

# “Pacing” Ourselves: Saving Medicaid through Programs of All-Inclusive Care for the Elderly

Megan Ingram-French\*

## ABSTRACT

The baby boomer generation is aging, and those in the boomer generation will soon pose an unparalleled burden on government-subsidized health care systems like Medicaid. To sustain this impending burden, these systems must undergo significant reform. Most elderly individuals require long-term care at some point in their lives. Today, many baby boomers are providing this care to their elderly parents, and this practice has kept most of the elderly in need of care at home and out of long-term care facilities. As the baby boomers age, though, they will have fewer family members available to care for them and will depend on outside sources for care. Furthermore, the baby boomers will depend on Medicaid to pay for this care. However, this health care system is already strained, even with the current trend of family caregivers.

Fortunately, one health care program could lighten this oncoming burden: Programs of All-Inclusive Care for the Elderly (PACE). Through PACE, patients can remain at home and in their communities while receiving care from an interdisciplinary team of professionals. Regulations controlling PACE demand high-quality care, and operating PACE organizations have experienced positive outcomes. Because of the cost benefits of home- and community-based care, states that have enacted PACE have also saved on health care costs.

Current PACE regulations allow states to optionally offer PACE through Medicaid. However, the high start-up costs of opening new PACE centers deter the program’s expansion. This Comment will advocate for the federal government to subsidize these start-up costs. Subsidizing start-up costs will expand PACE through Medicaid, effectively reaching PACE’s target audience. By expanding PACE, elderly citizens will enjoy the benefits of the program, and the federal government will reap the cost

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\*J.D. Candidate, The Pennsylvania State University, Penn State Law, Class of 2020. The author would like to thank her family for their continuous support and advice throughout her work on this Comment.

savings. This solution will relieve the strain on Medicaid while supporting the baby boomers' looming long-term care needs.

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#### I. INTRODUCTION

America's government-subsidized health care programs, Medicare<sup>1</sup> and Medicaid,<sup>2</sup> will soon face heavy burdens as the baby boomer generation ages and begins demanding long-term care.<sup>3</sup> This need for care will force massive costs onto these subsidized systems,<sup>4</sup> especially Medicaid, which covers the long-term care needs of its participants.<sup>5</sup> However, Programs of All-Inclusive Care for the Elderly<sup>6</sup> (PACE) has the

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1. 42 C.F.R. § 405 (2015). Although PACE programs would allow Medicare to save costs through reduced medical bills and similar expenses, Medicaid, the government-subsidized health care system that pays for long-term care, will experience the most substantial financial savings by paying for PACE medical care instead of nursing home bills. *See infra* notes 13–15, 29–31 and accompanying text.

2. 42 C.F.R. § 430.0 (1988).

3. Shana Siegel & Neil T. Rimsky, *Where Do We Go from Here? Long-Term Care in the Age of the Baby Boomers*, 11 NAELA J. 49, 50 (2015). The baby boomer generation includes people born between 1946 and 1964. Jim Chappelow, *Baby Boomer*, INVESTOPEDIA (last updated Feb. 28, 2020), [https://www.investopedia.com/terms/b/baby\\_boomer.asp](https://www.investopedia.com/terms/b/baby_boomer.asp).

4. Siegel & Rimsky, *supra* note 3, at 50.

5. *Medicaid Long-Term Care Services*, LONGTERMCARE.GOV, <https://bit.ly/2XhX2MF> (updated on Oct. 10, 2017).

6. 42 C.F.R. § 460 (1999).

potential to solve this impending problem. Through PACE, the federal government can provide the elderly with high-quality<sup>7</sup> home- and community-based care<sup>8</sup> while significantly saving costs.<sup>9</sup>

Current PACE coverage is wanting, with only 124 PACE organizations operating in 31 states.<sup>10</sup> However, the government could expand the program to satisfy the future demands of the baby boomers. The federal government could incentivize PACE expansion by subsidizing the high start-up costs of opening new PACE organizations.

In this Comment, Part II explains the causes and extent of the impending demand that the baby boomer generation will place on Medicaid.<sup>11</sup> Further, Part II explains PACE, detailing the program’s structure, enrollment qualifications, services offered to participants, and financing.<sup>12</sup> Part II will also illustrate the success of current PACE organizations and will provide statistics that demonstrate the inadequate coverage of PACE.<sup>13</sup>

Then, Part III analyzes the effectiveness of having the federal government subsidize the start-up costs of new PACE centers.<sup>14</sup> By subsidizing the start-up costs, the federal government will encourage states to expand PACE through Medicaid programs.<sup>15</sup> Expanding PACE through Medicaid will provide PACE’s services to its target audience and will save the federal government significant expenses in providing long-term care to the baby boomers.<sup>16</sup> Ultimately, Part III recommends that the federal government should incentivize PACE expansion by subsidizing the high

7. Jacqueline LaPointe, *Providers Investing in Home Health to Prepare for Aging Population*, REVCYCLE INTELLIGENCE (June 27, 2018), <https://bit.ly/2RDhBla> (reporting that “PACE patients receiv[ed] care with quality scores twice as high” as the care given to patients in other long-term care facilities).

8. *Program of All-Inclusive Care for the Elderly*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html> (last visited May 20, 2020). Community-based care is “health care . . . for people of all ages who need health care assistance at home.” *What is community-based health care?*, SETTLEMENT.ORG, <https://bit.ly/2UQFs1i> (last updated Oct. 29, 2018). Community-based health care can “include home support, nursing, physiotherapy and other rehabilitation services.” *Id.*

9. See *Program of All-Inclusive Care for the Elderly*, *supra* note 8; see also Mary Kate Nelson, *NY Times: PACE Changes Worry Critics*, HOME HEALTH CARE NEWS (Aug. 22, 2016), <https://homehealthcarenews.com/2016/08/ny-times-pace-changes-worry-critics/>.

10. CTRS. FOR MEDICARE & MEDICAID SERVS., 2017 PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) AUDIT AND ENFORCEMENT REPORT 4 (2018), <https://go.cms.gov/2y0h2su> [hereinafter 2017 AUDIT AND ENFORCEMENT REPORT].

11. See *infra* Section II.A.

12. See *infra* Sections II.B.1-4.

13. See *infra* Sections II.B.5-6.

14. See *infra* Section III.

15. See *infra* Section III.

16. See *infra* Section III.

start-up costs of opening new PACE organizations.<sup>17</sup> Finally, Part IV offers concluding statements on the issues raised in this Comment.<sup>18</sup>

## II. BACKGROUND

As the baby boomers age, they will need long-term care.<sup>19</sup> PACE provides high-quality, at-home care at low costs to Medicaid. But current PACE coverage cannot sustain the enormous burden of the baby boomers.<sup>20</sup>

### A. *The Growing Elderly Population and Elder Care*

The baby boomers of America are aging, and quickly.<sup>21</sup> As this large generation<sup>22</sup> ages, the elderly segment of the population will grow rapidly in number.<sup>23</sup> Specifically, the number of people in America over the age of 80 is expected to grow by 79% between 2010 and 2030.<sup>24</sup> By 2029, senior citizens<sup>25</sup> are expected to make up 20% of the entire population.<sup>26</sup> As the elderly segment of the population grows, the demand for long-term care will also grow.<sup>27</sup>

#### 1. Long-term Care Needs of the Elderly

Generally, elderly citizens require large amounts of care. To be exact, 70% of the elderly population<sup>28</sup> needs personal care.<sup>29</sup> The average elder depends on this care for about three years, but 20% of elderly citizens need

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17. See *infra* Section III.

18. See *infra* Section IV.

19. See Siegel & Rimsky, *supra* note 3, at 50.

20. See *infra* Section II.A.2.

21. Siegel & Rimsky, *supra* note 3, at 50. The baby boomer generation includes individuals born between 1946 and 1964. See *Baby Boomer*, MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/baby%20boomer> (last visited May 20, 2020).

22. See Sally Abrahms, *Five myths about baby boomers*, WASH. POST (Nov. 6, 2015), <https://wapo.st/34oHHex> (reporting that the number of Americans in the baby boomer generation is greater than the whole French population).

23. Siegel & Rimsky, *supra* note 3, at 50.

24. *Id.*

25. “Senior citizens” are people over the age of 65. *Senior citizen*, CAMBRIDGE DICTIONARY, <https://dictionary.cambridge.org/dictionary/english/senior-citizen> (last visited May 20, 2020).

26. LaPointe, *supra* note 7; see Tom Valeo, *Growing Old, Baby-Boomer Style*, WEBMD (Nov. 11, 2009), <https://www.webmd.com/healthy-aging/features/growing-old-baby-boomer-style#1>.

27. See *infra* Section III.

28. The “elderly population” includes people over the age of 65. *Elderly*, FREE DICTIONARY, <https://medical-dictionary.thefreedictionary.com/elderly> (last visited May 20, 2020).

