NORC at the University of Chicago

FINAL REPORT
March 2025

Program of All-Inclusive Care for the Elderly (PACE) Market Assessment: For-Profit Expansion and Growth

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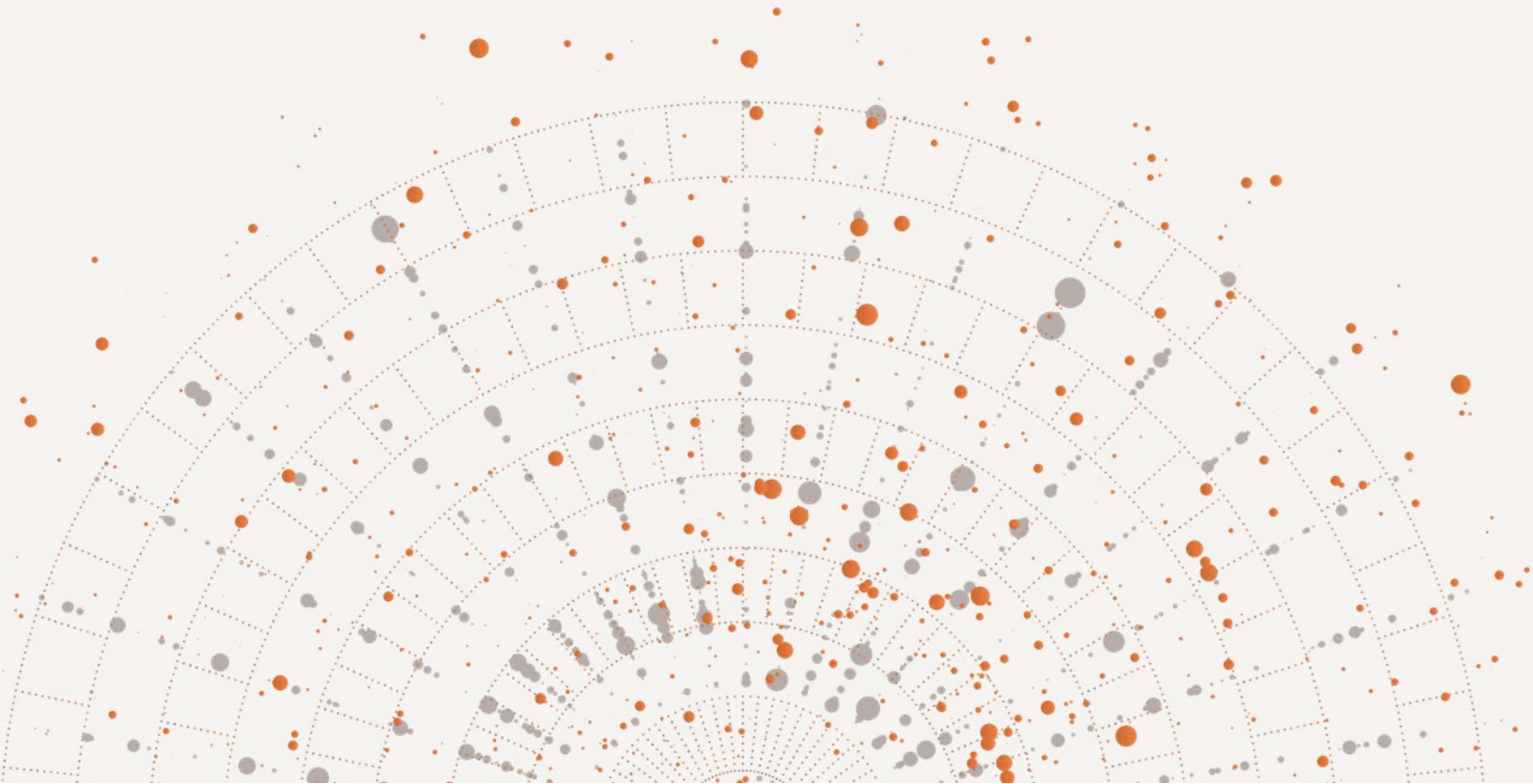

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Introduction

As the population of older adults in the United States continues to grow, so does the demand for effective and sustainable models of long-term care. The Program of All-Inclusive Care for the Elderly (PACE) has emerged as a comprehensive solution, designed to enable frail elderly individuals to remain in their homes and communities while receiving comprehensive and coordinated medical and social services. PACE provides a holistic approach that addresses both the medical and social needs of its enrollees and integrates funding streams among dually eligible Medicare and Medicaid participants.

Background

Lauded among some health care leaders as the "gold standard for community-based integrated care,"[i] PACE provides comprehensive medical and social support to vulnerable older adults, most of whom are dually eligible for Medicare and Medicaid benefits. The program enables participants to age in their homes and communities through individualized, interdisciplinary care delivered primarily via adult day health centers (i.e., PACE centers). These centers are supplemented by in-home and referral services as needed, with an interdisciplinary team coordinating all aspects of care—preventive, primary, acute, and long-term—through comprehensive 24/7 care plans.[ii] Program eligibility requires that individuals be at least 55 years old, reside in a PACE service area, qualify for nursing home care as certified by their state, and demonstrate the ability to safely live in a community setting at enrollment.[iii]

Operating as a Medicare program with an optional state Medicaid benefit component,[iv] PACE is currently available in 33 states and the District of Columbia.[v] The program utilizes a distinctive funding model that combines capitation payments from both Medicare and Medicaid sources[vi]. Approximately 90% of PACE participants are dually eligible for both programs[vii], and PACE organizations receive separate monthly capitation payments from each source for these enrollees[viii]. For participants eligible only for Medicaid, the state pays the full cost to PACE organizations, while those eligible only for Medicare pay monthly premiums equal to the Medicaid capitation amount plus a premium for Medicare Part D drugs[ix]. This consolidated funding structure allows PACE organizations to cover all necessary healthcare services while accepting full financial risk, enabling them to offer a broader range of services than traditional fee-for-service programs[x].

PACE originated in 1971 when members of San Francisco's Chinatown-North Beach community created the nonprofit On Lok Senior Health Services to provide long-term care for immigrant elders[xi]. This community-based system, which became known as PACE, established one of the nation's first adult day centers in 1973[xii]. After receiving Medicaid reimbursement and federal grant funding[xiii], On Lok's model was authorized as the original PACE demonstration by the Consolidated Omnibus Budget Reconciliation Act (COBRA) in 1983[xiv], with the Omnibus Budget Reconciliation Act (OBRA) expanding this in 1986 to test nationwide replication[xv].

In 1997, the Balanced Budget Act (BBA) established PACE as a permanent provider type under Medicare and Medicaid, transitioning it from a demonstration project[xvi]. The BBA maintained PACE's nonprofit foundation by requiring organizations to be (or be a distinct part of) a public or private nonprofit entity to operate as a PACE organization[xvii]. However, it also created a pathway for for-profit participation, allowing for-profit entities, through a limited number of waivers, to operate PACE programs on a demonstration basis[xviii]. Importantly, the BBA established that the nonprofit requirement would be lifted immediately after a report on the for-profit PACE demonstration was submitted to Congress[xix], provided that the report showed that for-profit PACE organizations performed comparably to nonprofit organizations regarding quality, access to care, and expenditure levels[xx].

The for-profit PACE demonstration program began in 2007[xxi], and the shift to permanent for-profit participation occurred in May 2015[xxii]. This transition followed a report from the Department of Health and Human Services (DHHS) to Congress[xxiii], which presented findings from a CMS-commissioned evaluation study conducted by Mathematica[xxiv]. Although there were emerging concerns about the validity of this evaluation[xxvxxvi], its conclusion—that for-profit providers demonstrated performance comparable to that of nonprofit organizations[xxvii]—served as the basis for this significant regulatory change. In 2019, CMS issued the PACE Final Rule, which updated regulations to officially remove the nonprofit requirement[xxviii].

