Fact Sheet

NATIONAL PACE ASSOCIATION

PACE: Frequently Asked Questions

What is PACE?

The Program of All-Inclusive Care for the Elderly (PACE®) is a comprehensive, fully integrated, provider-based health plan for the frailest and costliest members of our society – those who require a nursing home level of care. The PACE philosophy is centered on the belief that it is better for frail individuals and their families to be served in the community whenever possible. Although all PACE participants are eligible for nursing home care, 94 percent continue to live at home.

Who does PACE serve?

PACE serves over 78,000 participants in 33 states and the District of Columbia (see PACE in the States). PACE serves individuals who are age 55 or over and certified by their state as needing a nursing home level of care. The average participant is 76 years old and has multiple, complex medical conditions, cognitive and/or functional impairments, and significant health and long-term care needs. Approximately 80 percent are dually eligible for Medicare and Medicaid. PACE participants must live in a PACE service area and be able to live safely in the community with PACE services at the time of enrollment.

What benefits does PACE offer?

PACE organizations provide the entire continuum of medical care and long-term services and supports required by frail older adults. These include primary and specialty medical care; in-home services; prescription drugs; specialty care such as audiology, dentistry, optometry, podiatry and speech therapy; respite care; transportation; adult day services, including nursing, meals, nutritional counseling, social work, personal care, and physical, occupational and recreational therapies; and hospital and nursing home care, when necessary. In short, PACE covers all Medicare Parts A, B and D benefits, all Medicaid-covered benefits, and any other services or supports that are medically necessary to maintain or improve the health status of PACE program participants.

What makes the PACE model unique?

- **PACE Participants Are Served by a Comprehensive Team of Professionals:** Upon enrollment in PACE, participants and their caregivers meet with an interdisciplinary team (IDT) that includes doctors, nurses, therapists, social workers, dietitians, personal care aides, transportation drivers and others. Their needs are assessed, and an individualized care plan is developed to respond to all of the participant's needs – 24 hours a day, seven days a week, 365 days a year.
- **PACE Participants Receive Regular, "High-Touch" Care:** PACE participants receive comprehensive health and supportive services across a range of settings. At the PACE center they receive primary care, therapy, meals, recreation, socialization and personal care. In the home PACE offers skilled care, personal care supportive services, and supports such as ramps, grab bars, and other tools that facilitate participant safety. In the community PACE offers access to specialists and other providers.
- **PACE Is Both a Health Provider and a Health Plan:** PACE combines the intensity and personal touch of a provider with the coordination and efficiency of a health plan. IDT members deliver much of the care directly, enabling them to personally monitor participants' health and respond rapidly with any necessary changes. The PACE team also is responsible for managing and paying for services delivered by contracted providers such as hospitals, nursing homes and specialists. For more information, see Core Differences Between PACE and Medicare Advantage and Core Differences Between PACE and SNPs.

The National PACE Association advances the efforts of PACE programs across the country.

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How is PACE financed?

PACE organizations receive fixed monthly payments from Medicare, Medicaid and private payers (for program participants who are not dually eligible). These funds are pooled, and care is provided following a comprehensive assessment of a participant's needs. This bundled payment provides a strong incentive to avoid duplicative or unnecessary services and encourages the use of appropriate community-based alternatives to hospital and nursing home care. For more information, see Medicare and Medicaid Payment to PACE Organizations.

How does PACE ensure quality care and cost-effectiveness?

PACE emphasizes the following processes, which are recognized as highly effective in the provision of primary care for community-based older adults with complex care needs:

- development of a comprehensive participant assessment that includes a complete review of all medical, functional, psychosocial, lifestyle and values issues;
- creation and implementation of a care plan that addresses all health and long-term care needs;
- communication and care coordination among all those who provide care for the participant; and
- promotion of participant and caregiver engagement in health care decision-making.

Furthermore, because PACE organizations are fully responsible for the quality and cost of all care provided, they have a financial incentive to provide all necessary care. According to the "HHS Interim Report to Congress: The Quality and Cost of the Program of All-Inclusive Care for the Elderly," Medicare costs for PACE and a comparable group were analyzed for a 60-month period and found to be similar, suggesting that Medicare capitation rates for PACE were set appropriately.

Similarly, the Medicaid statute requires that PACE rates be set below the upper payment level for a similar population. According to an analysis done by the National PACE Association, PACE rates are 12 percent less than the state costs of providing alternative services to a comparable population. For additional information on the quality and cost-effectiveness of PACE, see NPA Analysis of PACE Upper Payment Limits and Capitation.

How is PACE authorized and regulated?

Congress authorized PACE as a permanent Medicare provider and Medicaid state option in the Balanced Budget Act of 1997 by establishing Sections 1894 (42 U.S.C. 1395eee) and 1934 (42 U.S.C. 1396u-4) of the Social Security Act. In the Deficit Reduction Act of 2005, Congress established a program to expand PACE to rural areas of the country. Regulatory authority for PACE can be found in 42 CFR Part 460. Operationally, the PACE program is unique and implemented through three-way program agreements among the Centers for Medicare & Medicaid Services (CMS), states and PACE organizations. CMS and the state are responsible for monitoring the operations, cost, quality and effectiveness of PACE programs. For more information about PACE regulatory requirements, see 42 CFR Part 460 and the **CMS PACE Manual**.

Who sponsors PACE organizations?

PACE organizations often are part of larger health care systems or organizations, including hospital systems, medical groups, federally qualified health centers, area agencies on aging, hospice organizations, and collaborations among several different entities. Some PACE programs operate as stand-alone entities.

What is the PACE Part D Penalty?

A restrictive drug coverage requirement makes the PACE program unaffordable for some Medicare beneficiaries with complex needs, preventing them from receiving the personalized and coordinated home care services they need. Current law mandates Medicare-only participants are required to enroll in PACE's Part D drug benefit, which costs on average more than $13,000 a year–22x higher than the average premium for Medicare Part D plans.

Congress can easily fix the Part D penalty by passing the PACE Part D Choice Act, so more Medicare enrollees with complex conditions can receive the high-quality care PACE provides.

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