Program of All-Inclusive Care for the Elderly: A Comprehensive, Cost-Effective Alternative for Frail Elderly Individuals

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The Program of All-Inclusive Care for the Elderly (PACE) is a capitated health care program that allows individuals who qualify for the level of care provided by a nursing home to remain in their communities instead. PACE meets a critical need in the continuum of care for frail elderly individuals, providing a high-quality, cost-effective, community-based alternative to institutionalization. This innovative program includes comprehensive care provided by an interdisciplinary team, a medical day program, patient care coordination, intensive work with families, and provision of transportation and home care as needed. As part of this program, PACE provides and pays for all medically necessary services, including primary care, hospital care, specialty care, and institutional long-term care; it is thus both a health care provider and an insurer.

Each PACE program is a 3-way partnership between the Centers for Medicare & Medicaid Services (CMS), the Division of Medical Assistance in the North Carolina Department of Health and Human Services, and the health care organization operating the program. PACE was authorized as a permanent Medicare provider in 1997 and was approved as an optional Medicaid service in North Carolina in 2007. To enroll in PACE, an individual must qualify for the level of care provided by a skilled nursing facility, be 55 years of age or older, reside in an area served by PACE, and be able to live in the community with support. On average, PACE participants are 80 years old, have 8 medical conditions, and are taking up to 12 medications when they enroll. Almost half (48%) have a dementia diagnosis [1]. In addition, most participants have low incomes; approximately 96% of North Carolina participants are eligible for Medicaid.

PACE assumes full risk for participants’ medical care and expenses in exchange for a capitated payment that covers every aspect of the participant’s care. All health care for the participant is coordinated through, paid for, and/or delivered by PACE. Because PACE is responsible for all costs, PACE providers have a great incentive to keep participants as healthy as possible, to practice preventive measures, and to take a holistic and pre-emptive approach that will keep participants out of hospitals, emergency departments, and nursing homes.

The PACE model integrates medical care with social, family, environmental, and other factors that influence the participant’s health. An interdisciplinary team consisting of physicians, nurses, social workers, therapists, and other professionals evaluates each participant and works collaboratively to determine and implement a unique, comprehensive plan of services. Transportation, meals, exercise, therapy, socialization, personal care, medication, and medical attention are provided at the PACE health center and at the participant’s home, as needed. Because caregiver fatigue is a key factor in institutional placements, PACE also provides support, information, and respite for family caregivers.

This model has produced excellent health outcomes.
According to the executive director of Piedmont Health Senior Care, during the period from January 1, 2010 to December 31, 2013, participants in this North Carolina PACE program experienced 0.4 hospitalizations per member per year, 0.3 emergency department visits per member per year, and a low rate of hospital readmissions; all of these rates were lower than those of comparable participants in other Medicaid programs. Despite being eligible for nursing home care, only 6% of PACE participants were in a nursing home or assisted living facility, and more than one-third (35%) were living at home alone, with PACE support. The remainder of participants (59%) lived with a caregiver in the home. Nationally, only 8% of PACE participants reside in a nursing home, and the average length of time in the program is 3 years [1].

PACE also saves money for the state Medicaid program. As both the insurer and the provider, PACE assumes full financial risk for its participants; there is no cost to the state beyond the capitated payment. If a participant ultimately requires nursing home care, PACE pays for it. Specialist care, tests, dental care, vision care, and end-of-life care are all provided either directly by the PACE organization’s staff members or through its network of contracted providers. The all-inclusive PACE capitated payment from Medicaid is less than the cost of a nursing home, yielding savings of at least $16,800 annually for every Medicaid-eligible person PACE keeps in the community. In addition, the state can forecast and control Medicaid expenditures for the rapidly growing population of individuals over age 65 years; these costs were otherwise predicted by CMS to grow more than 8% per year through 2020 [2].

North Carolina’s first PACE program, Elderhaus, opened in Wilmington in 2008. Nine PACE programs now operate at 10 sites in Wilmington, Burlington, Fayetteville, Greensboro, Lexington, Newton, Charlotte, Durham, Pittsboro, and Gastonia. All operating organizations are not-for-profit entities in the predominantly low-income communities they serve. PACE programs in Asheville and Asheboro should open by 2015, and additional communities also have been targeted for programs pending state approval.

In June 2014, slightly more than 1,000 North Carolinians were enrolled in PACE. These programs have grown steadily in North Carolina, but Medicaid funding and administrative issues have curtailed growth substantially. NCMJ


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References