The for-profit sector's presence in PACE has expanded dramatically since the 2015 regulatory shift. From just six for-profit organizations in 2015[xxix] (all operated by SeniorLIFE corporation in Pennsylvania)[xxx], the number has grown to 47 for-profit PACE organizations as of January 2025.[xxxi] According to our findings, by 2022, private equity (PE) and venture capital (VC) firms backed more than half of these for-profit organizations, indicating PACE's growing appeal as an investment opportunity. Most notably, the growth rate of for-profit PACE organizations has significantly outpaced their nonprofit counterparts: between 2016 and 2022, for-profit organizations and enrollment increased by 182% and 173% respectively, while nonprofits grew by only 6% in organizations and 44% in enrollment.

Purpose of the Study

The entry of for-profit organizations—particularly those with PE and VC backing—has fundamentally reshaped the PACE landscape. Despite this significant shift, there remains a relative dearth of analyses examining how, where, and why for-profit PACE has grown, as well as how this growth pattern differs from traditional nonprofit PACE expansion. This landscape assessment seeks to fill that critical knowledge gap by providing a comprehensive analysis of for-profit PACE development since the 2015 regulatory shift. Furthermore, it aims to establish a robust baseline for future research evaluating how for-profit PACE models compare with traditional, nonprofit approaches in meeting the complex health care and social support needs of vulnerable older adults. Understanding these patterns and their implications is essential for policymakers, health care providers, and stakeholders working to ensure the sustainable expansion of high-quality, integrated care for the aging population.

Methods

Study Design

This retrospective, descriptive study examined the growth of for-profit and nonprofit PACE organizations from 2016 through 2022. The analyses focused on three major areas: (1) documenting changes in the number of contracts and enrollment by tax status, (2) characterizing demographic and geographic patterns of expansion, and (3) determining the degree to which PE or VC investments were associated with for-profit PACE growth.

Data Sources

Table 1 describes how each data source was used in the analyses. Data sources include enrollment and claims data from the Chronic Condition Warehouse including Traditional Medicare administrative claims data (Fee-for-Service, FFS), Medicare Advantage encounter data, the Transformed Medicaid Statistical Information System (T-MSIS)—as well as publicly available data from the CMS and other government agencies. NORC used administrative data through 2022, which is the most recently available MA encounter and TMSIS data.

Table 1. Secondary Data Sources and Use

Data Source	Use
CY 2016-2024 Medicare Advantage Plan Contract Directories	To Identify active PACE contracts, their effective dates and tax status
CY 2016-2022 Medicare enrollment data (MBSF)	To Identify PACE-enrollees and study population: dual eligible and Medicare-only beneficiaries
CY 2022 Medicare FFS claims	To identify PACE eligible population who meet a nursing facility level of care (NFLOC)
CY 2022 Medicare Advantage encounter data	To identify PACE eligible population who meet a nursing facility level of care
CY 2016-2022 Transformed Medicaid Statistical Information System (T-MSIS) Analytic File (TAF) DE file	To identify PACE-enrollees and study population: dual eligible and Medicaid-only beneficiaries
CY 2022 TAF FFS claims and managed care encounter data	To identify PACE eligible population who meet a nursing facility level of care
2018-2022 American Community Survey (ACS)	To append county level socioeconomic indicators
2010 ZIP level USDA rural-urban commuting area (RUCA) code	To classify ZIP codes into urban and rural

Analytic Approach

The analysis proceeded in three main tasks. Task 1 established a baseline PACE landscape by compiling a year-by-year table of contracts (for-profit vs. nonprofit) and total enrollment. Calendar year 2016 served as our base year, while subsequent years (2017–2022) captured new contracts and enrollment growth. Tax status was updated annually through the CMS plan directories, and beneficiary-level data were aggregated at the county level to capture broader geographic trends. Beneficiaries were categorized by age group (55–64, 65–74, ≥75), race/ethnicity (Black, Hispanic/Latino, AAPI, White, Other), and coverage type (dual-eligible, Medicaid-only, Medicare-only).

Task 2 stratified the data further by ownership status and integrated additional sociodemographic information. County-level and contract-level analyses examined whether for-profit and nonprofit PACE organizations served populations differing in racial/ethnic composition, coverage mix, and socioeconomic status. To assess geographic reach, market penetration rates were calculated using a proxy denominator of individuals aged 55 or older who met nursing facility–level-of-care criteria.[xxxii] Rurality was assessed by linking beneficiary ZIP codes to RUCA data, and expansions in urban versus rural areas were compared. For for-profit organizations, we identified PE or VC investments and tracked the timing of these investments relative to changes in enrollment or service area.

Lastly, to contextualize these quantitative findings, we conducted semi-structured interviews with leadership from selected for-profit PACE organizations and additional stakeholders in Task 3. Interviews focused on perceived drivers of growth and the potential influence of private investment on operational decisions.

Limitations

Complete enrollment, claims, and encounter data were available through 2022; as a result, we are not capturing all nonprofit PACE activity to-date as of 2025. Aggregating data at the contract or county level may obscure variations within individual PACE sites. Small populations or suppressed cell counts reduce the granularity of certain subgroup analyses. Additionally, incomplete or lagged Medicaid data may lead to slight underestimates of enrollment in some regions. Private investment data rely on records from PitchBook and Crunchbase, which may under-capture smaller or undisclosed transactions. The interview sample, while providing valuable qualitative context, reflects the experiences of a subset of for-profit PACE leaders and other stakeholders, which may not capture all perspectives in the rapidly evolving PACE market.

Findings

Growth Patterns of For-Profit and Nonprofit PACE Organizations

Between 2016 and 2022, PACE experienced substantial growth across both for-profit and nonprofit sectors. The number of active PACE contracts increased by 22%, rising from 122 to 149, with for-profit organizations representing 21% of all contracts by 2022 (Exhibit 1). Total enrollment grew even more dramatically, expanding by 60% from 50,016 to 80,013 participants, with for-profit organizations serving 26% of all enrollees (Exhibit 2).

