

# UNDERSTANDING PACE

## Profile of PACE

### The PACE Model

Programs of All-inclusive Care for the Elderly (PACE) are innovative because they provide continuous care and services offering individuals eligible for nursing home care the option of continuing to live in the community. Because these health care costs are traditionally paid for through the Medicare and Medicaid programs and out of people's pockets, access to a comprehensive system of care that encompasses preventive, primary, acute and long term care is usually not possible. One key to the PACE model is the combining of dollars from different funding streams in order to deliver a comprehensive set of services focused on the health and well-being of the individual.

Because PACE delivers care differently from traditional long term care providers, it can be difficult to understand how all the elements of the program work together. For example, the public may be mostly aware of the PACE program's vans that provide transportation to PACE participants. Policy makers may view PACE as a program that integrates Medicare and long term care funding in a way that saves taxpayer dollars while providing more effective care. PACE participants and their family members might see the PACE center that they attend as the central part of the program. But it is the combination of the different components of the PACE model, including the work of the interdisciplinary team, that results in care and services that are tailored to the individual needs of each PACE participant.

### What is PACE?

The ability to coordinate the care of each participant enrolled in PACE is key to the model. PACE programs coordinate and provide all needed preventive, primary, acute and long term care services so that their participants can continue living in the community. To understand how PACE works, it is important to learn about the components of PACE that enable it to respond to the unique needs of each participant enrolled in the program.

**Interdisciplinary Teams:** Teams comprised of physicians, nurse practitioners, nurses, social workers, therapists, van drivers, aides and others—meet regularly to exchange information and solve problems as the conditions and needs of PACE participants change. Through interdisciplinary teams, the viewpoints of different disciplines are brought together, and information gained through interaction with the PACE participants over time and in different settings is shared. This approach empowers those involved and allows more information to be available at the critical points when decisions are being made.

**Capitated Payment Arrangements:** PACE receives a monthly capitated payment (i.e., a lump sum from Medicare combined with Medicaid or a participant's private pay resources that is used to pay for a variety of comprehensive services) and is responsible for the care their participants need. As such, the financial interests of the PACE program and the care needs of the persons they serve are aligned in a unique way. Regardless of whether needed services would be reimbursed under traditional fee-for-service Medicare and Medicaid, PACE provides a comprehensive set of preventive, primary, acute and long term care services that are specifically tailored to the needs of each PACE participant to help them avoid hospital or nursing home placement to the greatest extent

possible. The program is designed to closely monitor participants for even subtle changes in needs, which if left unattended could lead to costly acute care episodes.

For example, a Medicare beneficiary shows up at the emergency room every month to be treated for skin infections caused by flea bites. The traditional, fragmented care delivery system would have trouble addressing the root cause of her condition and might just keep treating the patient's flea bites. For a PACE enrollee, the team, with input from social workers, home health aides and drivers who have been in her home, may decide to fumigate her home and provide a flea dip for her pet. This flexibility can produce more cost effective solutions and a higher quality of life than prescribing costly medications or continually hospitalizing an individual.

**PACE Centers:** PACE participants regularly attend the PACE center on an average of three days per week. This center includes a health clinic with an on-site physician and nurse practitioner, physical and occupational therapy facilities, and at least one common room for social and recreational activities. Unlike fee-for-service Medicare and Medicaid programs, PACE has the flexibility to provide services such as occupational and physical therapies even when the goal is to maintain or slow the decline of an ability—not to cause measurable improvement. Because PACE participants have regular contact with primary care professionals who know them well, slight changes in their health status or mood can be immediately addressed.

**Transportation:** Transportation for PACE participants is another covered benefit. Transportation is critical to the implementation of the care plan. It is a key way in which PACE supports families who are providing care for their loved ones. Transportation is provided not only to and from the day center, but also to other appointments. Providing transportation also places a driver, who has been trained to observe cues, in the home of the PACE participant. Drivers can then report these cues that may signal a change in health status or other changes that should be monitored.

## How Did PACE Begin?

The PACE model of care was created in 1973 in an effort to help the Asian-American community in San Francisco care for its elders in their own homes. For these families the option of placing their elders in nursing homes was not a culturally acceptable solution. In order to meet this community need, On Lok Senior Services (“On Lok” is Cantonese for “peaceful, happy abode”) created an innovative way to offer a comprehensive array of medical supervision, physical and occupational therapies, nutrition, transportation, respite care, socialization and other needed services using home care and an adult day setting.

In 1986, the Robert Wood Johnson Foundation provided funding for six sites, in addition to On Lok, to develop PACE demonstration programs, made possible by Congressional authorization of additional Medicare and Medicaid waivers. Based on the success of the demonstration programs, PACE was able to make the rare transition from demonstration program to permanent provider type. The Balanced Budget Act of 1997 approved the granting of provider status to PACE programs under Medicare and gave State Medicaid agencies the option to include PACE as a Medicaid benefit.

## Who Develops PACE Programs?

PACE programs are sponsored by a variety of different types of non-profit organizations including health systems, free standing community agencies, community health centers, long term care providers, and hospitals.

## What Does the PACE Population Look Like?

In order to qualify for PACE, a person must be 55 years of age or older, live in a PACE service area, and be certified by the State to need nursing home-level care. Like nursing homes, PACE tends to attract participants who are older and who have very high care needs. The average PACE participant is:

- 80 years old (74 percent are 75 or older; more than 33 percent are 85 or older);
- female (75 percent of participants are female); and
- has 7.9 medical conditions (many of which are chronic conditions including diabetes, dementia, coronary artery disease, and cerebrovascular disease).

Although extremely frail, most PACE participants live alone in the community; only seven percent live in nursing homes. However, when participants need nursing home care, they do not disenroll from PACE. The PACE program pays for nursing home care whenever necessary. The care of the interdisciplinary team follows them through all care settings including hospital stays and nursing home placements. PACE helps arrange supportive housing when appropriate.

## How Does Housing Fit into the PACE Model?

Housing is not a covered benefit or service under PACE. However, most PACE programs find that strong relationships with accessible, affordable housing providers are important. As PACE programs mature and their participants continue to age, arranging appropriate housing becomes a key to maintaining participants in the least restrictive and often most cost effective environments.

## Does PACE Serve Only People with Low Incomes?

There is no income eligibility requirement for participating in PACE. However, during the PACE demonstration process many providers and State policy makers were interested in how the PACE model could be used to provide care to hard-to-serve populations. PACE has been a successful model of care because it integrates across the full continuum of care and services possible, regardless of who is paying.

In the future, it is likely that payment sources for PACE enrollees will be more mixed as programs seek to serve many different income levels. PACE participants already use a variety of payment sources, including Medicaid, long term care insurance benefits, and their own out-of-pocket resources.

## Can the PACE Model Be Used with Other Groups?

Current legislation provides only for the frail elderly population. However, providers are experimenting with using the PACE model concepts in programs that serve other populations (e.g., children and persons with AIDS). Separate legislation and financing would be needed to extend the PACE services and financing model to other populations.

## What Is the Future of PACE?

The National PACE Association is working with health and aging service providers across the country, in rural and urban service areas, to develop new PACE programs. NPA is also assisting state governments in building their capacity to administer PACE programs and promote their growth.

For additional information and assistance, visit the National PACE Association website at [www.NPAonline.org](http://www.NPAonline.org) or a technical assistance center to discuss options for constructing a business plan for PACE