29. HOWARD GLECKMAN, *CARING FOR OUR PARENTS 2* (2009); *Long-Term Care: Plan for the Future*, AARP, <https://bit.ly/2RTmtlv> (last visited May 20, 2020).

care for at least five years.<sup>30</sup> This length of care will likely extend with the baby boomers, because those in the boomer generation have a “rapidly increasing life expectancy.”<sup>31</sup>

For those that require it, long-term personal care typically involves assisting an elder with daily tasks.<sup>32</sup> Of those over the age of 85, 40% require assistance leaving their homes, 25% cannot individually perform household tasks such as cooking and cleaning, and over 10% require assistance when transitioning from a bed into a chair.<sup>33</sup> As the baby boomer generation ages and the elderly population expands, the need for this type of long-term care will also grow.<sup>34</sup> However, as the demand for long-term care increases, the number of caregivers available to provide long-term care will decrease.<sup>35</sup>

## 2. The Impact of Family Caregivers

This increased demand for long-term care will impact the health care system in unprecedented ways. Currently, individuals within the baby boomer generation are taking care of those in the Silent Generation,<sup>36</sup> which is the elderly generation presently in need of long-term care.<sup>37</sup> Approximately 44 million individuals act as family caregivers to the Silent Generation, devoting time and energy to helping those who would otherwise need professional care.<sup>38</sup> These voluntary caregivers are typically the spouses or adult children of those receiving the care.<sup>39</sup>

30. GLECKMAN, *supra* note 29, at 2; *How Much Care Will You Need?*, LONGTERMCARE.GOV (Oct. 10, 2017), <https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html>.

31. GLECKMAN, *supra* note 29, at 198; *see also* Abrahms, *supra* note 22 (explaining that the life expectancy for a baby boomer is 84.3 years old); *Baby boomers are living longer, but at a lower quality of life: study*, DAILY NEWS (May 12, 2015), <https://bit.ly/3c28LD3>; *Life Expectancy at Birth by Race and Sex, 1930-2010*, INFOPLEASE, <https://bit.ly/3aTTXpT> (updated Feb. 28, 2017) (stating that the average life expectancy of a person born in 1930 was 59.7 years old).

32. *See* GLECKMAN, *supra* note 29, at 26.

33. *Id.*

34. Siegel & Rimsky, *supra* note 3, at 50.

35. *Id.*

36. *See The Silent Generation, “The Lucky Few” (Part 3 of 7)*, FORBES (Aug. 13, 2014), <https://www.forbes.com/sites/neilhowe/2014/08/13/the-silent-generation-the-lucky-few-part-3-of-7/#5188748e2c63>. The silent generation is made up of individuals born between 1925 and 1942. *Id.*

37. Siegel & Rimsky, *supra* note 3, at 50; *see also* Lauren Hill, *10 Tips for Baby Boomers Taking Care of Aging Parents*, LAKE OCONEE BOOMERS (June 28, 2014), <https://bit.ly/2Xl3Rgw>.

38. GLECKMAN, *supra* note 29, at 18. Specifically, in 2015, there were approximately seven caregivers available for each elderly person. Siegel & Rimsky, *supra* note 3, at 50; *see also* ARI HOUSER ET AL., *ACROSS THE STATES: PROFILES OF LONG-TERM SERVICES AND SUPPORTS* 1, 2, 11 (2018), *available at* <https://bit.ly/2W0FhhT>.

39. GLECKMAN, *supra* note 29, at 18; *see also* Martha Stettinius, *Why You’re So Tired: Long-Term Caregiving is a New Phenomenon*, CAREGIVERS (Aug. 19, 2014), <https://bit.ly/2yG77Zq>; Paula Span, *Aging Without Children*, N.Y. TIMES (Mar. 25, 2011),

This assistance from family members has kept a substantial number of elderly citizens out of nursing homes<sup>40</sup> and has saved Medicaid an immense sum of money.<sup>41</sup> These family caregivers provide about 80% of the long-term care administered to America's elderly.<sup>42</sup> This voluntary care is valued at approximately \$470 billion each year.<sup>43</sup> Because family caregivers provide substantial amounts of care that Medicaid would otherwise pay for in nursing home bills, the government health care systems have not yet felt the true impacts of elder citizens' long-term care needs.<sup>44</sup>

However, this practice of family caregivers providing at-home care is unsustainable.<sup>45</sup> As members of the baby boomer generation age, they will no longer be able to provide care for others. Instead, they will need care themselves.<sup>46</sup> When the baby boomers need this care, fewer people will be available to provide the care.<sup>47</sup> Specifically, in 2015, the ratio between caregivers and elderly persons was seven to one. By 2050, the ratio will shrink to fewer than three caregivers for each elderly person.<sup>48</sup>

This decline is predicted for multiple reasons. First, divorced individuals make up 14% of the baby boomer generation, and another 14% of that generation have never been married.<sup>49</sup> These statistics mean that a significant number of baby boomers will not have a spousal caregiver available, unlike those in the Silent Generation.<sup>50</sup>

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3:12 PM), <https://nyti.ms/3e5oqU7>. For more detail on the typical tasks of familial caregivers, see Linsey Knerl, *Top 11 caregiver duties to know*, CARE.COM (May 24, 2018), <https://bit.ly/2Vf4Z2l>.

40. Siegel & Rimsky, *supra* note 3, at 50 (explaining that family caregivers have kept approximately three million elderly persons who require nursing-home levels of care out of such facilities).

41. GLECKMAN, *supra* note 29, at 19; see Everette James & Meredith Hughes, *Embracing The Role Of Family Caregivers In The U.S. Health System*, HEALTH AFF. (Sept. 8, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160908.056387/full/>.

42. GLECKMAN, *supra* note 29, at 19; *Are you Prepared to be a Family Caregiver? Families Provide 80% of all Care!*, ELDERCARE SERVICES (Apr. 10, 2017), <https://eldercareanswers.com/family-caregiver/>.

43. HOUSER ET AL., *supra* note 38, at 11; James & Hughes, *supra* note 41.

44. *Are you Prepared to be a Family Caregiver? Families Provide 80% of all Care!*, *supra* note 42; GLECKMAN, *supra* note 29, at 19; HOUSER ET AL., *supra* note 38, at 11; James & Hughes, *supra* note 41.

45. Siegel & Rimsky, *supra* note 3, at 50.

46. *See id.*

47. *Id.*; see Janet Adamy & Paul Overberg, *The Loneliest Generation: Americans, More Than Ever, Are Aging Alone*, WALL ST. J. (Dec. 11, 2018), <https://on.wsj.com/2ryjKz8> (stating that one in eleven people in America do not have a spouse or adult children).

48. Siegel & Rimsky, *supra* note 3, at 50; see also HOUSER ET AL., *supra* note 38, at 2.

49. GLECKMAN, *supra* note 29, at 200.

50. *Id.*; see also *Breaking Down Divorce by Generation*, GOLDBERG JONES (Aug. 9, 2018), <https://www.goldbergjones-wa.com/divorce/divorce-by-generation/> (describing the Silent Generation's view of marriage "as an unbreakable bond" and that "divorce wasn't

Second, fewer adult children are available to provide care to baby boomers.<sup>51</sup> Fewer children are available because, on average, the baby boomers had one-third fewer children than the Silent Generation.<sup>52</sup> Moreover, 20% of those in the baby boomer generation have no children.<sup>53</sup>

Third, of the adult children who were born to baby boomers, many are more active in the workforce than their parents were.<sup>54</sup> The vast majority of these working children will struggle to balance their caregiver and professional responsibilities.<sup>55</sup> An adult child caring for a parent usually devotes 15 to 20 hours each week to providing elder care.<sup>56</sup> This significant time demand often impacts the caregiver’s career.<sup>57</sup> Among family caregivers providing limited care to a loved one, 40% had to cut back hours at their jobs, 17% were required to take an extended leave from their jobs, and 6% had to quit.<sup>58</sup> These percentages skyrocketed once the caregiver’s parent or relative required a greater level of care: 83% had to cut back on hours at work, 41% had to take an extended leave,<sup>59</sup> and over 33% had to quit.<sup>60</sup>

Lastly, many children of the baby boomer generation live far away from their parents, and the large geographic distances make providing care difficult.<sup>61</sup> The predicted decrease in available familial caregivers, coupled with the larger volume of the baby boomer generation, will likely inflict an unprecedented burden on Medicaid.<sup>62</sup>

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often a realistic option” for this Generation, but “the most dramatic shift [in divorce rates and social opinions regarding divorce] occur[ed]” with the baby boomer generation); Frank Olito, *How the divorce rate has changed over the last 150 years*, INSIDER (Jan. 30, 2019), <https://www.insider.com/divorce-rate-changes-over-time-2019-1> (explaining that the divorce rate in the 1950s was approximately 2.3 divorces for every 1,000 people).

51. GLECKMAN, *supra* note 29, at 200.

52. *See id.*

53. *Id.*; *see* Span, *supra* note 39.