Exhibit 1. Total PACE Contracts by Tax Status, 2016 & 2022

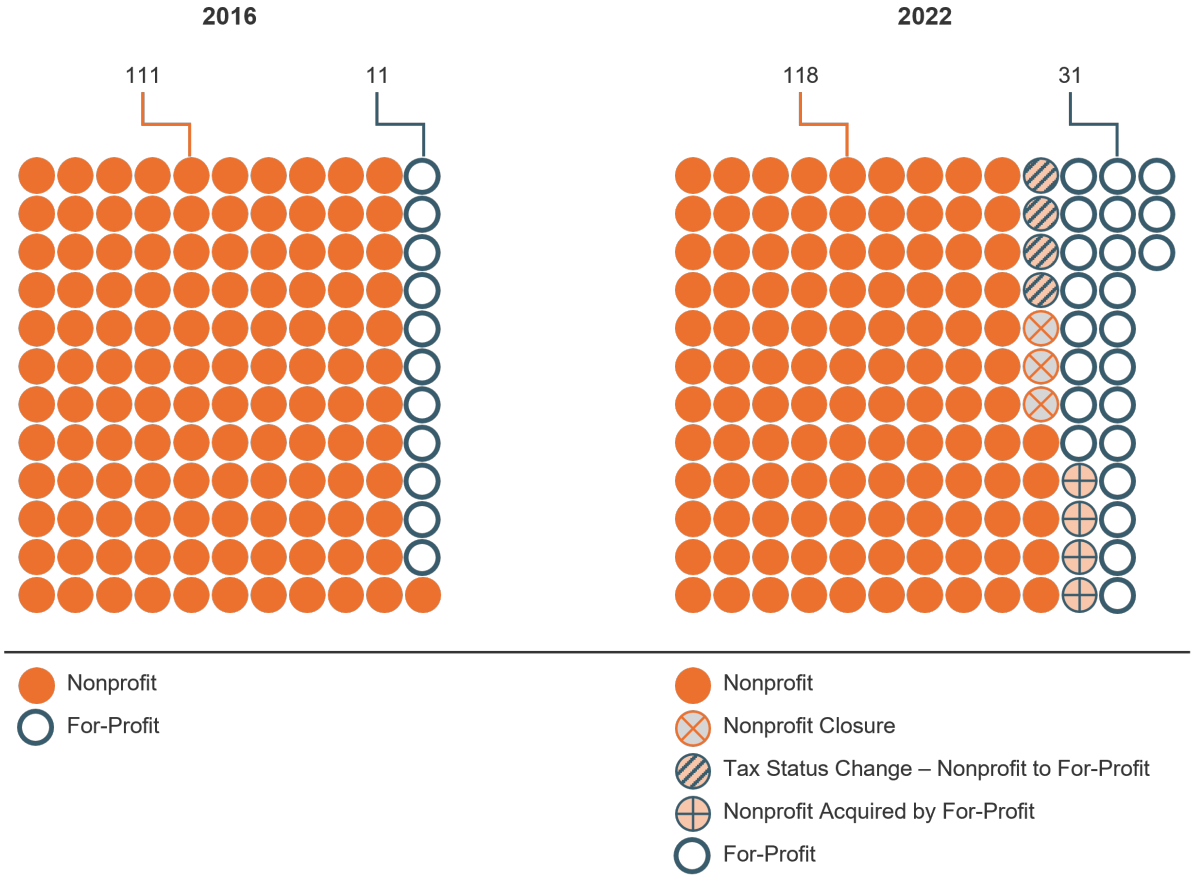
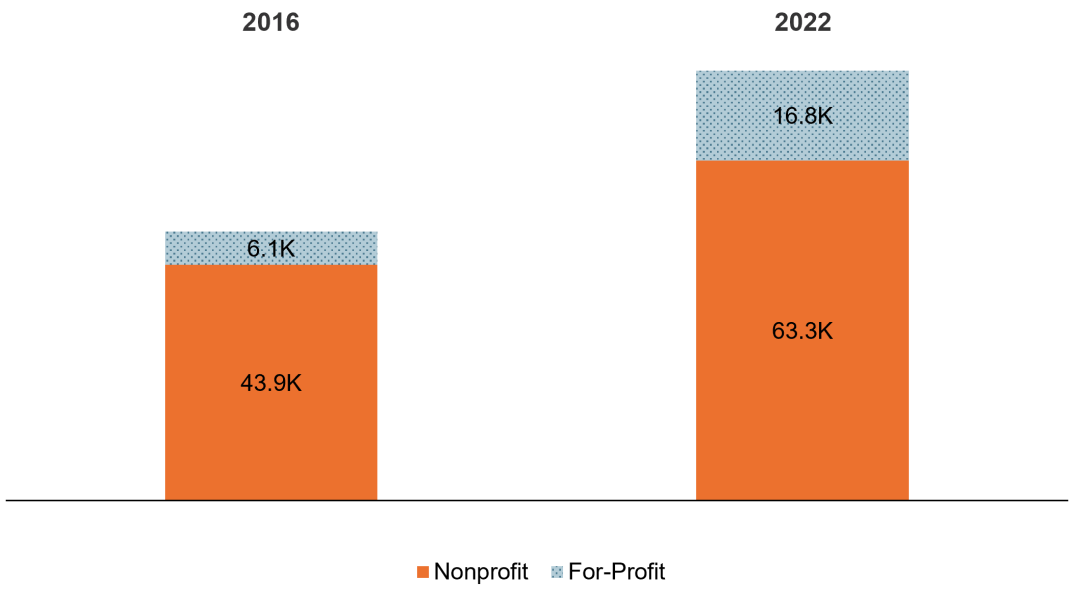


Exhibit 2. Total PACE Enrollment by Tax Status, 2016 & 2022



While nonprofit organizations maintained the majority share of contracts and enrollees, for-profit PACE organizations demonstrated substantially more aggressive growth. From 2016 to 2022, for-profit organizations expanded their contract base by 182% and increased enrollment by 173%, compared to nonprofit organizations' more modest growth of 6% in contracts and 44% in enrollment.

Organization Closures and Tax Status Changes

During this period, three nonprofit organizations ceased operations due to reasons ranging from financial constraints to operational challenges (Table 2). In Wyoming and Missouri, these closures resulted in the complete elimination of PACE services in those states.

Table 2. PACE Contract Closures, 2016-2022

Organization	Tax Status	State	Contract Closed	Peak Enrollment 2016-2022	Closure Year Enrollment	% of State Enrollment at Close
InovaCares for Seniors (PACE)	Nonprofit	VI	2018	164	134	7%
Wyoming PACE	Nonprofit	WY	2021	168	31	100%
Alexian Brothers Community Services (PACE)	Nonprofit	MO	2016	170	170	100%

Additionally, eight nonprofit PACE organizations transitioned to for-profit status between 2016 and 2022 (Table 3). A notable example was Total Community Options' purchase of three organizations in 2019. Total Community Options, Inc. (doing business as InnovAge) was originally formed in May 2007[xxxiii] as a Colorado nonprofit corporation when it acquired Total Longterm Care, Inc.[xxxiv] (now known as InnovAge Colorado PACE)—one of the original PACE organizations that joined the PACE demonstration program in 1991 and transitioned to permanent status in 2003[xxxv]. In 2016, private equity firm Welsh, Carson, Anderson and Stowe (WCAS) acquired majority ownership of InnovAge, converting it to for-profit status[xxxvi]. This made InnovAge the first PACE organization to achieve for-profit status[xxxvii]. In March 2021, the company completed its initial public offering (IPO)[xxxviii], becoming the first and, to date, only publicly traded PACE organization.

Table 3. PACE Contracts Tax Status Changes, 2016-2022

PACE Organization (Current Name)	New Parent Organization	State	Year of Tax Status Change
InnovAge Virginia PACE - Blue Ridge	Total Community Options, Inc.	VA	2019
InnovAge Virginia PACE - Richmond and Peninsula	Total Community Options, Inc.	VA	2019
InnovAge Pennsylvania LIFE	Total Community Options, Inc.	PA	2019
CarePartners PACE	HCA Healthcare, Inc.	NC	2020
Innovative Integrated Health Inc.	Innovative Integrated Health, Inc.	CA	2019
LIFE Northwestern Pennsylvania	One Senior Care, Inc.	PA	2022
The Oaks PACE	Orangeburg Senior Helping Center, LLC	SC	2022
Valir PACE	Valir PACE, LLC	OK	2022

Competitive Dynamics by State

Some states experienced marked shifts in PACE organization composition. Pennsylvania (Exhibit 3) and Virginia (Exhibit 4) demonstrated significant for-profit enrollment growth concurrent with nonprofit enrollment declines, suggesting intensifying market competition.

