



PACE: THE ACCOUNTABLE CARE PIONEER *Bridging Value and Quality Through Innovation*

As the Commonwealth begins implementation of Accountable Care Organizations (ACOs) for the under-65 Medicaid population, the Program of All-Inclusive Care for the Elderly (PACE) model stands as a more than 25 year-old program that has a demonstrated ability to **manage total cost and care** while improving the lives of some of the most vulnerable older adults in the Commonwealth: the nursing-home eligible who want to live in the community. PACE features a **one-stop shop** approach to service delivery with a commitment to **individualized care planning**, a track record of **innovative and successful partnerships with community-based entities**, and a proven ability to **delay nursing home entry**.

PACE Succeeds in Serving a Unique and Frail Population of Older Adults

- ***PACE Participants Are Amongst the Vulnerable in the Commonwealth*** All PACE “participants” are 55+ and nursing home eligible. These participants require the comprehensive, intensive services PACE provides to allow them to live safely in the community, at a much lower cost to the State than nursing home care.
- ***PACE Brings Care to Participants Where and When They Need It*** Unlike any other entity in the long-term services and supports (LTSS) community-based care landscape, PACE is a one-stop shop. For those with complex and intensive LTSS needs who cannot “stitch together” the multiple services and provider needs on their own, PACE does it for them, bringing care to them where it can most effectively and seamlessly meet their needs (be it in a PACE Center, their homes, etc.), averting costly hospitalizations and lengthy skilled nursing admissions.
- ***PACE Is a Flexible and Comprehensive Model*** PACE programs develop an individualized care plan for each participant in partnership with the individual and families. PACE features comprehensive care integration that joins behavioral health, rehabilitation services, community supports and primary care while assuming full responsibility for the total cost of LTSS and medical services. This unique set of wrap-around supports is essential to making community care safe and effective.
- ***PACE Innovates in Partnership with Non-Medical Providers*** PACE programs have a proven ability to partner with non-medical providers, particularly in the housing sector, to make community living possible for their participants. PACE programs have led pioneering work with housing authorities, rest homes, assisted living facilities, homeless organizations, and established supportive housing sites.

PACE Brings Value to the Commonwealth, Improving Outcomes & Quality for MassHealth Members While Saving Money

- ✓ **PACE Puts the Right Incentives in Place** In PACE, clinicians, payers, and participants have a shared goal of keeping members at home long as possible, which means incentives are aligned and billable visits are not a motivating factor. PACE organizations receive the same PMPM regardless of a participant’s care setting, further incentivizing maximum time in the community.
- ✓ **PACE Keeps People Out of Nursing Homes** Even though 100% of PACE participants are certified by the state as needing a nursing home level of care, a recent Massachusetts-specific study by JEN Associates found that those in PACE spent significantly more time living safely in the community and less in a nursing home than similarly frail elders not in PACE.
- ✓ **PACE Reduces Mortality for Older Adults** Massachusetts PACE programs have been shown to reduce the risk of mortality for their participants, as compared to similar populations not enrolled in PACE.

PACE: A Strong Core Model That Is Evolving and Responsive

Even as the original ACO model, PACE remains on the cutting edge of accountable care. Beyond the traditional core components which include comprehensive medical care and non-medical support, an interdisciplinary care team, individualized care planning, and transportation to and from a PACE center, PACE providers are focused on the latest care delivery approaches, including intensifying their behavioral health integration efforts. In addition, today’s PACE organizations are responding to emerging needs amongst new populations such as those with chronic conditions, substance use disorders, the homeless, and those with long term disabilities, as well as evolving their models to best care for and support them. Proposed federal PACE regulation changes and anticipated pilots through the recently enacted PACE Innovation Act stand to offer additional efficiencies and allow more agility to respond to the changing aging landscape with innovations such as alternative care sites, integration of community-based physicians, and interdisciplinary care teams with expertise further tailored to the evolving needs of individual patients.