54. GLECKMAN, *supra* note 29, at 48. Only about half of the women in the baby boomer generation were employed, but almost two-thirds of the baby boomers’ adult daughters are involved in the workforce. *Id.* at 200–01.

55. GLECKMAN, *supra* note 29, at 48.

56. *Id.* at 40; *see* *Caregiving*, FAM. CAREGIVER ALLIANCE, <https://www.caregiver.org/caregiving> (last visited Jan. 20, 2019).

57. GLECKMAN, *supra* note 29, at 48.

58. *Id.*

59. *Id.*

60. *Id.*; *see also* David Harrison, *Employers Need to Address ‘Caregiving Crisis,’ Study Finds*, WALL ST. J. (Jan. 16, 2019), <https://on.wsj.com/2U39NFM> (stating that 32% of familial caregivers had to quit their jobs because “they couldn’t balance work and family duties”).

61. GLECKMAN, *supra* note 29, at 198.

62. Siegel & Rimsky, *supra* note 3, at 50; *see also* Houser et al., *supra* note 38, at 2.

### 3. Long-term Care Impacts on Medicaid

Currently, Medicaid is strained, even with the Silent Generation receiving substantial amounts of care from family caregivers.<sup>63</sup> About half of current Medicaid spending goes towards long-term care<sup>64</sup>—about \$100 billion every year.<sup>65</sup> In some states, the percentage of Medicaid funding dedicated to long-term care is even greater.<sup>66</sup> For instance, Oklahoma spends approximately 70% of its Medicaid funding on long-term care.<sup>67</sup>

Nationwide, the average elderly citizen incurs about \$157 every day, or \$4,710 every month, in long-term care bills that Medicaid pays.<sup>68</sup> Most of these bills are from nursing homes or other facilities.<sup>69</sup> Among the \$100 billion Medicaid pays each year in long-term care costs,<sup>70</sup> only 25% is used to pay for home-based care for the elderly.<sup>71</sup> Even though surveys repeatedly find that elderly persons would prefer to be treated in their own homes,<sup>72</sup> about 1.4 million elderly individuals reside in nursing homes across the country.<sup>73</sup> Approximately 65% of those individuals residing in nursing homes receive Medicaid benefits.<sup>74</sup> Considering that Medicaid is already stretched thin even with so many baby boomers providing care to the Silent Generation, Medicaid will be on the brink of collapse once those

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63. Siegel & Rimsky, *supra* note 3, at 50.

64. *Id.* at 50–51; Richard Eisenberg, *Medicare, Medicaid and Long-Term Care: Your Questions Answered*, FORBES (Nov. 21, 2017), <https://www.forbes.com/sites/nextavenue/2017/11/21/medicare-medicare-and-long-term-care-your-questions-answered/#2de16d9f76c9>.

65. GLECKMAN, *supra* note 29, at 148.

66. Victoria Sackett, *States Moving in the Right Direction on Long-Term Care Services*, AARP (June 14, 2017), <https://www.aarp.org/caregiving/health/info-2017/states-long-term-care-scorecard-fd.html> (reporting that Minnesota devotes two-thirds of its Medicaid funding to home- and community-based long-term care); *see also* Corey Jones, *Beacon of hope flashes among many dire findings in AARP report on state's care of the elderly – the 'Oklahoma standard'*, TULSA WORLD (Sept. 9, 2018), <https://bit.ly/2AThAPC> (referencing an AARP report that stated Oklahoma spends 70% of its Medicaid funding on “long-term services and support”).

67. Jones, *supra* note 66.

68. GLECKMAN, *supra* note 29, at 90.

69. *Id.* at 149.

70. *Id.* at 148.

71. *Id.* at 133. “Home[-]based [c]are can include . . . nursing care, rehabilitation services . . ., assistance with activities of daily living . . ., assistance with housekeeping, chores and meal preparation, or assistance with activities to maintain health such as taking medications.” *Home Based Care*, MD. HEALTH CARE COMMISSION, <http://mhcc.maryland.gov/consumerinfo/longtermcare/HomeBasedCare.aspx> (last visited May 20, 2020).

72. GLECKMAN, *supra* note 29, at 112; *Ageing in Place: Growing Old at Home*, NAT'L INST. ON AGING (May 1, 2017), <https://www.nia.nih.gov/health/aging-place-growing-old-home>.

73. GLECKMAN, *supra* note 29, at 28; Jordan Rau, *Medicaid Cuts May Force Retirees, Out of Nursing Homes*, N.Y. TIMES (June 24, 2017), <https://nyti.ms/2R1qYWn>.

74. GLECKMAN, *supra* note 29, at 149; *see also* Elizabeth Dickey, *When California's Medi-Cal Will Pay for a Nursing Home, Assisted Living, or Home Care*, NOLO (Dec. 5, 2018), <https://bit.ly/2URBVix>.



in the large baby boomer generation require care themselves.<sup>75</sup> In addition to the financial need of a health care reform,<sup>76</sup> the quality of elder health care offered through the current long-term care programs would benefit from reform.<sup>77</sup>

#### 4. Quality of Care under the Current System

Despite the economic and social benefits they offer, family caregivers<sup>78</sup> may lack one essential element of elder health care: quality.<sup>79</sup> More than half—60%—of family caregivers have not been instructed by trained health care professionals on how to care for their loved ones.<sup>80</sup> One of every three family caregivers was “never shown how to change bandages or dressings, which is critical training, since small mistakes can easily lead to deadly infections.”<sup>81</sup>

On the other hand, the quality of care provided by some nursing homes is also poor.<sup>82</sup> In Pennsylvania, 36% of nurses and other employees who work in nursing homes reported witnessing verbally abusive behavior directed towards residents, 28% observed psychological abuse of the residents, and 19% observed medication administration inconsistent with prescribed schedules.<sup>83</sup> Although some nursing homes do provide high-quality care to residents, a significant number of facilities have been flagged for providing unhealthy qualities of care.<sup>84</sup> To be exact, 4,037 care facilities<sup>85</sup> across the country were found to physically restrain residents, and a substantial number of residents within these facilities “suffer from painful and potentially deadly pressure sores.”<sup>86</sup>

Further, two-thirds of nursing-home residents are treated with antidepressants or other psychiatric drugs.<sup>87</sup> One-third of these residents

75. GLECKMAN, *supra* note 29, at 198.

76. *Id.*

77. *See id.* at 87, 117; *see also* Jordan Rau, *Poor Patient Care at Many Nursing Homes Despite Stricter Oversight*, N.Y. TIMES (July 5, 2017), <https://www.nytimes.com/2017/07/05/health/failing-nursing-homes-oversight.html>.

78. GLECKMAN, *supra* note 29, at 112; *Aging in Place: Growing Old at Home*, *supra* note 72.

79. GLECKMAN, *supra* note 29, at 117.

80. *Id.*

81. *Id.* at 177.

82. *Id.* at 87; *see also* *Poor Patient Care*, *supra* note 77.

83. Brief for AARP as Amicus Curiae Supporting Petitioner at 8, *United States v. Momen Meadows Nursing Ctr., Inc.*, 764 F.3d 699 (2014) (Nos. 13-1886, 13-1936).

84. GLECKMAN, *supra* note 29, at 87; *see* *Poor Patient Care*, *supra* note 77.

85. “Care facilities” refers to facilities that “provide[] rehabilitative, restorative, and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living.” William C. Shiel, Jr., *Medical Definition of Long-term care facility*, MEDICINET (Dec. 12, 2018), <https://www.medicinenet.com/script/main/art.asp?articlekey=24859>.

86. GLECKMAN, *supra* note 29, at 87.

87. *Id.* at 88.

are treated with stronger psychiatric medications.<sup>88</sup> Sadly, research shows that 20% of the residents receiving these psychiatric medications “have never been diagnosed with any form of psychosis.”<sup>89</sup> One hypothesis as to why some nursing homes provide healthy patients with unnecessary psychiatric medication is that “drowsy” patients are easier and faster to care for.<sup>90</sup>

Nursing homes, despite sometimes providing low-quality care, are expensive. And the long-term care needed by baby boomers will demand enormous Medicaid funding.<sup>91</sup> The federal and state legislatures have approximately 20 years until the baby boomers begin demanding care.<sup>92</sup> Accordingly, the government has 20 years to find a solution that provides the baby boomer generation with high-quality, low-cost, at-home elder care. However, 20 years is a short time span to reform legislation. Regulations may take a minimum of two years to propose, finalize, and enact. Accordingly, Congress must begin the process of reformation to ensure that effective regulations are in place and the appropriate changes are established and prepared for the oncoming demand.<sup>93</sup> One solution to this predicament is PACE.<sup>94</sup>

#### B. *Programs of All-Inclusive Care for the Elderly*

In 1990, Medicare and Medicaid granted the first PACE organization approval to operate.<sup>95</sup> Congress officially enacted PACE in 1997,<sup>96</sup> describing the purpose of PACE as “provid[ing] pre-paid, capitated, comprehensive health care services” that “[e]nhance the quality of life and autonomy for frail, older adults” and “[e]nable” those adults “to live in the community as long as medically and socially feasible.”<sup>97</sup> The objective of PACE organizations is to provide high-quality long-term care to elderly participants at the participants’ homes.<sup>98</sup> Congress designed the structure of PACE programs to meet this objective and purpose.