Exhibit 3. Pennsylvania PACE Enrollment by Tax Status, 2016 & 2022

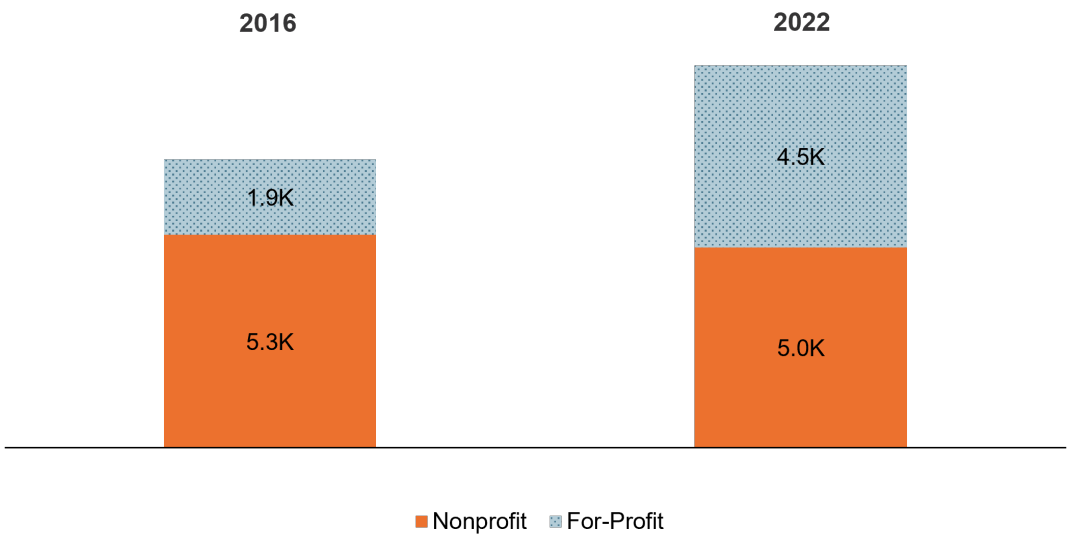
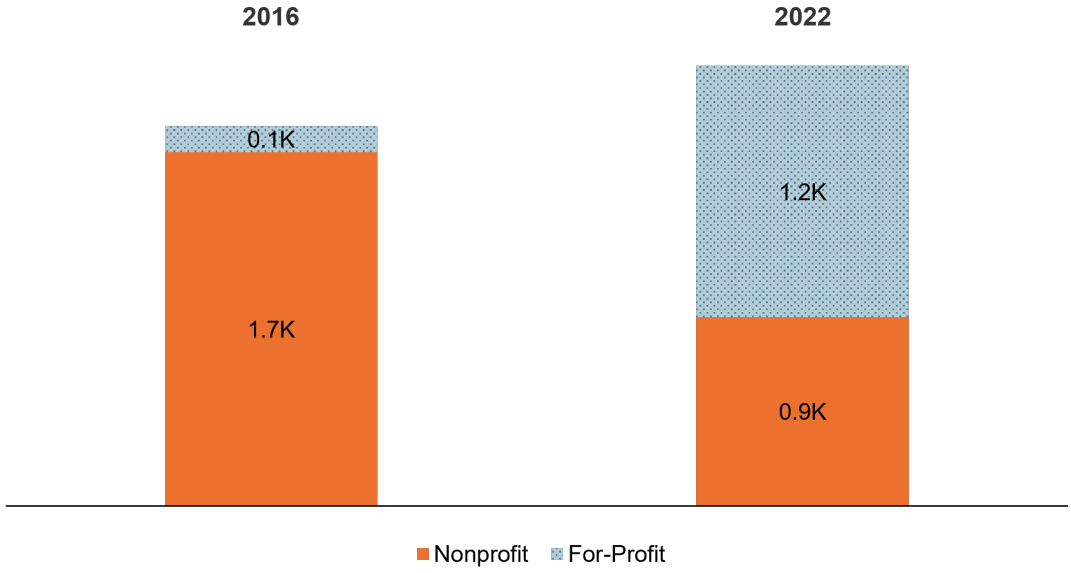


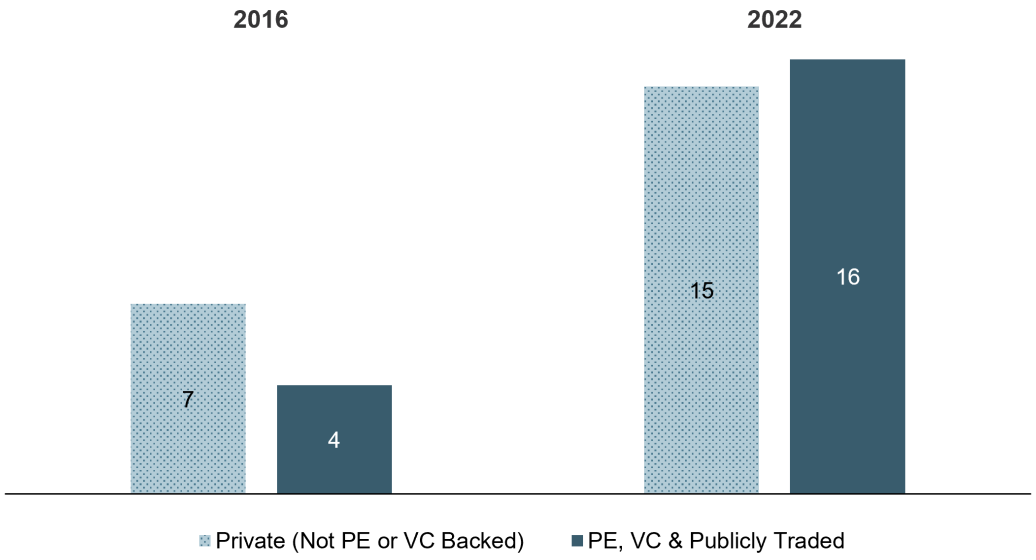
Exhibit 4. Virginia PACE Enrollment by Tax Status, 2016 & 2022



Investment Trends in For-Profit PACE Organizations

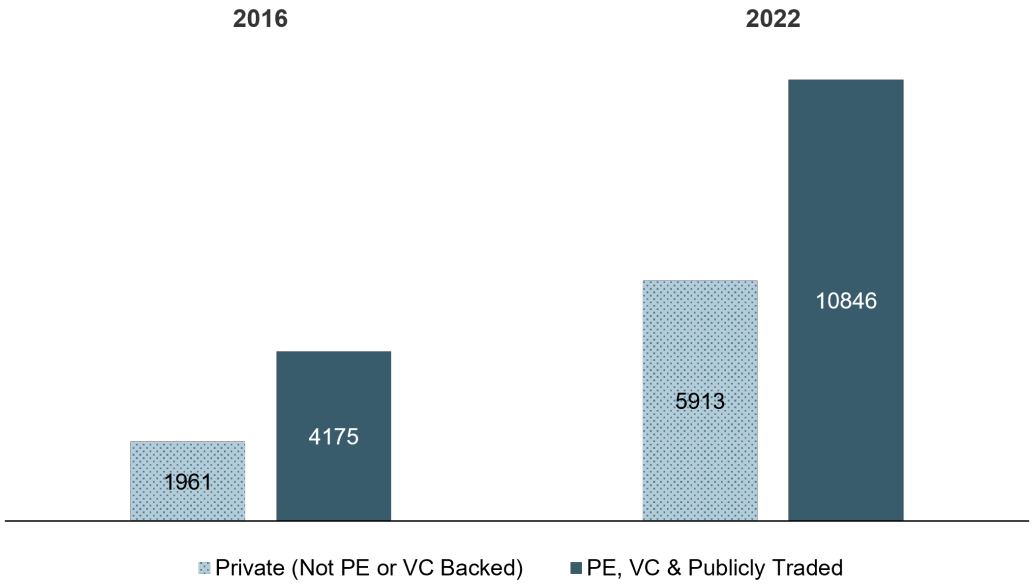
PE and VC investment in PACE organizations increased substantially during the study period. The number of PE/VC-backed for-profit PACE organizations grew by 300%, expanding from four to sixteen organizations over the six-year period. During the same timeframe, for-profit PACE organizations without external investment grew by 114%, increasing from seven to fifteen entities (Exhibit 5).

Exhibit 5. Number of PACE Organizations by Financing Status, 2016 & 2022



Notably, investor-backed for-profit PACE organizations saw enrollment approximately double that of privately held for-profit organizations (Exhibit 6).

Exhibit 6. Number of For-Profit PACE Participants by Financing Status, 2016 & 2022



Population Characteristics

For-profit PACE enrollment is becoming progressively younger and more racially/ethnically diverse. By 2022, 41% of for-profit enrollees were aged 75 and older (Exhibit 7), compared to 48% in nonprofit organizations (Exhibit 8). From 2016 to 2022, the percentage of for-profit enrollees aged 75 and older decreased by 12 percentage points, while nonprofit organizations saw an 8-percentage-point decline.

