific PACE center and location.[17] The median center enrolls around 250 people while the average center enrolls around 400 people indicating that some centers are significantly larger than the average.[18]

Applying these costs to the 186 PACE programs that currently exist,[19] establishing these centers has required capital investments between $930 million and $1.9 billion. Relative to the 84,000 participants served, the investment requirements are between $11,000 and $22,000 per participant. Based on these costs, reaching a goal of serving 200,000 participants by 2028 will require additional investments of $1.3 billion to $2.6 billion.[20] Reaching a goal of 1 million participants would require a total investment of $10.1 billion to $20.3 billion.

Given these large upfront costs, it is unsurprising that for-profit organizations are driving the program's growth. Miller et al. (2025) specifically cite for-profit's "ability to withstand the high startup capital investments (eg, day center building, transportation, staffing requirements), an often-cited barrier to expanding PACE"[21] as a primary driver of their growth. Similarly, the NORC study cited the for-profit entities access to capital as a major competitive advantage driving their growth,

> this rapid expansion is a result of both policy and regulatory changes, as well as the robust access to capital enjoyed by for-profit organizations, particularly those backed by PE and VC firms.
>
> This capital advantage has created distinct growth patterns between organization types. For-profit PACE organizations, primarily those backed by external investors, benefit from more robust access to capital, enabling them to implement aggressive growth strategies such as launching multiple sites simultaneously, acquiring existing programs, investing heavily in marketing and enrollment outreach, and leveraging centralized administrative functions.[22]

Changes that impede the growth of these for-profit entities will limit the ability of the PACE program to serve an expanded population to the detriment of patients. This observation is essential. Expanding the reach of the PACE program in a timely manner requires providers to have access to sufficient capital resources. For-profit providers, including those backed by venture capitalists, have the requisite access to these resources, which is evidenced by the reality that these are the organizations driving growth.

Quality of Services Concerns Are Unsubstantiated

As documented above, participants in the PACE program experience significantly better health outcomes compared to patients who are served in nursing homes or lack care at all. Patients served by PACE centers require fewer health care services that include hospitalizations and rehospitalizations, emergency department use, and the need for long-term nursing facility care. They also include better health outcomes that include reduced mortality rates, lower rates of functional decline, and better reported health status / quality of life.

Since for-profit entities have not been serving as PACE centers for very long, there are only a few empirical analyses that compare the quality of services between PACE centers based on their profit-status. Thus far, the analyses find that both nonprofit and for-profit entities provide the same quality services, however.

For example, in summarizing the results from the pilot study that compared the quality of for-profit PACE organizations to nonprofit entities in Pennsylvania, the Centers for Medicare & Medicaid Services (CMS) states

that "there was no statistically significant difference between the for-profit PACE organizations and not-for-profit PACE organizations on a majority of the measures."

Despite the evidence showing comparable quality, critics will allege that for-profit centers may provide lower quality of services. For example, after documenting the faster growth rates of for-profit entities, Miller et al. (2025) assert that "the entry of for-profit entities may result in practices that maximize profits at the expense of quality of care."

The authors provide no evidence supporting this assertion and even note that "PACE models are highly regulated by CMS" and "little evidence exists regarding whether program processes and outcomes vary by ownership." Put differently, despite the authors' allegations, the evidence does not show that there is a difference in the quality of services provided to patients between for-profit and nonprofit entities.

> "While recognizing the benefits from expanding the coverage of the PACE program, critics allege that for-profit centers may provide lower quality services.

A Mathematica Policy Research analysis also claimed that "the access to and quality of care received by for-profit enrollees in PACE plans in Pennsylvania is lower along several dimensions compared to the care received by their not-for-profit counterparts." Taken at face value this appears to provide support to the allegation that for-profit centers provide lower quality care. However, the study notes that "many of the differences were not statistically significant."

The findings were not statistically significant because the populations served were so different. Specifically, as CMS notes,

> several underlying differences between the two sets of PACE participants were found, reflecting the different population characteristics prevalent in the PACE organization service areas. These confounding population-level characteristics are likely associated with the observed differences in access to and quality of care measures. The participants receiving care from the for-profit PACE organizations were more likely to live independently versus in an assisted living facility or an institutional setting, such as a nursing home. They also lived in less urban areas in Pennsylvania, and may not have had access to the same amount and diversity of medical providers. It is possible that some of the differences in participant experiences, such as "fallen in the past six months" or "injured by a fall in the past six months," may be due to living independently in the community and living in less urban areas; thus, these differences are not likely a reflection of the care provided by the for-profit PACE organizations.

In other words, there were material differences between the participants in for-profit centers and participants in nonprofit centers. Once these differences are considered, there are no discernible differences in the quality-of-care participants received based on the organization's profit status. This finding of no difference in quality is also consistent with other findings from the Mathematica study such as enrollees' satisfaction with care being similar between for-profit and nonprofit entities.