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88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.* at 112, 156; Siegel & Rimsky, *supra* note 3, at 50.

92. Siegel & Rimsky, *supra* note 3, at 60.

93. See Comprehensive Care for Seniors Act of 2018, H.R. 6561, 115th Cong. 1–2 (2018); see also 81 Fed. Reg. 54,666-01 (proposed Aug. 16, 2016).

94. *Program of All-Inclusive Care for the Elderly*, *supra* note 8.

95. Siegel & Rimsky, *supra* note 3, at 50.

96. *Medicare and Medicaid Programs*, 64 Fed. Reg. 66,234 (1999).

97. 42 C.F.R. § 460.4(b) (1999).

98. See 42 C.F.R. §460.4(b) (1999).

### 1. Structure of PACE Programs

Essentially, PACE creates a “partnership” between three entities: the federal government, the state government, and the PACE organization.<sup>99</sup> PACE organizations are either non-profit<sup>100</sup> or for-profit organizations<sup>101</sup> that receive funding from federal and state governments<sup>102</sup> to provide elder care that abides by the regulations and standards set forth by the federal government.<sup>103</sup> Federal regulations require PACE organizations to focus on qualifying elderly<sup>104</sup> individuals<sup>105</sup> who require the level of care provided in a nursing facility.<sup>106</sup> PACE organizations must provide “comprehensive[]”, integrated long-term care services through an “[i]nterdisciplinary team” of health care professionals.<sup>107</sup>

Further, PACE organizations are required to be financially responsible for the PACE center from which the team administers care.<sup>108</sup> The PACE organization operating the center must use “capitat[ed]”,<sup>109</sup> integrated financing that allows the health care provider to pool payments received from public and private programs and individuals.<sup>110</sup> The primary focus of PACE organizations is to provide PACE-related services.<sup>111</sup> PACE organizations are also responsible for the financing and related risks of the program.<sup>112</sup> PACE is primarily offered through Medicare, but states

99. 42 C.F.R. § 460.30(a) (1999); 2017 AUDIT AND ENFORCEMENT REPORT, *supra* note 10, at 3.

100. A “non-profit organization” is one that “conducts business for the benefit of the general public . . . and without a profit motive.” *Nonprofit*, FREE DICTIONARY, <https://legal-dictionary.thefreedictionary.com/nonprofit> (last visited May 20, 2020).

101. 42 C.F.R. § 460.60(a) (1999); *see* Nelson, *supra* note 9. A “for-profit organization” is “established, maintained, or conducted for the purpose of making a profit.” *For-profit*, MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/for-profit> (last visited May 20, 2020).

102. 42 C.F.R. §§ 460.180(a), 460.182(a) (1999); *see also* Chapter 13—Payments to PACE Organizations, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) (2011), <https://go.cms.gov/3c2Hy35>.

103. *See* 2017 AUDIT AND ENFORCEMENT REPORT, *supra* note 10, at 3; *see also* *Programs of All-Inclusive Care for the Elderly for States*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/ltss/pace/pace-for-states/index.html> (last visited Sept. 13, 2018) (“Section 903 of the Benefits Improvement and Protection Act (BIPA) of 2000 allows states to modify or waive certain regulatory provisions to meet the needs of PACE organizations.”).

104. 42 C.F.R. § 460.4(b)(1) (1999).

105. *See infra*, Section II.B.2.

106. 42 C.F.R. § 460.150(b)(2) (1999); *see also* *Programs of All-Inclusive Care for the Elderly for States*, *supra* note 103.

107. 42 C.F.R. § 460.102(a)(1) (2007).

108. *Programs of All-Inclusive Care for the Elderly for States*, *supra* note 103.

109. 42 C.F.R. § 460.180(a).

110. *Programs of All-Inclusive Care for the Elderly for States*, *supra* note 103.

111. *Programs of All-Inclusive Care for the Elderly*, *supra* note 8.

112. *See* *Programs of All-Inclusive Care for the Elderly for States*, *supra* note 103; *see also* 42 C.F.R. §§ 460.180(b)(7), 460.182(c) (1999) (explaining that the capitated rate

may voluntarily elect to offer PACE services through Medicaid.<sup>113</sup> In addition to prescribing the structure of PACE organizations, Congress has enacted requirements that elderly individuals must meet to become PACE participants.<sup>114</sup>

## 2. Eligibility and Enrollment in PACE

PACE is designed to target the “frail” elderly.<sup>115</sup> Participants must be at least 55 years of age, eligible for a nursing home, and able to safely reside within the community.<sup>116</sup> To be eligible for a nursing home, a person would “need[] the level of care required under the State Medicaid plan for coverage of nursing facility services.”<sup>117</sup> Additionally, PACE participants must be eligible for either Medicare or Medicaid.<sup>118</sup>

To enroll in PACE, the potential participant must first complete the “intake process.”<sup>119</sup> This process involves evaluating the elderly individual’s home to ensure that the individual’s health status allows the individual to safely reside in the home instead of residing in a care facility.<sup>120</sup> In addition to evaluating homes, the state administering agency and the PACE staff personally evaluate elderly individuals who are potential PACE participants to determine whether those individuals require nursing-home level care and can safely reside within their community.<sup>121</sup> During the intake process, the terms of PACE are extensively explained to the participants.<sup>122</sup>

If the interested individuals are deemed eligible for PACE, enrollment begins on the first day of the following month.<sup>123</sup> If individuals

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paid to the PACE organization by Medicare and Medicaid is the only funding that the organization will receive from those government sources).

113. *Program of All-Inclusive Care for the Elderly*, *supra* note 8. As stated above, this Comment will primarily focus on the impacts PACE would have on Medicaid, which would otherwise be paying for nursing home bills. *See supra* note 1.

114. 42 C.F.R. § 460.150(b)(1)-(3) (1999); Jones, *supra* note 66.

115. 42 C.F.R. § 460.4(b)(1) (1999); *see Program of All-Inclusive Care for the Elderly*, *supra* note 8.

116. 42 C.F.R. § 460.150(b)(1)-(3); Jones, *supra* note 66. An individual can “safely reside within a community” if that “individual’s health or safety would [not] be jeopardized by living in a community setting” as opposed to a nursing home setting. 42 C.F.R. § 460.150(c)(2) (1999).

117. 42 C.F.R. § 460.152(a)(3).

118. 42 C.F.R. § 460.150(d); Jones, *supra* note 66.

119. 42 C.F.R. § 460.152(a); JOHN J. REGAN ET AL., TAX, ESTATE & FINANCIAL PLANNING FOR THE ELDERLY § 9.24[3] (2018).

120. *See* 42 C.F.R. § 460.152(a)-(b); REGAN, *supra* note 119, at § 9.24[3].

121. 42 C.F.R. § 460.152(a)(3)-(4); REGAN, *supra* note 119, at § 9.24[3].

122. 42 C.F.R. § 460.152(a); REGAN, *supra* note 119, at § 9.24[3]. Such terms include PACE being the sole health care provider for participants and potential premiums the participant may have to pay. 42 C.F.R. § 460.152(a)(1)(ii), (iv).

123. 42 C.F.R. § 460.158; REGAN, *supra* note 119, at § 9.24[3]. For example, if an individual is approved for PACE on March 31, that individual’s enrollment in PACE is effective on April 1.

are denied from the program, they are provided with a written explanation for their denial and referred to another service that can better fulfill their needs.<sup>124</sup> Once a person is a PACE participant, that participant’s enrollment in the program will continue<sup>125</sup> regardless of any detrimental changes in the participant’s health status.<sup>126</sup> When an individual is enrolled in PACE, that individual begins receiving the services offered through PACE.<sup>127</sup>

### 3. Services Provided through PACE

Once a participant is enrolled in PACE, the participant will receive all services offered through both Medicare and Medicaid.<sup>128</sup> Some PACE benefits and services include: primary care; emergency services; occupational, physical, and recreational therapy; nutritional counseling; social services; meals; and transportation to and from these services.<sup>129</sup> This list is certainly not exhaustive—any other services deemed necessary for the health of the PACE participant will be provided through

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124. 42 C.F.R. § 460.152(b)(1)–(2); REGAN, *supra* note 119, at § 9.24[3]. Individuals who apply to participate in PACE may be denied because remaining within the community may “risk the applicant’s health or safety.” REGAN, *supra* note 119, at § 9.24[3]. The denial must be documented adequately, and notice of the denial must be sent to designated federal and state government agencies. 42 C.F.R. § 460.152(b)(3)–(4).

