Department of Health & Human Services
Centers for Medicare & Medicaid Services
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Medicare Drug & Health Plan Contract Administration Group

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TO: Programs for All Inclusive Care for the Elderly Organizations
State Medicaid Agencies

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SUBJECT: Policies Related to Expanding Access to Program of All-Inclusive Care for the Elderly in Rural Areas

The Centers for Medicare & Medicaid Services (CMS) is committed to strengthening rural communities across America by improving healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem as part of the Rural Health Transformation Program (RHT Program). Multiple states are planning to use their funds to expand access to Program of All-Inclusive Care for the Elderly (PACE) in rural areas to allow seniors to age in place and receive person-centered care from an interdisciplinary team.

CMS recognizes that PACE organizations have cited difficulties expanding PACE in rural areas, given the disparate geographies, provider networks, and other factors related to the unique contexts of rural and frontier areas. This memo is intended to provide policy guidance on potential strategies to address these barriers, while clarifying current policies that are in place to protect the integrity of the PACE program. With the exception of the final section related to the RHT Program, this memo is broadly applicable to all PACE organizations.

Strategies to Increase Access to Care in Rural Geographies
CMS understands that transportation to and from PACE centers or other healthcare settings can present a challenge for participants in rural geographies. Mobile clinics have been identified as one strategy to extend PACE clinical services to rural participants. A mobile clinic is considered acceptable as an Alternative Care Setting (ACS), provided it meets all requirements detailed in CMS's memoranda on ACSs, in compliance with all applicable local, State, and Federal health care facility regulations, and any State-specific requirements on mobile clinics.

As defined in the HPMS memo titled "Alternative Care Settings in the PACE Program," issued December 5, 2014, an ACS can be any physical location in the PACE organization's CMS-approved existing service area other than the participant's home, an inpatient facility, or PACE center. The services furnished at an ACS supplement and do not replace services provided at the PACE center, in accordance with 42 CFR § 460.98(c). Please also refer to the HPMS memo titled "Clarification on the Requirements for Alternative Care Settings in the PACE Program,"

issued June 30, 2016, which notes that an ACS may provide some, but not all, of the required PACE services.

For any documentation in HPMS or elsewhere, it must clearly be noted that the location is a mobile clinic. This can be indicated in parentheses next to the street address (e.g., 123 Main Street (Mobile Clinic), Anytown, USA) in Legal Entity Address 1 or the second address field (Legal Entity Address 2). The PACE organization may list its primary address or center location as the address with the mobile clinic notation.

CMS has also received questions about whether there are specific time and distance standards for participant travel to PACE centers that have implications on service area geographies and PACE center locations. Under 42 CFR § 460.98(e)(2), a PACE organization must ensure accessible and adequate services to meet the needs of its participants. It follows to note that, if necessary to satisfy this requirement, a PACE organization must increase the number of PACE centers, staff, or other PACE services. We want to clarify that CMS does not have a specific travel time requirement (e.g., maximum travel time of 60 minutes); however, states may have their own travel policies. CMS encourages PACE organizations to consult with their respective State administering agencies to explore available options within the existing regulatory framework. Additionally, some PACE organizations have become approved sites for the National Health Service Corps (NHSC) and the Nurse Corps. Serving as a site for these training programs has allowed these PACE organizations to access additional trainees to support care delivery within their organization. All PACE organizations, including those that are rural, may want to consider whether this might be a fit for their organization. PACE organizations can review the requirements for becoming a NHSC site and critical shortage facility for the Nurse Corps on HRSA's webpage.

Telehealth and PACE Assessments

CMS recognizes the value of technology in increasing access to care for rural participants. With the exception of participant assessments that are required to be conducted in person as outlined at § 460.104, CMS notes that the use of remote technologies by PACE organizations to deliver care and services is permissible and can be a promising strategy to increase access to care. As noted in the Final Rule, CMS-4201-F (88 FR 22301), PACE organizations may use telehealth; however, the Interdisciplinary Team (IDT) should carefully consider the service in question to ensure that it is appropriate for the participant and their unique context. Decisions to provide a service must be based on the participant's current medical, physical, emotional, and social needs as required under § 460.92(b)(1). For example, the IDT may determine that telehealth is appropriate for one participant in one situation, but not for another participant based on that individual's condition. Additionally, PACE organizations must ensure that all other regulatory requirements are met when providing services via telehealth.