Exhibit 7. For-Profit PACE Enrollment by Age, 2016 & 2022

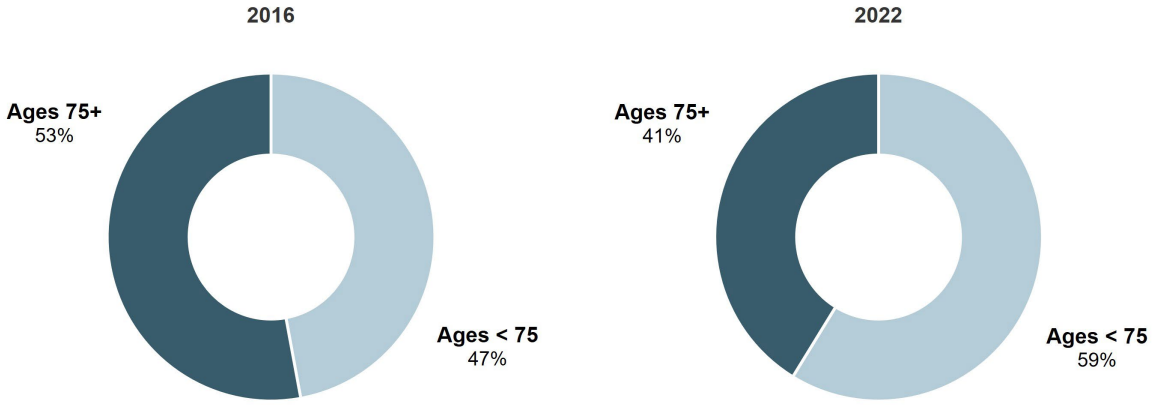
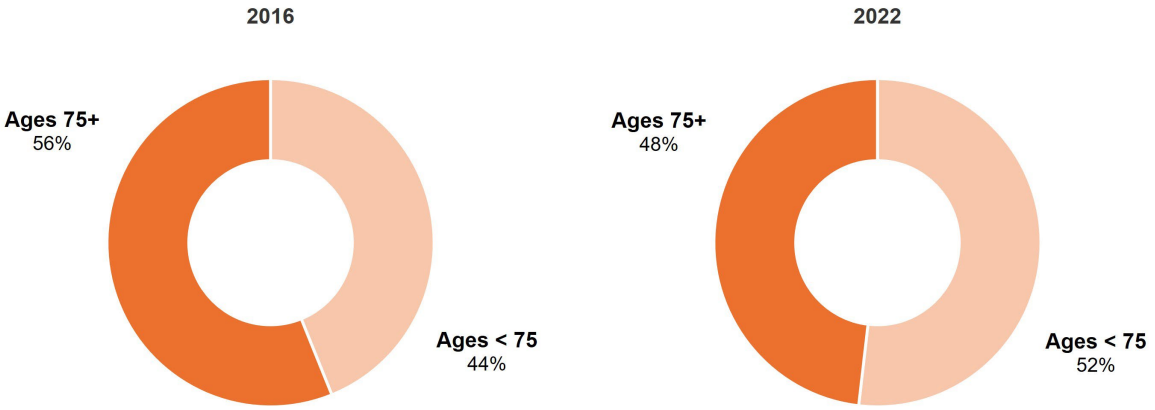


Exhibit 8. Nonprofit PACE Enrollment by Age, 2016 & 2022



Racial and ethnic diversity expanded significantly in for-profit PACE organizations. People of color represented an increasing proportion of for-profit enrollees, growing from 29% to 43% between 2016 and 2022 (Exhibit 9). Additionally, for-profit entities increased Black participant enrollment by over 400% between 2016 and 2022, compared to a 5% increase among nonprofits (Exhibit 10). While nonprofit PACE enrollment remains more diverse overall (52% people of color in both 2016 and 2020), for-profit organizations have made substantial progress in participant diversification.