125. REGAN, *supra* note 119, at § 9.24[3]. A PACE participant may be dismissed from PACE involuntarily for not paying applicable Medicare premiums, for engaging in “disruptive or threatening behavior,” or if the state government decides to discontinue funding for the PACE organization providing care for the participant. *Id.* PACE participants may voluntarily dis-enroll from the program at any time. *See* 42 C.F.R. § 460.162; Jones, *supra* note 66. However, only 7% of PACE participants disenroll each year. *See Research, NAT’L PACE ASS’N*, <https://www.npaonline.org/policy-advocacy/state-policy/research> (last visited Feb. 12, 2020).

126. *See* 42 C.F.R. § 460.160(a); REGAN, *supra* note 119, at § 9.24[3]; *see also* Jones, *supra* note 66. The level of care the participant requires is typically re-evaluated every year, and failure to meet the requisite nursing-home level of care may result in disenrollment from the program. *See* 42 C.F.R. § 460.160(b); REGAN, *supra* note 119, at § 9.24[3]. However, even if a participant is found to not require nursing-home level care, that participant’s enrollment in PACE may nevertheless continue if the evaluating health care professional reasonably believes that the participant, if disenrolled from PACE, would require nursing-home level care within six months of disenrollment. *See* 42 C.F.R. § 460.160(b); REGAN, *supra* note 119, at § 9.24[3].

127. *See* 42 C.F.R. § 460.90.

128. 42 C.F.R. § 460.92(a)–(b); *Programs of All-Inclusive Care for the Elderly Benefits*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html> (last visited Mar. 6, 2020).

129. 42 C.F.R. §§ 460.98(c), 460.100, 460.102(b); *Program of All-Inclusive Care for the Elderly*, *supra* note 8.

specialists.<sup>130</sup> PACE participants receive all of their needed health care services solely through members of the PACE interdisciplinary team.<sup>131</sup>

Perhaps the greatest boon of PACE is that program participants remain at home and in the community.<sup>132</sup> Most of the services offered through PACE, like health care and social services, are administered at adult daycare centers, and PACE drivers transport participants to and from the center.<sup>133</sup> Other services, like housekeeping and personal care, are delivered at the participants' homes.<sup>134</sup> All health care services, including those provided in the participant's home, are administered by health care professionals.<sup>135</sup>

The health care professionals assigned to a PACE participant collaborate to form an "interdisciplinary team."<sup>136</sup> These professionals include primary care physicians, nurses, occupational and physical therapists, dietitians, activity coordinators, a PACE center manager, a home care coordinator, a personal care attendant, and drivers who transport participants to and from services and appointments.<sup>137</sup> Participants of PACE are assigned their own specialized teams, and the teams develop health care plans to meet the needs of each participant and provide the health care services outlined in that plan.<sup>138</sup> Any one team is only assigned to a small group of participants, allowing the team to develop personal relationships with each participant and obtain deep, thorough knowledge of the needs of each individual.<sup>139</sup>

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130. *PACE Vermont—Better Care, Lower Cost!*, AARP (May 4, 2010), <https://bit.ly/2JSt7Ta>; see also 42 C.F.R. § 460.92(c) (explaining that "[t]he PACE benefit package for all participants" includes "[o]ther services determined to be necessary by the interdisciplinary team to improve and maintain the participant's overall health status").

131. 42 C.F.R. §§ 460.90(b), 460.152(a)(1)(ii)–(iii) (noting that the PACE participant must receive a list of the PACE health care providers and employees who administer health care); *Programs of All-Inclusive Care for the Elderly Benefits*, *supra* note 8.

132. *Program of All-Inclusive Care for the Elderly*, *supra* note 8.

133. *PACE Vermont*, *supra* note 130; *Cherokee Elder Care celebrates National PACE Month*, TAHLEQUAH DAILY PRESS (Oct. 1, 2017), <https://bit.ly/2UY2TFE>.

134. *PACE Vermont*, *supra* note 130; see also 42 C.F.R. § 460.98(b)(2) (explaining that the services administered by PACE "must be furnished in at least the PACE center, the home, and inpatient facilities").

135. *Quick Facts about Programs of All-inclusive Care for the Elderly (PACE)*, CENTERS FOR MEDICARE & MEDICAID SERVICES (Jan. 2008), <https://www.cms.gov/Medicare/Health-Plans/pace/downloads/externalfactsheet.pdf>.

136. 42 C.F.R. § 460.102(a)(1); *Quick Facts about Programs of All-inclusive Care for the Elderly (PACE)*, *supra* note 135.

137. See 42 C.F.R. § 460.102(b); see also *Quick Facts about Programs of All-inclusive Care for the Elderly (PACE)*, *supra* note 135; *Program of All-Inclusive Care for the Elderly*, *supra* note 8.

138. See 42 C.F.R. § 460.106(a); *Program of All-Inclusive Care for the Elderly*, *supra* note 8.

139. *PACE*, MEDICARE.GOV, <https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/pace> (last visited May 20, 2020).

Although each member of the team has a specialized role, each member’s duties are expanded to ensure complete care.<sup>140</sup> For example, team members who are designated as drivers are also trained to look for warning signs when they arrive at the participant’s home.<sup>141</sup> Through this training, warning signs are reported early and can be addressed before they bud into more serious issues.<sup>142</sup> Any warning signs that must be addressed are communicated quickly among team members, because the PACE teams typically meet daily to analyze and discuss the progress of the PACE participant.<sup>143</sup> In addition to the PACE participants benefitting from the range of home- and community-based care offered through PACE, the federal government also benefits because of the financing of PACE.

#### 4. Financing of PACE

Because PACE is a federal program, most of its funding comes from Medicaid and Medicare.<sup>144</sup> PACE organizations receive a monthly capitated payment for each PACE participant they provide services to,<sup>145</sup> and the exact amount of the capitated rate is negotiated between the health care systems and the organization.<sup>146</sup>

For example, an operating PACE center in Maryland receives funding from the government health care systems for which the patient qualifies.<sup>147</sup> Specifically, Medicaid contributes approximately \$2,200 for each patient served by the Maryland PACE center that qualifies for Medicaid, and Medicare contributes another \$3,000 for each patient that qualifies for Medicare.<sup>148</sup> These capitated payments are “designed to result in cost savings relative to expenditures that would otherwise be paid for

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140. See *Cherokee Elder Care celebrates National PACE Month*, *supra* note 133.

141. *Id.*

142. *Id.*

143. *Program of All-Inclusive Care for the Elderly*, *supra* note 8; see also 42 C.F.R. § 460.102(d)–(e) (describing the responsibilities of the interdisciplinary team, which include “[d]ocumenting changes of a participant’s condition” and “establish[ing], implement[ing], and maintain[ing]” communication between members of the interdisciplinary team).

144. 2017 AUDIT AND ENFORCEMENT REPORT, *supra* note 10, at 3; see also *supra* Section II.A.3 (explaining the current and impending financial burden Medicaid faces in paying long-term care); *infra* Section II.B.4 (providing an example of how PACE programs can save Medicaid funding).

145. 42 C.F.R. §§ 460.180, 460.182; *Program of All-Inclusive Care for the Elderly*, *supra* note 8.

146. 42 C.F.R. § 460.182(b); *Chapter 13—Payments to PACE Organizations*, *supra* note 104. The formula used to determine the rate includes various factors, such as the “risk factor” and frailty of the individual patient and the costs of similar health care services offered within the surrounding area. See 42 C.F.R. § 460.182(b).

147. GLECKMAN, *supra* note 29, at 166.

148. See *id.*

by [a] comparable nursing facility-eligible population not enrolled under the PACE program.”<sup>149</sup>

When PACE uses the capitated payment system, the cost savings for Medicaid manifest. For example, if Medicaid pays (on average) \$157 a day for an elderly individual’s long-term care administered by a nursing home (not PACE),<sup>150</sup> then Medicaid pays about \$4,700 every month for that individual’s long-term care.<sup>151</sup> But if the individual’s care is administered by PACE, Medicaid would only pay \$2,200 each month for the same care. Accordingly, by using PACE, Medicaid saves 53% of its costs of covering the individual’s health care needs.<sup>152</sup>

Regardless of what capitated rate is ultimately negotiated between the health care systems and the organization, the rate paid by the state to the PACE organization must be “lower than the amount that would otherwise have been paid under the State plan if the participant[] were not enrolled under the PACE program.”<sup>153</sup> Therefore, this capitated system necessarily saves state Medicaid systems money for each elderly individual enrolled in PACE. Once the state and the PACE organization agree on a capitated rate, that rate is fixed for that participant, even if the participant’s health status changes.<sup>154</sup> The capitated rate allocated for each participant may be re-negotiated by the state and the PACE organization each year.<sup>155</sup>

By using this capitation system and allowing the organization to spend money at its discretion, PACE participants can receive all of the services needed instead of only those that would otherwise be reimbursed through Medicare or Medicaid.<sup>156</sup> Elderly individuals enrolled in PACE

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149. *Chapter 13—Payments to PACE Organizations*, *supra* note 102; *see also* 42 C.F.R. § 460.182(b)(1) (requiring that the capitated rate is “less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program”).

