



**Care That Works:  
Program of All-Inclusive  
Care for the Elderly (PACE)**

February 2018



# Care That Works: Program of All-Inclusive Care for the Elderly (PACE)

*This is the first in an occasional series highlighting promising strategies for person-centered care for people with complex care needs.*

## WHAT IS PACE?

The PACE Model of Care – Program of All-Inclusive Care for the Elderly (PACE) – was started back in the early 1970s, when the Chinatown-North Beach community of San Francisco saw the pressing needs for long-term care services in families whose elders had immigrated from Italy, China and the Philippines. A core belief of PACE is that seniors with chronic care needs and their families are better served in the community whenever possible. Today there are 122 PACE programs in 31 states offering a continuum of medical and social support services to older adults.

The goal of PACE is to help older adults live in the community as independently as possible for as long as possible. To do that, these programs offer a wide range of services, from adult day programs to medical, nursing, social services, transportation, pharmacy and long-term services and supports. Care is provided at PACE centers, at home or in the community via contracts with other providers. When an enrollee comes to a center, she or he may receive medication, dialysis, counseling, a meal or a flu shot. The range of services and supports require PACE sites to have strong, interdisciplinary care teams working together to ensure communication and integration for the enrollees and their families.

### Quick Facts about PACE

- PACE members receive comprehensive medical and social services according to an individualized plan
- PACE serves over 40,000 older Americans with chronic care needs
- The locus of PACE activity is the PACE center: attendance is meant to promote socialization, alleviate caregiver burden, and help the team monitor enrollee's health and functioning
- Over 90 percent of participants are dually eligible for Medicare and Medicaid
- Average age of participants was 83 in 2015

### Eligibility Criteria

- 55 years or older, able to live safely at home
- Eligible for Medicaid
- Live within a PACE organization's service area
- Certified as needing a nursing facility level of care

PACE was the first major effort in the United States to integrate primary and long-term care for low-income Medicare and Medicaid beneficiaries. A demonstration was launched in 1991 and the 1997 Balanced Budget Act (BBA) approved PACE as a Medicare program. Today, there are efforts underway to expand the PACE model with regulations pending at CMS, as well as a pilot under consideration at CMS to expand the program to people with disabilities under age 55.<sup>1</sup> After a for-profit demonstration in Pennsylvania and a corresponding 2013 study to CMS that reported no differences in access, quality or cost, CMS authorized states to allow for-profit PACE operators.<sup>2</sup>

Since then, several programs have converted to for-profit status. PACE programs have drawn an influx of funding and interest from private equity and venture capital firms, who are betting these providers can cut costs by keeping patients in homes and out of institutions, though raising concern about whether the historical mission-oriented nature of PACE programs will be compromised.

The PACE model has delivered promising results:

- Relative to a comparison group PACE participants reported: 1) better self-rated health status; 2) better preventive care, with respect to hearing and vision screenings, flu shots and pneumococcal vaccines; 3) fewer unmet needs, such as getting around and dressing; 4) less pain interfering with normal daily functioning; 5) less likelihood of depression; 6) and better management of health care.<sup>3</sup>
- Participants have lower long-term mortality relative to a comparison group of patients in nursing homes or in home and community-based services programs.<sup>4</sup>
- PACE has proven to be a cost-effective alternative to expensive nursing home care by reducing preventable hospitalizations and generating Medicare savings.<sup>5,6</sup>
- PACE has been shown to prevent and/or significantly reduce preventable hospitalizations and emergency room visits.<sup>7</sup> For example, a 17 percent cost savings relative to the TennCare managed care organization/behavioral health organization nursing facility system. Similar results were found from studies in Massachusetts, Wisconsin and New York.
- Surveys indicate that compared with HCBS enrollees, PACE enrollees had better health management outcomes – they were more likely to have end-of-life documents in place, reported less pain that interfered with normal daily functioning, and were less likely to report unmet needs in getting around and dressing, (two activities of daily living).<sup>8</sup>
- An analysis by the state of Oklahoma indicated that for every 100 participants served by its PACE program the state saves \$103,587 per month, or \$1,243,044 per year.<sup>9</sup>

## THE CONSUMER EXPERIENCE: MR. CLARENCE SEMMES' STORY



A PACE participant since 2013, Mr. Clarence Semmes is a 67-year-old retired music and art teacher and concert singer-composer who has toured Europe and United States performing solo classical and African American spiritual pieces with the Detroit Symphony. He has been a Detroit resident for 28 years and currently lives in senior housing. He is a father of two and, at the time of the interview, was expecting his first grandchild. He heard about PACE from family members who were researching care options that would allow Mr. Semmes to remain in his home.

PACE could not have entered Mr. Semmes' life at a better time.

Before joining PACE, he faced financial instability due to the loss of his pension and was struggling with a number of chronic illnesses, including diabetes and kidney failure.

“PACE was my only serious option,” said Mr. Semmes.

“[Before] becoming a PACE participant, I was not quite sure what might happen. I wasn't eligible for Medicare so I didn't have any insurance. There were times when I should have been in the hospital. Instead, I was kind of self-medicating. It was a fearful situation.”

Since joining PACE in 2013, he has received care from a multi-disciplinary team that includes a primary care doctor, nurses, nurse practitioners, specialists through Henry Ford Hospital, transportation providers, physical and occupational therapists, social workers, health center staff, an in-home caregiver and a housekeeper.

“[Now,] I am the ultimate PACE participant. I do physical therapy, occupational therapy and dialysis. I have a home caregiver and a housekeeper. I go into the day health center three days a week. The days I go in, I have breakfast and lunch. There are all sorts of activities going on. And if I have an appointment at Henry Ford (a Detroit-based health system), they provide transportation and will send an aide with me. There is someone to hold your hand even at the away appointments.”