Exhibit 9. For-Profit PACE Enrollment by Race & Ethnicity, 2016 & 2022

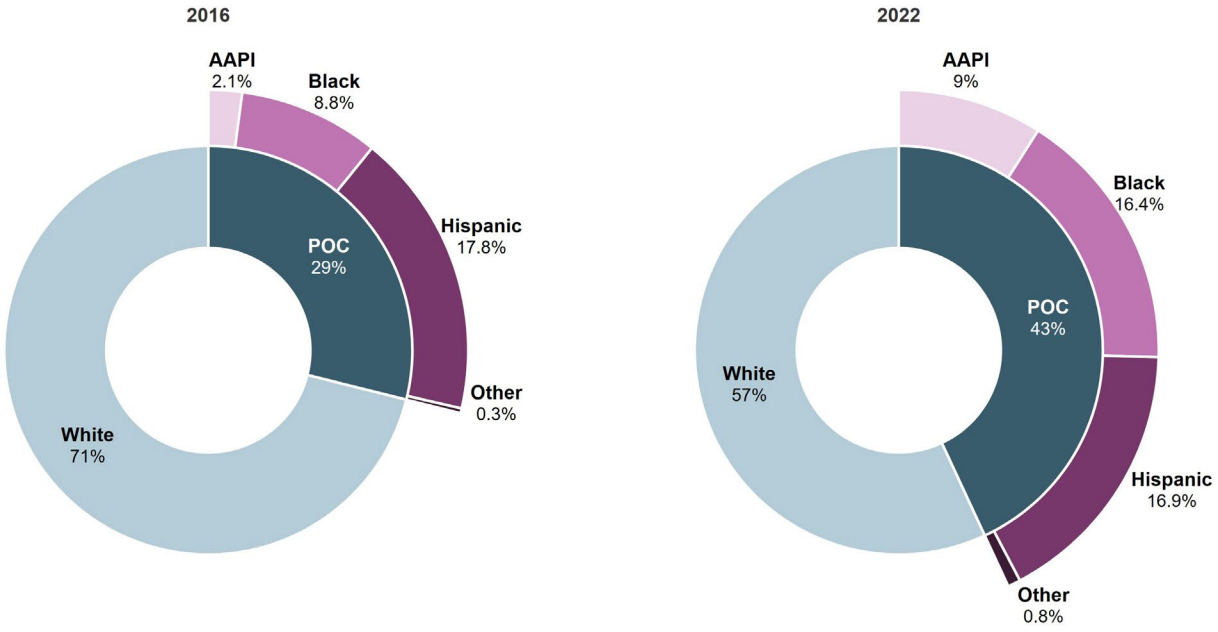


Exhibit 10. Nonprofit PACE Enrollment by Race & Ethnicity, 2016 & 2022

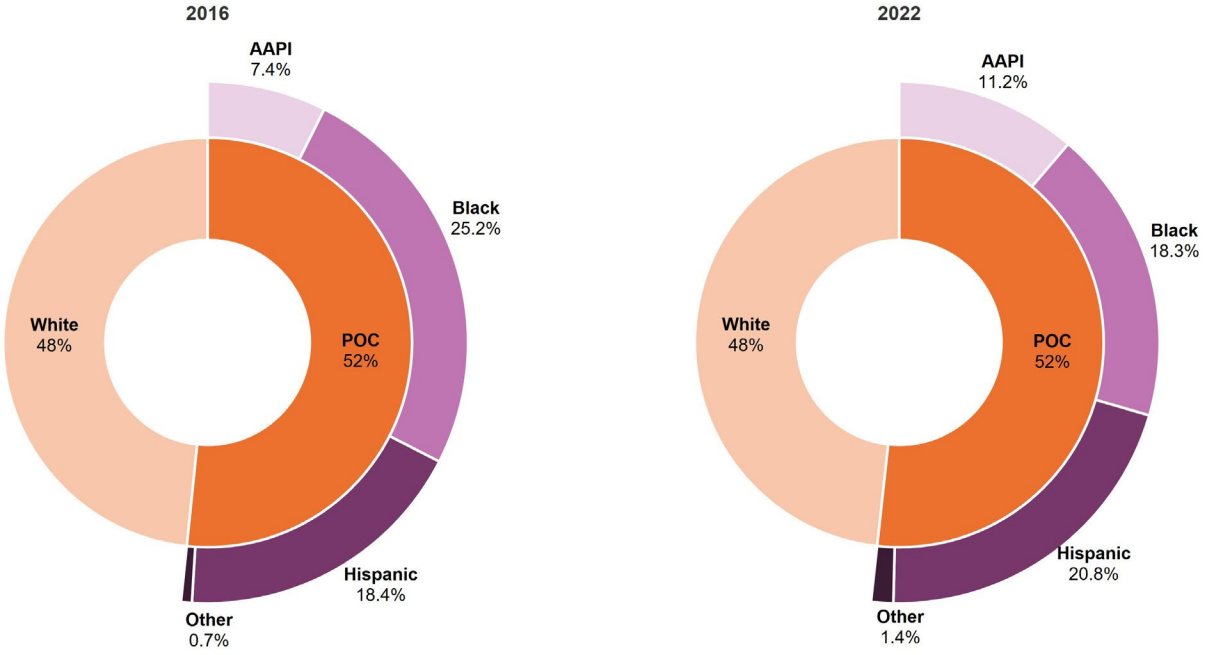
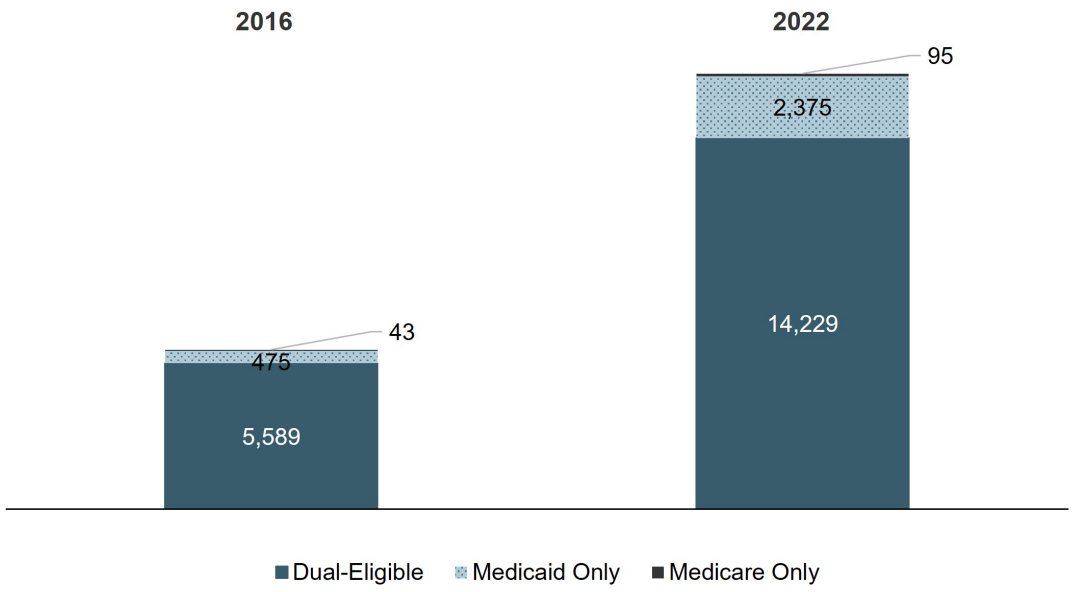
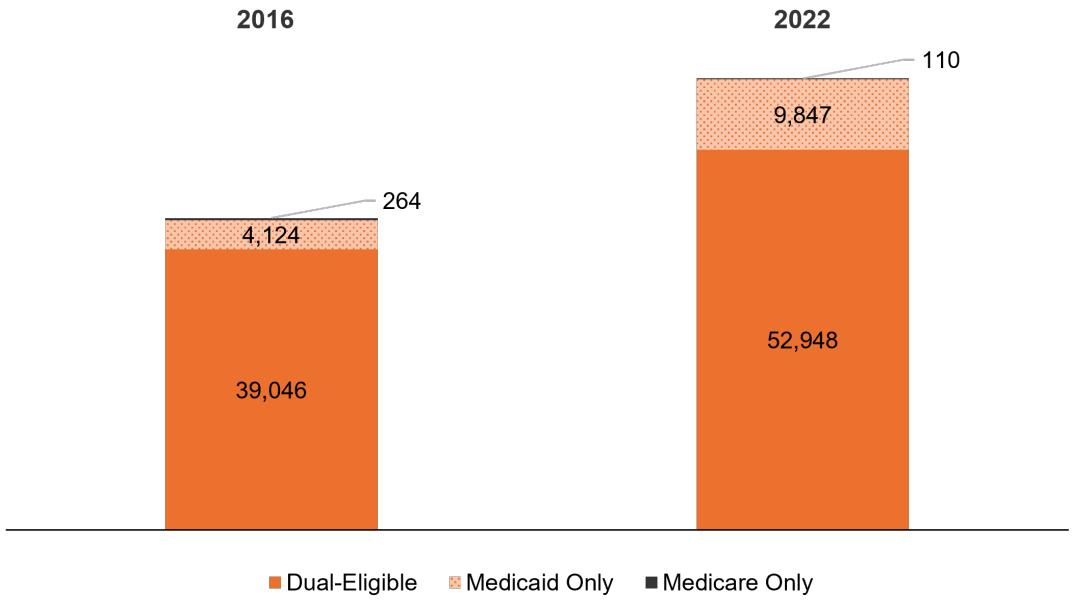


Exhibit 11. For-Profit PACE Enrollment by Insurance Coverage Groups, 2016 & 2022



For-profit PACE organizations experienced notable shifts in insurance coverage groups. Medicaid-only enrollment in for-profit organizations saw a particularly dramatic 400% increase (Exhibit 11), compared to a 139% rise in nonprofits (Exhibit 12). Nonprofits continue to maintain a larger share of Medicaid-only participants.

Exhibit 12. Nonprofit PACE Enrollment by Insurance Coverage Groups, 2016 & 2022



Service Area Characteristics

For-profit PACE organizations significantly expanded their presence in rural and low-income areas. Rural ZIP code enrollment of for-profit organizations surged by 493%, growing from 99 participants in 2016 to 587 in 2022 (Exhibit 13). In comparison, nonprofit PACE organizations increased rural enrollment by 58%, rising from 1,693 to 2,679 participants (Exhibit 14).