150. GLECKMAN, *supra* note 29, at 90.

151. *Cf. id.*

152. *Cf. id.* at 90, 166.

153. 42 C.F.R. § 460.182(b)(1); *see also Chapter 13—Payments to PACE Organizations*, *supra* note 102.

154. 42 C.F.R. § 460.182(b)(3); *see also Chapter 13—Payments to PACE Organizations*, *supra* note 102. As previously stated in Section 10, each PACE organization assumes the financial risks for its PACE center and program. If a participant ultimately requires more care than was initially estimated and accrues more costs, the PACE organization must bear the extra costs. Conversely, if a participant does not require the estimated amount of health care, the PACE organization retains any unspent amount of the capitated rate it received from the state government for that participant. *See Programs of All-Inclusive Care for the Elderly for States*, *supra* note 103.

155. 42 C.F.R. § 460.182(b)(4); *Chapter 13—Payments to PACE Organizations*, *supra* note 102.

156. *Program of All-Inclusive Care for the Elderly*, *supra* note 8.



and eligible for Medicaid are not required to pay for the long-term care portion of PACE services.<sup>157</sup>

Specifically, these participants will not be billed for prescriptions, services, or care provided by their teams of health care professionals.<sup>158</sup> Alternatively, a person who is not enrolled in Medicaid (or Medicare) may still enroll in a PACE program by opting to privately pay for PACE services.<sup>159</sup> In short, PACE organizations provide the at-home and community-based care that participants want and need<sup>160</sup> at costs lower than what Medicaid would otherwise pay for facility-based care.<sup>161</sup>

### 5. Success of Current PACE Organizations

Overall, the results and feedback for services offered by current PACE organizations have been positive.<sup>162</sup> Participants in PACE organizations receive better quality care through the program than they would in nursing homes.<sup>163</sup> In New York, the quality of care that participants received was twice that of the care received by elderly persons in nursing homes or other institutions.<sup>164</sup> PACE has also been successful because the vast majority of participants who require a high level of care can remain in their communities instead of living in nursing homes.<sup>165</sup> Approximately 95% of PACE participants remain within their communities even though all PACE participants necessarily qualify for nursing home care.<sup>166</sup> Additionally, hospitalization<sup>167</sup> and mortality rates

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157. *PACE*, *supra* note 139.

158. *Id.*

159. *Id.*

160. GLECKMAN, *supra* note 29, at 54 (explaining that elderly individuals prefer to receive care in their homes instead of in nursing homes or other care facilities); *Aging in Place*, *supra* note 72.

161. *Chapter 13—Payments to PACE Organizations*, *supra* note 102. “Facility-based care” refers to care administered at care facilities. *See supra* note 85.

162. Siegel & Rimsky, *supra* note 3, at 49; LaPointe, *supra* note 7.

163. Siegel & Rimsky, *supra* note 3, at 49.

164. LaPointe, *supra* note 7.

165. Siegel & Rimsky, *supra* note 3, at 49; *Cherokee Elder Care celebrates National PACE Month*, *supra* note 133; *PACE by the Numbers*, NAT’L PACE ASS’N, <https://bit.ly/2WOG3kc> (last visited May 20, 2020).

166. *Cherokee Elder Care celebrates National PACE Month*, *supra* note 133; *PACE by the Numbers*, *supra* note 165.

167. Siegel & Rimsky, *supra* note 3, at 49; *Research*, *supra* note 125; GLECKMAN, *supra* note 29, at 27 (explaining that this decrease in hospitalization rates is the result of regular and preventative care provided by the PACE interdisciplinary team); *PACE Vermont*, *supra* note 130 (noting that when a PACE participant does have to be hospitalized, the length of the participant’s stay is generally shorter than that of individuals who are not enrolled in PACE); Micah Segelman et al., *Hospitalizations in the Program of All-Inclusive Care for the Elderly*, 62 J. AM. GERIATRICS SOC’Y 320, 322 (2014) (explaining that hospitalization rates among PACE participants was 24% lower than the hospitalization rates for individuals who qualified for Medicare and Medicaid but did not participate in PACE).

are reduced among PACE participants as compared with the general population.<sup>168</sup> Professionals involved in PACE programs reported that it is rare for PACE participants not to experience an improvement in health after enrolling in the program.<sup>169</sup>

In addition to the increased quality of care provided to the elderly through PACE, existing PACE organizations have also brought positive financial impacts to Medicaid.<sup>170</sup> PACE participants, because they receive care at home or at adult daycare centers instead of in nursing homes, require fewer health care expenses than typical recipients of long-term care.<sup>171</sup>

In fact, a report produced by the American Association of Retired Persons (AARP) found that providing health care services in a community typically costs one-third of the amount for nursing home care.<sup>172</sup> Vermont, in particular, found that an individual receiving care at home costs the state about half as much as an individual receiving care in a nursing home.<sup>173</sup> Similarly, after California began transitioning to community-based elder care, health care costs in that state dropped by 31%.<sup>174</sup> Nationwide, PACE is projected to save Medicaid millions of dollars because of the cost benefits of community-based care.<sup>175</sup> Because of the lower health care costs associated with PACE, coupled with the greater quality of health care, PACE has been deemed the “future of elder care.”<sup>176</sup>

## 6. Inadequate Coverage and Expansion of PACE

Perhaps the most negative aspect of PACE is that it is only offered in limited geographic areas.<sup>177</sup> Currently, states retain the option to open and fund PACE organizations.<sup>178</sup> This option preserves states’ constitutional rights to choose how to provide health care to citizens,<sup>179</sup> and PACE is only offered in states that have taken the initiative to offer PACE through

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168. Jones, *supra* note 66; ADMIN. FOR COMMUNITY LIVING, PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY 8 (2010), *available at* <https://acl.gov/sites/default/files/programs/2017-03/PACE-ADEPP-Summary-2014.pdf> (explaining that the survival among high-risk individuals enrolled in PACE was extended from 2.0 years to 3.0 years).

169. Jones, *supra* note 66.

170. *See* Nelson, *supra* note 9.

171. Siegel & Rimsky, *supra* note 3, at 55.

172. Jones, *supra* note 66.

173. GLECKMAN, *supra* note 29, at 151.

174. LaPointe, *supra* note 7.

175. Nelson, *supra* note 9.

176. LaPointe, *supra* note 7.

177. *See* 2017 AUDIT AND ENFORCEMENT REPORT, *supra* note 10, at 4 (stating that PACE provided services to 47,240 participants in 31 states).

178. PACE, *supra* note 139.

179. Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Health Care*, 12 J. CONST. L. 1325, 1337 (2010).

Medicaid.<sup>180</sup> An audit performed by the Centers for Medicare and Medicaid Services (CMS) in 2017 found that PACE provided services to 47,240 participants in only 31 states.<sup>181</sup> At the time of this audit, only 124 PACE organizations operated throughout the country.<sup>182</sup>

These numbers, however, present a skewed appearance of PACE coverage. Although the statistics portray a low level of coverage, the actual coverage of PACE programs is even worse.<sup>183</sup> Of the 124 functioning PACE organizations, 50% of them are located in just five states.<sup>184</sup> Further, 14 of the 31 states that have chosen to fund PACE organizations offer care through only one PACE center.<sup>185</sup> But one PACE center cannot possibly provide health care to every elderly individual in that state. Presumably, there are substantial numbers of elderly people in these states who are not within their states’ PACE geographic jurisdictions even though they could benefit from the high-quality care offered through PACE.

Not only is the current geographic coverage of PACE inadequate to fulfill the needs of elderly Americans, but current methods to expand PACE will not solve this issue.<sup>186</sup> The number of PACE participants across the country increased by only 12% between 2016 and 2017.<sup>187</sup> Considering the concurrent 79% expansion rate of the elderly population in need of long-term care, this 12% growth rate in PACE participation is insufficient to accommodate the impending demand.<sup>188</sup>

The lack of PACE organizations may be due to high start-up costs.<sup>189</sup> A new PACE organization incurs numerous costs, including costs for acquiring the adult daycare center where services will be administered, purchasing equipment to fill the center, consulting with experts and authorities on the most effective way to develop the center, purchasing

180. *PACE*, *supra* note 139.

181. 2017 AUDIT AND ENFORCEMENT REPORT, *supra* note 10, at 4. For context, almost 64 million individuals were enrolled in Medicaid in December 2019. *December 2019 Medicaid & CHIP Enrollment Data Highlights*, MEDICAID.GOV, <https://bit.ly/3ebuBWL> (last visited Apr. 10, 2020).

182. 2017 AUDIT AND ENFORCEMENT REPORT, *supra* note 10, at 4.

