The Affordable Care Act (ACA) presents the Program of All-Inclusive Care for the Elderly (PACE) with opportunities for growth, development, and evolution. The current interest and concern regarding how to best assure high-quality, appropriate, and effective care for frail older adults in the community also allows PACE, with its history of serving this population well, to contribute some of its lessons learned.

PACE is an innovative, person-centered approach to comprehensively meeting the medical and long-term-care needs of older adults with complex chronic conditions, and functional or cognitive disabilities. Working with program participants and their caregivers, PACE programs strive to help elders maintain their independence for as long as possible at home and in their communities by delaying or avoiding permanent nursing home placement.

**A Short History of PACE**

On Lok, the first PACE program, was established in San Francisco in 1973. It began a major cultural shift in health and long-term care by integrating all Medicare- and Medicaid-covered services and financing into a single comprehensive benefit. PACE participants—who are at least 55 years old and eligible for nursing-level care—receive all medically necessary services, including Medicare- and Medicaid-covered services, along with other social supportive services from their PACE organizations. Many services are provided by PACE staff; others through contracts with community providers. Regardless, PACE is fully accountable for the quality and cost of all services.

Like a health plan, PACE organizations become the payer for services. In contrast to most health plans, PACE organizations provide...
healthcare directly. An interdisciplinary team of healthcare professionals works with participants and their caregivers to assess needs, and to develop and implement care plans.

Now there are seventy-five PACE organizations nationwide, serving more than 23,000 participants in twenty-nine states.

Based on its success as a national demonstration program, in 1997 PACE became a permanent Medicare and Medicaid provider. Now there are seventy-five PACE organizations nationwide, serving more than 23,000 participants in twenty-nine states. A number of these programs serve rural areas where access to community-based alternatives to institutional care is often limited.

Despite consistent growth in the number of PACE organizations, several barriers prevent PACE from growing more quickly. Among these are the considerable time and monetary investment required of prospective PACE organizations. Also, developing a PACE program requires the active support of state Medicaid agencies. Support for a new program, regardless of its merit, can be difficult in times (such as we are currently experiencing) of severe budget and resource constraints. It is also possible that characteristics of the PACE model may deter some eligible individuals from enrolling. The requirement that PACE participants receive their primary medical care from a PACE physician is off-putting to some, although several PACE organizations include community-based physicians on their interdisciplinary teams and more will likely do so in the future.

In order to respond to the growing numbers of individuals who need the comprehensive, coordinated care provided by PACE, and the need to improve the effectiveness of care for persons with complex, chronic care needs, attention has focused on expanding PACE. This may involve increasing the pool of individuals eligible for PACE, perhaps to include individuals younger than age 55, or to alter the model in other ways that would expand enrollment without jeopardizing outcomes.

Encouraging PACE Expansion
Given its focus on improving care for the population enrolled in PACE, the ACA presents several opportunities that may encourage PACE growth.

Within the Centers for Medicare and Medicaid Services (CMS), the ACA established an office focusing exclusively on opportunities to improve care for Medicare and Medicaid beneficiaries (the Duals Office). The ACA also established the CMS Center for Medicare and Medicaid Innovation to test models of care that will reduce costs while preserving or enhancing quality. These may be new opportunities to raise awareness of PACE among states or test variations on the current PACE model that will address some of the previously identified barriers to growth.

To address budget constraints states may face in developing PACE, various provisions in the ACA create financial incentives for states to expand their use of community-based versus institutional care. These include an extension of the Money Follows the Person Demonstration; enhanced federal funding for Medicaid health homes; and, for eligible states, enhanced federal funding to support long-term-care systems rebalancing. PACE organizations should work with their states to determine the extent to which these opportunities can incorporate and support PACE development.

Presently, PACE organizations serve an almost exclusively dual eligible population, in part because of the lack of financing for long-term care for many middle-income Americans. To address this, the ACA created a voluntary long-term-care insurance program, the Community Living Assistance for Services and Supports (CLASS) Plan, which, when implemented, will
be a payment source for community-based support services, including PACE.

PACE organizations also can be an important resource for policy makers pursuing strategies to improve the delivery of healthcare to individuals with complex chronic care needs. One example is including PACE's care coordination principles in Medicare Advantage Special Needs Plans so they can be most effective in serving their populations. Another is the relatively low institutional use rate for PACE participants (Kane et al., 2006; Friedman et al., 2005), an area currently being advanced by other regulatory efforts.

**PACE, Ahead of the ACA**

PACE has already implemented several healthcare delivery system reforms included in the ACA. For example, embedded in the core of PACE are the concepts of accountable care, health homes, and patient-centeredness. Fully responsible for the quality and cost of all care provided directly by PACE staff and contracted providers, PACE organizations provide accountable care across preventive, primary, acute, and long-term-care services.

**PACE emphasizes preventive, primary, and community-based care over avoidable high-cost specialty and institutional care.**

PACE programs are the epitome of medical health homes, responsible for providing care twenty-four hours a day, seven days a week, over time and across all care delivery settings. PACE is person-centered—participants work together with their healthcare providers to develop individualized care plans based on their personal goals and objectives. PACE organizations receive a monthly capitated payment for all Medicare- and Medicaid-covered benefits, as well as additional services necessary to maintain participants' health and well-being. These funds are pooled, so services are provided without regard to payer source, or the incentives of PACE organizations and their participants (and payers are closely aligned).

Finally, PACE emphasizes preventive, primary, and community-based care over avoidable high-cost specialty and institutional care. The result is greater independence and function within the community, and far less need for hospital, emergency room, and long-term institutional care.

For more than twenty-five years, PACE has provided quality, comprehensive care to frail elders. Now, with the advent of the ACA, PACE organizations have new opportunities to expand and serve additional populations.

---

**References**