As an older adult with a limited income and multiple chronic conditions, Mr. Semmes speaks highly of PACE’s integrated care model: “Having things like transportation and making sure that you are at your appointment on time, it makes such a difference. Particularly for a person who is homebound, they can be picked up and brought to the day center, and have the social interaction. There are all sorts of things going on at the center. I can’t really say enough wonderful things about PACE. PACE has been a lifesaver.”

Four weeks after becoming a participant, Mr. Semmes unexpectedly had to undergo gastrointestinal surgery. The care team at PACE helped to find a surgeon for Mr. Semmes and ensured a smooth transition for him from the hospital to a rehabilitation facility and eventually back home. “I had to go for dialysis three times a week. They came to rehab, picked me up and made sure that I got to dialysis on a timely basis. At the end of the six months in rehab, I moved back to my apartment.”



“They took care of little things like making sure that I had my clothing to wear. PACE was always a step ahead of me. They made sure that I did not have to worry about anything except getting well. Before, I was so worried about the other things that it hindered the healing process.”

Mr. Semmes’ experience as a PACE member was reinforced by one of his team members, Kelsey Schmelling, LMSW. Ms. Schmelling works as a social worker and helps members like Mr. Semmes get to appointments, coordinates respite stays, assists with applying for medications and food stamps, and facilitates family meetings. For her, working effectively as part of an interdisciplinary team is critical to her job.

*Providers at Mr. Semmes’ PACE program (PACE of Southeastern Michigan) describe some of the ways in which they achieve this person-centered care, including:*

- Strong teamwork, including a daily interdisciplinary team meeting;
- Emphasis on patient education;
- Partnership with patients and families; and
- Deep commitment to the population served.

Kelsey discusses her role: “Being sick is scary, and having a model that provides comfort and continuity of care is invaluable. I know patients with COPD or dementia-related behaviors who, before entering PACE, passively utilized the Emergency Room as a physician’s office because they did not have the information about other options to receive preventive and non-emergency care. Once entering PACE, patients receive education about these options, and the assistance to utilize them. Their time in the ER and hospitals go down, because we reach them before they get to that point of needing ER services. We are their safety net before they reach out to other services.” Regular communication with a family member is also important to keep them updated on the care plan.



“Older adults represent a forgotten and huge population,” Kelsey notes when emphasizing the importance of a community-based care model for this population. “People do not want to be in a nursing home, but in their own homes.”

Gwendolyn Graddy, MD, medical director for PACE of Southeast Michigan sums up the approach: “The care coordination available through this program allows participants to receive services when and where they need it. Staying in front of challenging conditions helps keep our participants healthier, reduces avoidable hospitalizations and enables them to remain independent in their own homes.”

\*\*\*\*\*

Acknowledgements: We would like to thank PACE of Southeast Michigan for assisting with this issue brief. PACE of Southeast Michigan is co-owned by the Henry Ford Health System and the Presbyterian Villages of Michigan, and has three PACE sites in the region that serve 48 cities.

## References

1. PACE Innovation Act. 2017 <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACE/PACEInnovationAct.html>. Accessed February 5, 2018.
2. Gonzalez L. A Focus on the Program of All-Inclusive Care for the Elderly (PACE). *J Aging Soc Policy*. 2017;29(5):475-490. doi:10.1080/08959420.2017.1281092.
3. Chatterji P, Burstein NR, Kidder D, White A. Evaluation of the Program of All- Inclusive Care for the Elderly (PACE) Demonstration The Impact of PACE on Participant Outcomes FINAL. 1998. <https://innovation.cms.gov/Files/Migrated-Medicare-Demonstration-x/EvalPACE-OutcomeImpact.pdf>. Accessed February 5, 2018.
4. Ghosh A, Schmitz R, Brown R. Office of the Assistant Secretary for Planning and Evaluation. Effect of PACE on Costs, Nursing Home Admissions, and Mortality. 2006. [http://aspe.hhs.gov/office\\_specific/daltcp.cfm](http://aspe.hhs.gov/office_specific/daltcp.cfm). Accessed February 5, 2018.
5. White AJ. Evaluation of the Program of All-Inclusive Care for the Elderly (PACE) Demonstration; The Effect of PACE on Costs to Medicare: A Comparison of Medicare Capitation Rates to Projected Costs in the Absence of PACE Final Report; Medicare-Only Capitation Analysis 1. 1998. <http://www.abtassociates.com/reports/19986221706191.pdf>. Accessed February 5, 2018.
6. Friedman SM, Steinwachs DM, Rathouz PJ, Burton LC, Mukamel DB. Characteristics predicting nursing home admission in the program of all-inclusive care for elderly people. *Gerontologist*. 2005;45(2):157-166.
7. Segelman M, Szydlowski J, Kinosian B, et al. Hospitalizations in the Program of All-Inclusive Care for the Elderly. *J Am Geriatr Soc*. 2014;62(2):320-324. doi:10.1111/jgs.12637.
8. Leavitt MO. Interim Report to Congress the Quality and Cost of the Program of All-Inclusive Care for the Elderly (PACE). <https://static1.squarespace.com/static/57111ffc22482ed03d9f3a5d/t/5769b00f6b8f5ba0f5561480/1466544143650/Leavitt+Interim+Report+to+Congress.pdf>. Accessed February 5, 2018.
9. Oklahoma Health Care Authority. Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees; Demonstration Proposal: Oklahoma. <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/OKProposal.pdf>. Accessed February 5, 2018.



**@CCEHI**

**[healthinnovation.org](http://healthinnovation.org)**

COMMUNITY CATALYST  
ONE FEDERAL STREET, 5<sup>TH</sup> FLOOR  
BOSTON, MA 02110  
617.338.6035