183. *Cf. id.*

184. *See id.* at 1. These five states are Pennsylvania, Michigan, North Carolina, California, and New York. *See id.*

185. *See id.* Audits show that quality of care is better at PACE organizations that have fewer participants, so offering only one organization for an entire state’s worth of participants suggests a lower quality of care. *See id.* at 50.

186. *Cf. id.* at 1.

187. *Id.*

188. Siegel & Rimsky, *supra* note 3, at 49.

189. *See PACE Program Development Considerations: Program Start-up and Development Costs*, NAT’L PACE ASS’N, <https://www.npaonline.org/sites/default/files/uploads/Program%20Start-up%20and%20Development%20Costs%2010-03.pdf> (last visited May 20, 2020).

vans to transport participants to and from the center, building and maintaining working capital, and preserving “[s]olvency reserves.”<sup>190</sup>

The total investment cost for each PACE start-up varies depending on the choices of each organization. For example, a new PACE organization that constructs a custom-built center and purchases new equipment will certainly accrue more expenses than an organization that opts to lease the real estate and fills the center with previously-owned equipment.<sup>191</sup> Generally, though, the mid-range costs of starting a new PACE organization total approximately \$3.7 million.<sup>192</sup> Research of existing PACE organizations shows that PACE organizations “break-even” with approximately 100 participants enrolled at the center, which typically occurs after operating for 16 months.<sup>193</sup> Over time, organizations can expect to earn “solid return[s]” on these start-up investment costs.<sup>194</sup>

The federal government has an opportunity to help overcome the hurdles of financing new PACE centers. Unfortunately, regulatory and legislative efforts to expand PACE have fallen short. In 2016, CMS proposed new methods of expanding PACE.<sup>195</sup> Notably, though, in September of 2018, the House of Representatives passed a bill mandating that CMS finalize the proposed expansion methods by the end of 2018.<sup>196</sup> This forceful Congressional action suggests that CMS has not been acting effectively on its own to expand PACE.<sup>197</sup> If proposing, finalizing, and enacting new PACE regulations takes almost two years<sup>198</sup> (as is typical) before the process of planning, constructing, and implementing many new PACE centers can begin, PACE will not be equipped to handle the impending demand of the baby boomer generation.

The proposed regulations, which CMS was mandated to finalize by the end of 2018,<sup>199</sup> call for a relaxation of the regulations and standards demanded of PACE organizations.<sup>200</sup> Congress’s and CMS’s rationale in

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190. *Id.*

191. *See id.*

192. *Id.*

193. *Id.*

194. *Id.*

195. Comprehensive Care for Seniors Act of 2018, H.R. 6561, 115th Cong. 1–2 (2018); 81 Fed. Reg. 54,666-01 (proposed Aug. 16, 2016).

196. *Id.*

197. *See id.*

198. *Id.*; *see also* 81 Fed. Reg. 54,666-01.

199. *See* Comprehensive Care for Seniors Act of 2018, H.R. 6561, 115th Cong. 1-2 (2018); 81 Fed. Reg. 54,666-01 (proposed Aug. 16, 2016). Portions of the PACE regulations contained in 42 C.F.R. § 460 were updated in 2019. *See* 42 C.F.R. § 460 (2019).

200. *House Passes Legislation to Increase PACE Availability by Mandating Final Rule*, NAT’L PACE ASS’N (Sept. 12, 2018), <https://bit.ly/2CRvRzz>. Specifically, the regulations includes, among other things, changes to the interdisciplinary team and “the delivery of services outside the enrollee’s home or PACE center.” *Id.*

pursuing this approach is that less-stringent regulations will encourage more states to voluntarily expand PACE.<sup>201</sup>

Within the next 20 years, the baby boomers will begin demanding care,<sup>202</sup> with insufficient support available from both Medicaid<sup>203</sup> and family caregivers.<sup>204</sup> Even though PACE is the “future of elder care,”<sup>205</sup> by allowing elderly individuals to remain in their homes<sup>206</sup> and reducing Medicaid’s long-term care expenses,<sup>207</sup> there are not enough PACE centers to support the impending burden of the baby boomers’ long-term care. The current methods of voluntary state enactment and CMS-discretionary expansion, which have resulted in inadequate geographic coverage and expansion, will not prepare PACE for the projected needs of baby boomers.<sup>208</sup> Before the baby boomers begin needing care, Congress must take different measures to ensure that PACE’s geographic coverage has expanded and the program is prepared to handle the baby boomers’ burden.

### III. ANALYSIS

The best method of expanding PACE is for the federal government to incentivize states to provide PACE through state Medicaid programs by subsidizing the start-up costs of new PACE centers. Through this method, PACE will reach its target audience of Medicaid beneficiaries,<sup>209</sup> and the federal government will incentivize states to opt into PACE coverage while maintaining states’ constitutional rights.<sup>210</sup>

#### A. *Expanding PACE through Medicaid*

State Medicaid programs are the most effective vehicle through which to expand PACE nationwide. Most of the elderly participants currently enrolled in PACE qualify for Medicaid.<sup>211</sup> Additionally, approximately 65% of individuals residing in nursing homes receive Medicaid benefits.<sup>212</sup> If the number of operating PACE centers grows through state Medicaid programs, these Medicaid beneficiaries who

201. *Id.*

202. Siegel & Rimsky, *supra* note 3, at 60.

203. GLECKMAN, *supra* note 29, at 198.

204. Siegel & Rimsky, *supra* note 3, at 50.

205. LaPointe, *supra* note 7.

206. *See* GLECKMAN, *supra* note 29, at 54 (explaining that elderly individuals prefer to receive care in their own homes and communities instead of residing in nursing homes).

207. *See supra* Section II.B.4.

208. *See supra* Section II.B.6.

209. *See also cf.* 2017 AUDIT AND ENFORCEMENT REPORT, *supra* note 10, at 7; *see also Programs of All-Inclusive Care for the Elderly*, *supra* note 8.

210. *See infra* Section III.B.

211. 2017 AUDIT AND ENFORCEMENT REPORT, *supra* note 10, at 7; *see also Programs of All-Inclusive Care for the Elderly*, *supra* note 8.

212. GLECKMAN, *supra* note 29, at 28; Jordan Rau, *supra* note 73.

require nursing-home level care could instead receive long-term care through PACE, saving costs to Medicaid.<sup>213</sup> Therefore, expanding PACE through Medicaid would effectuate PACE's goal of providing high-quality long-term care to elderly participants at their homes instead of having the elderly participants otherwise reside in, and having Medicaid pay the bills for, nursing homes.<sup>214</sup>

Moreover, research suggests that baby boomers' lack of financial savings will leave them with inadequate funding to privately pay for their future health care needs.<sup>215</sup> Data on baby boomers' retirement savings suggests that the average baby boomer only has enough money saved to allow for \$7,112 to be withdrawn each year during their retirements.<sup>216</sup> Further, 45% of baby boomers have no retirement savings.<sup>217</sup> Lack of individual savings means that a substantial number of baby boomers will have to depend on Medicaid to pay for their future long-term care.<sup>218</sup> However, as stated above, Medicaid is unequipped to handle the financial burden of baby boomers' long-term care needs.<sup>219</sup> In order for these individuals—and for the state Medicaid systems footing the bill—to reap the benefits of PACE, PACE must be offered through states' Medicaid programs.<sup>220</sup>

In addition to reaching PACE's target audience of elderly individuals relying on the government to pay for their long-term care, providing incentives directly to states will help overcome the unwillingness of states to expand PACE programs—currently the largest inhibition to PACE expansion.<sup>221</sup> As stated above,<sup>222</sup> current PACE regulations allow states to choose whether they will offer PACE to their elderly citizens through Medicaid.<sup>223</sup> Under this current regulation, only 31 states have voluntarily opted to offer PACE through Medicaid.<sup>224</sup>

213. *Cf.* 2017 AUDIT AND ENFORCEMENT REPORT, *supra* note 10, at 7.

214. Jones, *supra* note 66.

215. GLECKMAN, *supra* note 29, at 133, 198.

216. Matthew Frankel, *9 Baby-Boomer Statistics That Will Blow You Away*, MOTLEY FOOL (July 29, 2017), <https://bit.ly/2RjKErC>. “The median 401(k) balance of someone in the 55–64 age group is \$177,805,” which, if spread throughout the boomer's retirement years, equates to approximately \$7,112 per year. *Id.*

217. *Id.*

218. See *Eligibility*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/eligibility/index.html> (last visited May 20, 2020) (explaining that Medicaid is designed to provide health care to low-income families).

219. See *supra* Sections II.B.4-.5.

220. See *supra* Sections II.B.4-.5.

221. See *cf.* Comprehensive Care for Seniors Act of 2018, H.R. 6561, 115th Cong. 1–2 (2018); 81 Fed. Reg. 54,666-01.

222. See *supra* Section II.B.6.

223. 42 C.F.R. § 460.2(b); *Programs of All-Inclusive Care for the Elderly*, *supra* note 8.