Exhibit 13. For-Profit PACE Enrollment by Rurality, 2016 & 2022

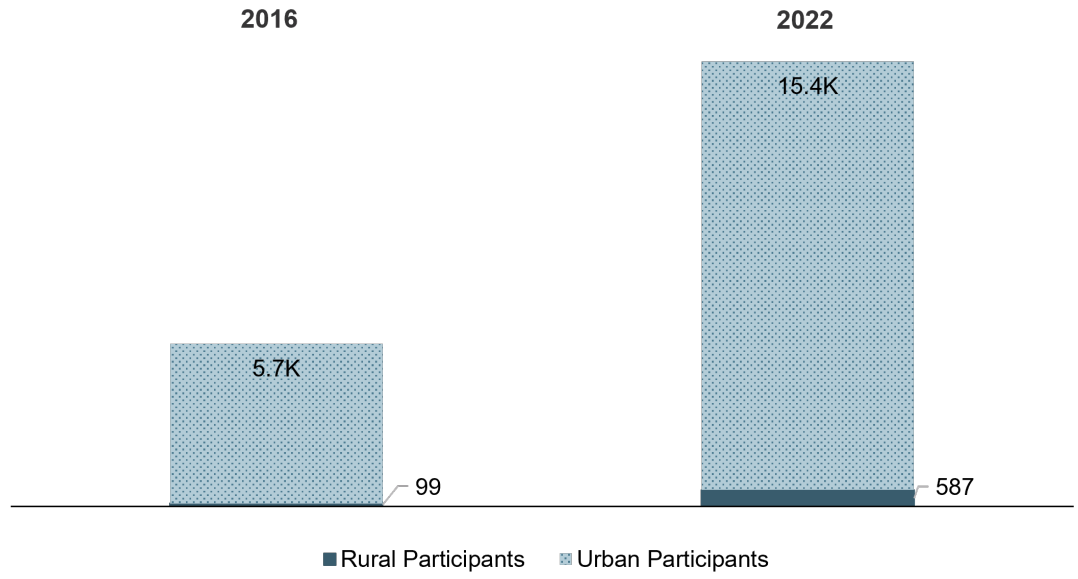
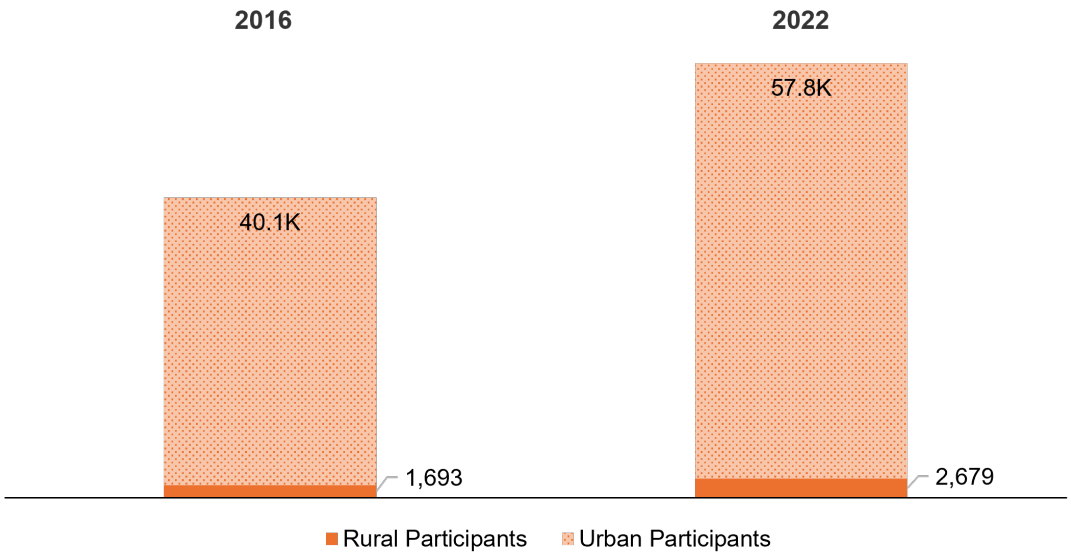


Exhibit 14. Nonprofit PACE Enrollment by Rurality, 2016 & 2022



PACE enrollment is concentrated in ZIP codes with lower median household incomes. For-profit organizations demonstrated substantial growth in these economically disadvantaged areas. Between 2016 and 2022, for-profit PACE enrollment in ZIP codes with median household incomes below $55,000 grew by 326% (Exhibit 15), compared to just 19% growth for nonprofit organizations (Exhibit 16).

Exhibit 15. For-Profit PACE Enrollment Growth by Median Household Income Quintile, 2016 & 2022

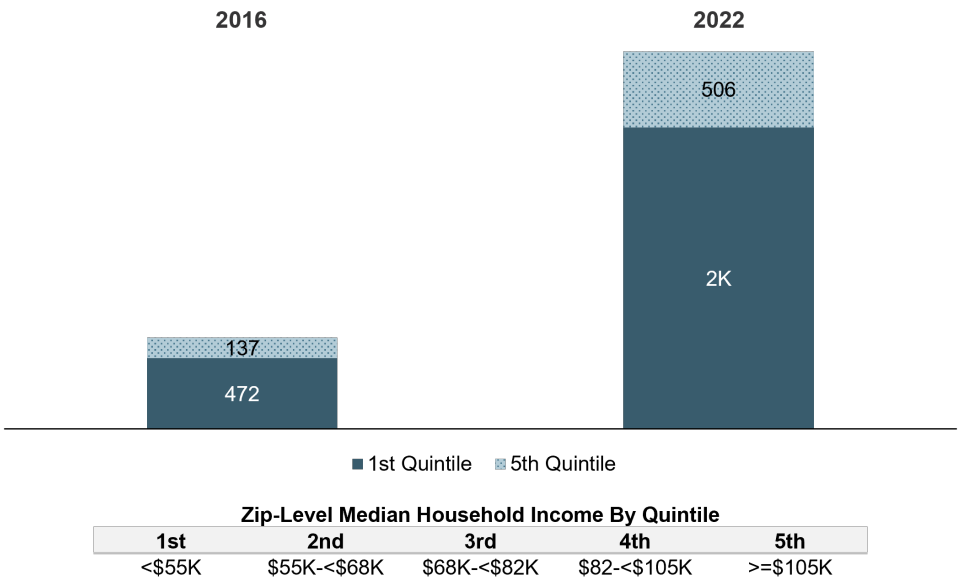
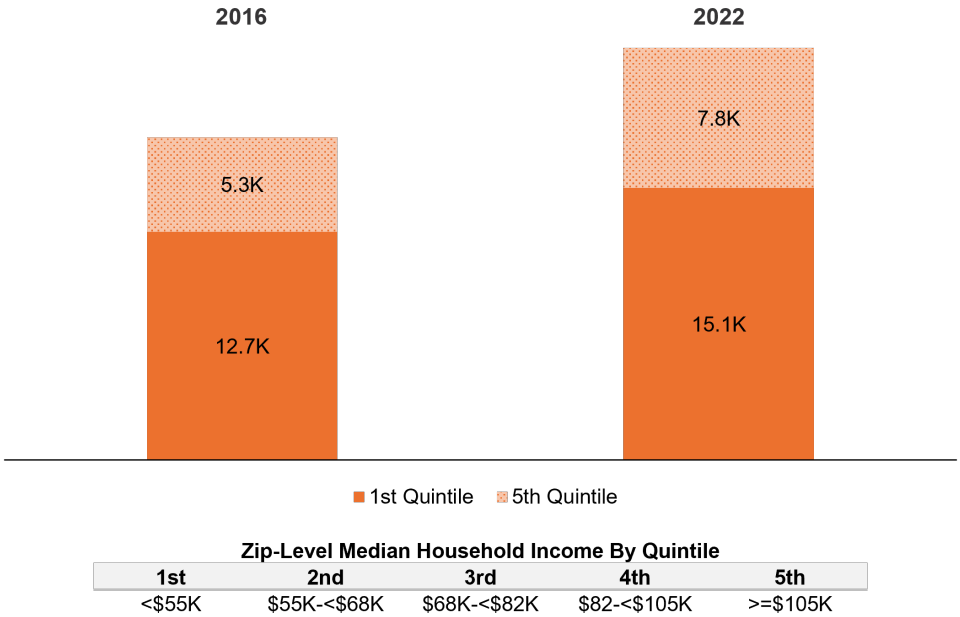


Exhibit 16. Nonprofit PACE Enrollment Growth by Median Household Income Quintile, 2016 & 2022



Discussion

Synthesis of Key Findings

This analysis reveals a significant transformation in the PACE landscape. The most prominent finding is the accelerated growth of for-profit PACE organizations, which have substantially outpaced their nonprofit counterparts in both the number of contracts and participant enrollment. Specifically, for-profit entities expanded their contract base by 182% and increased enrollment by 173%, compared to a modest 6% and 44% growth among nonprofit organizations. This rapid expansion is a result of both policy and regulatory changes, as well as the robust access to capital enjoyed by for-profit organizations, particularly those backed by PE and VC firms.