The findings of the analyses consequently demonstrate that the profit status of an organization is irrelevant. Compared to alternative nursing home care, PACE centers provide higher quality care at lower costs. Since for-profit providers are better positioned to raise the necessary capital, these organizations are essential for expanding the higher quality / lower cost services provided by PACE entities.

Also noteworthy, the evidence from the NORC study also demonstrates that for-profit providers are expanding the PACE program to a "more racially and ethnically diverse population, with a notable increase in Medicaid-only participants." This expansion demonstrates that the for-profit providers are fulfilling PACE's mission.

Undoubtedly, oversight ensuring quality control at PACE programs is warranted, regardless of whether those programs are run by for-profit or nonprofit organizations. Additionally, it is essential to ensure that the incentives of the program operators are aligned with the needs of program participants. However, the need for effective oversight should not distract from the important contributions that for-profit organizations have made to program enrollees.

Beneficial Policy Reforms

There are several policy reforms that, if implemented, would help expand the benefits created by the PACE programs.

Support the ability of for-profit providers to participate in the PACE program

The data reviewed above confirms that for-profit providers are well positioned to expand access to PACE services. It is essential, consequently, to maintain the 2015 expansion that allows for-profit entities to sponsor PACE centers. Ensuring that these organizations can continue to serve PACE participants on equal terms with nonprofit providers is essential for increasing the number of people who benefit from the program.

Streamline the regulatory burden for starting and operating a PACE program

The ability of both for-profit and not-for-profit entities to expand access to the PACE program can also be enhanced through broader regulatory reforms. For example, excessive "federal red tape" and timing delays for new applications increases the costs of establishing and running a PACE center. These costs can be lessened through legislative or regulatory reforms that reduce the administrative burdens entities must manage when submitting applications for new PACE programs and service areas, increase the frequency that potential expanded/new sites can submit applications, and require CMS to implement a shorter time limit than the current 90 days for approving new PACE organizations.

Expand eligibility to include current high-need, high-cost patients that have difficulties qualifying for the PACE program

Other reforms should consider expanding the eligibility requirements. For example, current rules make it difficult for high-need, high-cost individuals who have Medicare but not Medicaid to participate in the program. These barriers deny PACE services to elderly individuals who can benefit from the program and, because of the program's track record of providing higher-quality, lower-cost care, also forfeit potential opportunities to lower overall spending levels.

Conclusion

The retiring baby boom generation will likely significantly increase the demand for managed care programs. The growing body of evidence demonstrates that the PACE program can generate cost savings and improve health outcomes by ensuring that patients who require nursing home type care can receive the necessary care while avoiding more expensive institutional settings. Coupling this innovative delivery model with the more efficient capitated payment method enhances the savings enabled from avoiding nursing home care and further incentivizes better care management.

“The growing body of evidence demonstrates that the PACE program can generate cost savings and improve health outcomes by ensuring that patients who require nursing home type care can receive the necessary care while avoiding more expensive institutional settings.

However, starting a PACE program is an expensive and capital-intensive endeavor, which has been a hinderance to the program's growth. Congress's decision in 2015 to expand the program to for-profit providers—which have achieved comparable outcomes to non-profit providers—improves the industry's ability to expand the benefits offered by this innovative program to a significantly wider population, particularly in rural and underserved markets.

Given the limited scope of the program currently, there are numerous opportunities to expand the benefits created by PACE. These include ensuring the continued participation of for-profit entities, reducing unnecessary federal regulatory burdens for both for-profit and non-profit entities, and easing eligibility/access to non-Medicaid but high-need, high-cost individuals.

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About the Author

Wayne Winegarden

Wayne H. Winegarden, Ph.D. is a Senior Fellow in Business and Economics at the Pacific Research Institute and director of PRI's Center for Medical Economics and Innovation. He is also the Principal of Capitol Economic Advisors.

Dr. Winegarden has 25 years of business, economic, and policy experience with an expertise in applying quantitative and macroeconomic analyses to create greater insights on corporate strategy, public policy, and strategic planning. He advises clients on the economic, business, and investment implications from changes in broader macroeconomic trends and government policies. Clients have included Fortune 500 companies, financial organizations, small businesses, state legislative leaders, political candidates and trade associations.

Dr. Winegarden's columns have been published in the *Wall Street Journal, Chicago Tribune, Investor's Business Daily,* Forbes.com, and Townhall.com. He was previously economics faculty at Marymount University, has testified before the U.S. Congress, has been interviewed and quoted in such media as CNN and Bloomberg Radio, and is asked to present his research findings at policy conferences and meetings. Previously, Dr. Winegarden worked as a business economist in Hong Kong and New York City; and a policy economist for policy and trade associations in Washington D.C. Dr. Winegarden received his Ph.D. in Economics from George Mason University.

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