224. 2017 AUDIT AND ENFORCEMENT REPORT, *supra* note 10, at 4. The following are the 31 states that have chosen to offer PACE, listed in order from most PACE participants

The federal government has, essentially, acknowledged that slow PACE expansion is the result of state inaction.<sup>225</sup> The federal government’s current attempts to expand PACE include searching for incentives that will encourage states to opt into PACE coverage through Medicaid.<sup>226</sup> States’ hesitations to fund start-up costs are a significant roadblock for PACE expansion, and states require effective incentives to opt into PACE coverage that will preserve the quality of care offered through PACE.

*B. Incentivizing States by Subsidizing Start-Up Costs*

Instead of incentivizing states with relaxed regulations, which might sacrifice the quality of care demanded by current regulations, the federal government should subsidize the start-up costs of new PACE centers. The up-front costs are a major deterrent to states and potential PACE organizations.<sup>227</sup> If the federal government covers these costs, this deterrence will be eliminated, and states and PACE organizations will almost certainly be motivated to expand PACE.<sup>228</sup>

This proposal will benefit the federal government in the long-run, too. Although the federal government faces large expenses initially with PACE, the federal government will eventually shoulder the burden of paying for baby boomers’ long-term care needs through Medicaid.<sup>229</sup> Providing long-term care through a PACE program instead of a nursing home could save Medicaid approximately 53% of its costs, per individual.<sup>230</sup> Through PACE, the federal government has an opportunity to lessen its unavoidable, impending burden which is growing as baby boomers age.

Initiating new PACE centers sooner will allow the federal government to make an earlier return on its investment.<sup>231</sup> A PACE organization typically breaks-even with its start-up costs after 16 months

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to least PACE participants: California; Pennsylvania; New York; Massachusetts; Colorado; Michigan; Oregon; North Carolina; Florida; Virginia; Texas; New Jersey; Washington; Wisconsin; Kansas; South Carolina; Louisiana; Oklahoma; Iowa; Ohio; New Mexico; Rhode Island; Tennessee; Delaware; Arkansas; North Dakota; Nebraska; Alabama; Maryland; Indiana; Wyoming. *See id.* at 11.

225. *See cf.* House Report 6561; 81 Fed. Reg. 54,666-01.

226. *House Passes Legislation*, *supra* note 200.

227. *PACE Program Development Considerations*, *supra* note 189.

228. *Cf. id.*

229. *See supra* Section II.A.

230. *See supra* Section II.B.4. The ultimate percentage of savings that Medicaid enjoys could differ because the capitated rate for each PACE participant is negotiated between the health care systems and the PACE organization. The capitated rate may differ with each participant. *See supra* Section II.B.4.

231. *See supra* Section II.B.4.

of operation.<sup>232</sup> After the start-up costs are recovered, the federal government would begin experiencing cost savings.<sup>233</sup> Through reduced Medicaid funding as a result of PACE expansion, the federal government is expected to save millions of dollars,<sup>234</sup> especially with the oncoming surge in long-term care recipients in the aging baby boomer generation.<sup>235</sup> The federal government should aim to have substantially more PACE centers in operation nationwide within the next 20 years before the first baby boomers demand long-term care.<sup>236</sup> By doing so, the federal government can receive the most benefit of the savings from PACE.

Incentivizing states to expand PACE by subsidizing start-up costs will also preserve the high standards of care demanded by current PACE regulations. Keeping the stringent PACE regulations is better than relaxing the regulations, which is the method of expansion CMS proposed.<sup>237</sup> Although these laxer regulations may indeed expand PACE throughout states, lessening these standards may be detrimental to the quality of PACE care, which is arguably PACE's best feature.<sup>238</sup> The current regulations require high-quality health care,<sup>239</sup> and reducing these standards may sacrifice the quality of this care. With the necessary expansion and growth of PACE on the horizon, oversight of the entire system may become more difficult. Any possibility of a lesser quality of care through lower standards would compromise the very aspect of PACE that has contributed to its positive reviews and considerable success in the states in which it has been implemented.<sup>240</sup> Additionally, laxer regulations would not address the large start-up costs that deter the expansion of new PACE centers.<sup>241</sup> Subsidizing costs and maintaining the current quality standards will be far more beneficial for PACE participants than the incentives proposed by CMS.

Enforcing present regulations will preserve the quality of care each PACE center provides in a number of ways, including providing care to fewer participants at each PACE center.<sup>242</sup> By expanding the number of

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232. Cf. *PACE Program Development Considerations*, *supra* note 189 (explaining that "programs typically break-even at approximately 80-100 participants," and new programs "typically experience net enrollment growth of from five to eight new enrollees per month as they grow").

233. See *supra* Section II.B.4.

234. Nelson, *supra* note 9.

235. *Id.*; GLECKMAN, *supra* note 29, at 133, 198.

236. Siegel & Rimsky, *supra* note 3, at 60 (stating that baby boomers will begin to require long-term care within the next 20 years).

237. *House Passes Legislation*, *supra* note 200.

238. See *supra* Section II.B.5.

239. Siegel & Rimsky, *supra* note 3, at 49.

240. See LaPointe, *supra* note 7; *Cherokee Elder Care celebrates National PACE Month*, *supra* note 133.

241. See *supra* Section II.B.6.

242. See 2017 AUDIT AND ENFORCEMENT REPORT, *supra* note 10, at 28.



PACE organizations throughout each state, more PACE organizations will be available to fulfill the demands of elderly individuals.<sup>243</sup> In other words, the number of elderly individuals in need of care will be divided among more centers, and each center will treat fewer people than it would under the current geographic coverage.<sup>244</sup> Audits of PACE centers reveal that centers treating fewer residents receive better audit scores related to the quality of care administered by that center.<sup>245</sup> Accordingly, more centers with fewer participants at each center, coupled with the high-quality of care demanded by stringent regulations, ensure a higher quality of individualized care for each participant.<sup>246</sup>

Lastly, by expanding PACE through financial incentives, states retain autonomy in providing health care to their citizens.<sup>247</sup> Federalism requires that states be given the discretion to choose how to administer health care to their citizens.<sup>248</sup> Though simply requiring states to open more PACE centers would expand PACE, that method would remove states' choices and breach states' rights under federalism.<sup>249</sup> By providing the necessary funds to open new PACE centers, the federal government preserves the states' rights to choose health care services while simultaneously providing an option that provides high-quality health care<sup>250</sup> at reduced costs.<sup>251</sup> Essentially, the PACE option would be too good for states to refuse.

For the reasons stated above, the best solution to the oncoming long-term care crisis that baby boomers present is to have the federal government subsidize the start-up costs of new PACE organizations. Through this solution, PACE will reach more elderly citizens who need a nursing-home level of care and are eligible for Medicaid, the target participants of PACE.<sup>252</sup> Furthermore, PACE will save the federal government significant expense in providing long-term care to the baby boomer generation, who will rely on the federal government to pay these expenses.<sup>253</sup> Expanding PACE by incentivizing states will preserve the quality of PACE care and states' autonomy in choosing methods of providing health care. Altogether, having the federal government

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243. *See supra*. Section II.B.6.

244. *Cf. id.*

245. 2017 AUDIT AND ENFORCEMENT REPORT, *supra* note 10, at 28.

246. *See id.*

247. Leonard, *supra* note 179 (explaining that any power not expressly granted to the federal government by the First Amendment are “reserved to the states under the Tenth Amendment,” and “[w]hile the Constitution allows both federal and state governments to address health, the responsibility falls more squarely within states’ reserved powers”).

248. *Id.*

249. *Cf. id.*

250. Siegel & Rimsky, *supra* note 3, at 49.

251. *See supra* Section II.B.4.

252. *See supra* Section III.A.

253. *See supra* Section III.A.

subsidize start-up costs is the best option for potential PACE participants and the federal government.

#### IV. CONCLUSION

The aging baby boomer generation will place a heavy burden on Medicaid that the current system cannot withstand.<sup>254</sup> PACE, with its high-quality care at low costs, is the solution that the federal government needs to sustain this looming burden.<sup>255</sup> Although the present national coverage of PACE is inadequate to fulfill the future needs of the baby boomers,<sup>256</sup> having the federal government subsidize the start-up costs of new PACE centers will adequately expand PACE.<sup>257</sup>

Further, this method of expanding PACE will reach PACE's target audience—the frail elderly—and will overcome states' unwillingness to fund new PACE centers.<sup>258</sup> Although subsidizing start-up costs will incur an initial expense for the federal government, PACE will ultimately save the federal government long-term care expenses it will inevitably have to pay.<sup>259</sup> Incentivizing expansion by financial means will also preserve the high quality of care required by current regulations.<sup>260</sup> With its high-quality care and low costs, PACE is the solution to America's oncoming long-term care crisis.

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254. GLECKMAN, *supra* note 29, at 198.

255. *See supra* Section II.B.

256. *See supra* Section II.B.6.

257. *See supra* Section II.B.

258. *See supra* Section III.A.

259. *See supra* Section III.A.

260. *See supra* Section III.B.