As noted above, in-person participant assessments are required in PACE – these include the initial comprehensive assessment following enrollment, semi-annual reassessments, and unscheduled reassessments given a change in participant status or in response to a service determination request. In accordance with § 460.26(c)(1), CMS cannot waive program principles or requirements that focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility, and the delivery of comprehensive, integrated acute and long-term

care services. In-person assessments are an integral part of the PACE model as they serve as an important opportunity to identify changes in participant status and condition and are key to the delivery and coordination of comprehensive care and services to PACE participants. CMS acknowledges that this requirement was temporarily waived during the COVID-19 Public Health Emergency (PHE) due to the extraordinary circumstances posed by that crisis, during which in-person contact presented undue risk to this vulnerable population. However, outside of such exceptional circumstances, waiving this fundamental touchpoint would not be consistent with the goals and integrity of the PACE program. Of note, some rural PACE organizations have noted success with leveraging in-person visits to the PACE center or prescheduled primary care visits as an opportunity to perform the in-person semi-annual reassessments, which may be a strategy other PACE organizations may want to consider. PACE organizations may also do a home visit to conduct the assessments.

Waivers
CMS reminds PACE organizations that on a quarterly basis they may request waivers of certain regulatory requirements pursuant to the authority set forth in subpart B of 42 CFR part 460, which implements section 903 of the Benefits Improvement and Protection Act of 2000 (BIPA).

Section 903 of the BIPA gives CMS flexibility in exercising the waiver authority provided under sections 1894(f)(2)(B) and 1934(f)(2)(B) of the Social Security Act. Section 903 of the BIPA allows for specific modifications or waivers of certain regulatory provisions to meet the needs of PACE organizations. The following provisions may not be waived: 1) the focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility; 2) the delivery of comprehensive, integrated acute and long-term care services; 3) the interdisciplinary team approach to care management and service delivery; 4) capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals; and 5) the assumption by the provider of full financial risk. Please note that for CMS to approve a waiver, the relevant State administering agency must support the request. Each waiver request is reviewed independently and previous approval from CMS for a waiver request for one organization does not guarantee approval for other organizations.

PACE and RHT Program: Application and Payment Clarification
States that received funding through the RHT Program should be mindful of the quarterly deadlines for PACE applications (see the HPMS memo issued January 15, 2026, for the 2026 dates) as they partner with current PACE organizations or potential applicants. However, it is important to note that states may utilize their RHT Program funding, before and during application review, as approved by CMS to establish, support, or bolster PACE organizations and needed resources.

Additionally, CMS is providing the following clarification for those states that have proposed making payments to PACE organizations for the provision of health care items or services to PACE participants as part of their RHT Program proposals. States electing to make such payments must do so in a manner consistent with the requirements of 42 CFR § 460.182 and the PACE Medicaid Capitation Rate Setting Guide. Specifically, any additional payments to PACE providers for health care items or services must be incorporated into the PACE Medicaid capitation rates submitted to CMS for review and approval. Furthermore, those capitation rates

must remain below the amount that would otherwise have been paid (AWOP) for a comparable population in the absence of the PACE program.

As set forth in 42 CFR § 460.182(c), a PACE organization must accept the Medicaid capitation payment as payment in full for all covered items and services furnished to Medicaid participants. A PACE organization may not bill, charge, collect, or receive any other form of payment from the State administering agency, or from, or on behalf of, a participant, with the sole exception of any applicable spenddown or post-eligibility treatment of income liability.

It is important to note that this restriction applies only to payments for health care items and services furnished to PACE participants. It does not preclude a state from making payments to PACE organizations outside of the capitation rate for purposes unrelated to direct participant care, such as workforce and staffing support, health information technology updates, or other infrastructure needs.

Questions
If you have any questions concerning this guidance and waivers, please submit them to the PACE mailbox: https://pace.lmi.org/PaceMailbox/.