Welbe Health

Core Differences Between PACE and MA Plans

Programs of All-Inclusive Care for the Elderly (PACE®) and Medicare Advantage (MA) plans are both alternatives to the traditional fee-for-service Medicare benefit. While there are some similarities between PACE and MA, there are also fundamental differences. Understanding these differences is important so that changes intended for MA plans are not applied to PACE, especially those that could negatively affect the operational or financial viability of PACE.

The following are key distinctions between PACE and MA:

1 PACE and MA plans generally enroll different populations.

PACE only enrolls the most vulnerable Medicare beneficiaries, specifically those who meet state eligibility for nursing home care. These enrollees require comprehensive, ongoing and intensive services to meet their chronic health and long-term care needs. PACE organizations provide these Medicare beneficiaries with access to a comprehensive and highly coordinated health care delivery system.

MA plans typically enroll a general Medicare population. Within the MA program, Special Needs Plans (SNPs) focus on specific groups of Medicare beneficiaries. These include beneficiaries eligible for both Medicare and Medicaid, beneficiaries who meet institutional level-of-care requirements, and beneficiaries with specific types of chronic illness. Most SNPs are focused on beneficiaries with dual-eligibility, and – unlike PACE – most of these do not focus exclusively on beneficiaries with long-term care needs.

2 PACE and MA plans operate under separate statutory and regulatory authorities.

There are basic differences between PACE and MA. These variations are recognized in separate statutes and regulations governing the two plans. First and foremost, PACE organizations are health care providers, not large insurers like most MA plans. PACE organizations directly employ a broad range of health care providers – including physicians, nurses, therapists, health care aides and others. Each must comply with extensive requirements related to the composition of the PACE interdisciplinary team and its role in assessment and care planning. An important component of these requirements is to ensure that the same providers are responsible for assessing participants' needs, developing and updating care plans, and providing care.

MA plans generally consist of large networks of disparate providers. Plans process claims, collect information, make coverage determinations, and generally offer some level of care coordination. Decisions about coverage often are made by individuals who have no personal relationship with the beneficiary. Further, MA providers may be part of the same network but are not necessarily functioning in a coordinated system.

For more than 30 years, the uniqueness of PACE has been recognized by Congress, both in legislation and extensive hearings. Initially, Congress authorized a demonstration program involving On Lok, a health care provider in San Francisco that became the prototype for the PACE model. The success of On Lok eventually led to Congressional recognition of PACE as a permanent Medicare and Medicaid provider.

3 PACE and MA plans do not provide the same benefit package.

PACE is required to provide all Medicare and Medicaid covered benefits and additional medically necessary services. The explicit objective of PACE organizations is to develop patient-centered, comprehensive care plans that are not limited to Medicare services only but encompass the full range of medical and long-term care. These services are required to maximize the health and well-being of program participants. PACE provides a comprehensive, interdisciplinary approach to care coordination. It also delivers an effective use of outpatient and community-based services that lead to significant reductions in the need for inpatient care. The savings are used to support care coordination and expand the range and intensity of community-based care.

MA plans are only required to provide Medicare benefits. Since 2010, however, dual-eligible SNPs must contract with states to provide some Medicaid-covered services in addition to Medicare benefits.

4 PACE cannot respond to payment reductions by altering program benefits, raising premiums, or changing cost-sharing amounts.

Federal regulation does not allow PACE to charge their participants premiums for Medicare-covered services or any deductible or cost-sharing amounts. This means that when payment reductions occur, PACE organizations must absorb the additional costs and cannot pass them on to PACE participants. PACE never limits access to health care services by imposing benefit limitations or cost-sharing requirements.

MA plans can pass on costs and/or payment reductions to their enrollees by raising premiums and increasing cost-sharing amounts.

5 Payments to PACE and MA plans are set with different objectives.

Since PACE benefits include all services covered by Medicare and Medicaid, sites receive capitated payments from both. In general, PACE payments are based on what Medicare and Medicaid would otherwise spend on vulnerable individuals in the fee-for-service system.

When capitated payments reach PACE organizations, they are no longer linked to a specific payer source. These payments are used to provide services in the way that best meets each individual participant's medical and social needs. In PACE, care is provided without regard to fee-for-service reimbursement incentives or restrictions. This approach allows PACE organizations to provide services not traditionally covered by Medicare or Medicaid, such as care planning and care coordination activities. Medical need determines the care each participant receives.

We're always adding new centers. Contact us to see if we've opened in your city.
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