This capital advantage has created distinct growth patterns between organization types. For-profit PACE organizations, primarily those backed by external investors, benefit from more robust access to capital, enabling them to implement aggressive growth strategies such as launching multiple sites simultaneously, acquiring existing programs, investing heavily in marketing and enrollment outreach, and leveraging centralized administrative functions. In contrast, nonprofit organizations tend to grow more organically and may not have access to the same level of capital, resulting in more gradual and sequential growth and decision-making processes. This disparity in access to capital has enabled for-profit organizations to scale rapidly, sometimes outpacing their internal capacity and leading to heightened expectations for quick returns on investment[xxxix].

The timing of the for-profit growth surge observed in this analysis coincided with significant regulatory flexibilities granted by CMS during the COVID-19 pandemic. These included temporarily relaxed enforcement of requirements for Medicare/Medicaid provider enrollment, flexibility in risk adjustment submissions and telehealth usage, and permission to use remote technology for participant assessments, care planning, and monitoring[xl]. These regulatory flexibilities, combined with robust capital access, likely contributed to for-profits' accelerated expansion during this period.

Beyond growth metrics, the changing demographic profile of PACE enrollees further highlights this shift in the landscape. For-profit PACE organizations are serving a younger, more racially and ethnically diverse population, with a notable increase in Medicaid-only participants. By 2022, 41% of for-profit enrollees were aged 75 and older, compared to 48% in nonprofit organizations. The proportion of people of color among for-profit enrollees increased from 29% to 43% between 2016 and 2022, while remaining stable at 52% among nonprofit enrollees. These demographic shifts likely result from strategic targeting of underserved markets and states with more favorable policy environments, rather than deliberate strategies to diversify enrollee demographics. For example, in 2016, California passed the PACE Modernization Act, which modified rate-setting methodologies, removed limitations on the number of permitted PACE programs, allowed for-profit entities to operate as PACE organizations (aligning with the recent federal changes), and directed the Department of Health Care Services to pursue regulatory flexibility with federal authorities. These changes contributed substantially to for-profit growth in the state[xli].

The trend toward serving different populations is particularly evident in the growth of Medicaid-only participants, which occurred across both for-profit and nonprofit organizations. While nonprofits continued to serve a larger share of these participants, for-profits achieved a striking 400% enrollment growth rate among Medicaid-only participants between 2016 and 2022, compared to nonprofits' 139%. This trend likely reflects strategic targeting of specific markets rather than deliberate focus on Medicaid-only participants, who according to interviewed stakeholders, generally provide less favorable reimbursement rates than dual-eligible or Medicare-only participants.

California was a key driver of this trend, with Medicaid-only participants increasing from 1,549 in 2016 to 5,071 in 2022. State-specific policies likely contributed to this growth, including California's Older Adult Expansion (beginning May 2022), which provided full-scope Medi-Cal to qualifying individuals aged 50+ regardless of immigration status[xlii]. Moreover, the 2020 Families First Coronavirus Response Act's Continuous Enrollment Provision, requiring states to maintain continuous Medicaid enrollment through the end of the COVID-19 Public Health Emergency in exchange for enhanced federal funding[xliii], may have also increased the pool of Medicaid-only individuals eligible for PACE.

The geographic expansion patterns of PACE organizations further illustrate the changing landscape. For-profit PACE organizations have expanded into rural and economically disadvantaged ZIP codes. For-profit enrollment in rural areas surged by 493% (from only 99 participants in 2016 to 587 in 2022), compared to a 58% increase among nonprofits. Interviews with for-profit PACE executives and stakeholders suggest this rural expansion stems from oversaturation in urban markets, making historically underserved areas attractive markets for new entrants. While this expansion potentially addresses significant care gaps, it raises concerns about service quality and sustainability in these regions, particularly given the rapid scaling driven by investor expectations.

Policy and Regulatory Implications

The dramatic growth of for-profit PACE organizations is inextricably linked to evolving regulatory frameworks. State and federal regulations have significantly influenced for-profit PACE proliferation. The 2015 legislative change permitting permanent inclusion of for-profit PACE organizations created a conducive environment for investment and expansion. State reimbursement rates and regulatory frameworks have further shaped for-profit strategies, often incentivizing rapid growth and market penetration to maximize investment returns. As noted earlier, California's PACE Modernization Act has been crucial for for-profit growth in the state, while policies like California's Older Adult Expansion may have contributed to growth among younger, more diverse, and Medicaid-only populations.

However, this regulatory evolution raises critical questions about PACE's future direction. Ensuring balanced growth without compromising care quality is paramount. Policymakers must consider implementing safeguards that maintain high service standards while accommodating for-profit organizations' financial models. Additionally, monitoring the impact of variable state reimbursement rates and regulatory environments on equitable PACE service distribution is essential, particularly in underserved areas. The reliance on investor-backed growth strategies may necessitate stricter

oversight to prevent potential conflicts between profit motives and the holistic, participant-centered care that defines the PACE model.

Furthermore, policies like California's PACE Modernization Act highlight the importance of aligning state regulations with PACE's overarching goals. Policymakers should evaluate how these regulations influence for-profit organizations' geographic and demographic targeting, ensuring expansion efforts address the needs of vulnerable populations rather than pursuing market-driven incentives. Balancing financial sustainability with quality and equitable care requires ongoing assessment and adaptive regulatory frameworks responsive to the evolving PACE landscape.

Conclusion

The expansion of for-profit PACE organizations since 2016 has fundamentally reshaped the PACE landscape. These entities have increased contracts and enrollment far faster than nonprofits and extended services into previously underserved rural and low-income areas. The substantial involvement of PE and VC firms underscores the perceived financial viability and growth potential in the PACE model. For-profit organizations, particularly those with external investor backing, have leveraged their capital access to achieve rapid, extensive growth, often outpacing the more gradual, organic expansion typical of nonprofit providers.

Despite this promising growth trajectory, several critical questions remain unanswered:

- Are certain vulnerable populations still underserved despite overall PACE market expansion? While for-profits have increased enrollment in diverse and rural areas, we must assess whether specific groups continue facing access barriers and whether they receive equivalent care quality across different PACE operator types.
- How does rapid for-profit expansion impact care quality and long-term PACE program sustainability? Pressure for quick returns may compromise the holistic, participant-centered care model that defines PACE.
- How do varying state reimbursement rates and regulatory environments affect expansion strategies and operational effectiveness across for-profit versus nonprofit PACE organizations? Understanding these influences is crucial for developing policies ensuring equitable, high-quality care across regions.

To address these questions and ensure PACE's continued success, targeted research initiatives are necessary. Future research should focus on long-term studies assessing cost-effectiveness and quality outcomes across different PACE ownership structures. Comparative analyses between for-profit and nonprofit organizations are essential to evaluate health outcomes, beneficiary satisfaction, and financial sustainability. Ongoing monitoring of investor-backed PACE organizations is crucial to understand their market influence and ensure financial motivations don't undermine the primary goal of providing comprehensive, high-quality care to older adults. Research should also explore how state-specific policies impact geographic and demographic targeting of PACE services, providing insights into how regulatory environments shape the overall PACE landscape.

This study provides valuable insights for policymakers, health care providers, and PACE stakeholders navigating this transformed landscape. As for-profit organizations continue expanding within PACE, balancing financial sustainability with equitable, quality care delivery is imperative. Policymakers must ensure regulatory frameworks evolve alongside market dynamics to safeguard the interests of vulnerable older adults. By fostering an environment that encourages both innovation and accountability, the PACE program can continue to serve as a robust model for integrated, community-based long-term care. Ensuring growth doesn't compromise care quality or accessibility will be essential for PACE's sustained success and integrity in meeting an aging population's needs.

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