How the PACE Model Integrates Medical Care With Long-Term Services and Supports

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Adults who need long-term services and supports (LTSS)—that is, assistance with everyday activities such as bathing and preparing meals—often have complex medical care needs. At the same time, they may face significant barriers to obtaining needed, timely medical care, putting at risk their health and well-being. This Spotlight highlights a combined federal and state program designed to help overcome these barriers by integrating medical care and LTSS for people with significant LTSS needs. The Program of All-Inclusive Care for the Elderly (PACE) has demonstrated success in improving the health and well-being of participants as well as enhancing their ability to continue living at home as they age. It also has resulted in high satisfaction among family caregivers.

The PACE model has its origins in the early 1970s, when founders William Gee and Marie Louis Ansak sought a fully integrated system to help older adults with LTSS needs live safely at home and avoid or delay moves to nursing homes.1 In 1997, the federal government established PACE as an option for states to serve adults ages 55 and older with nursing-home levels of care needs and who, with PACE support, could live

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safely at home. The overwhelming majority of people served by PACE are enrolled in both Medicare and Medicaid, or in Medicaid alone, although PACE is open to other eligible adults.

Research has shown PACE to be beneficial to participants and family caregivers; it is also cost effective. Yet despite its success, only about 70,000 individuals are enrolled in about 300 PACE centers across 32 states plus the District of Columbia, as of August 2023. As states look to increase access to home and community-based options for people with LTSS needs, PACE offers an evidence-based model with potential for expansion to and within more states and communities nationwide.

What PACE is and how it works

PACE is a combined Medicare and Medicaid program that delivers an integrated range of health care and LTSS to eligible adults ages 55 and older.\(^2\) Participants must meet criteria indicating a “nursing-home level of need”—that is, a level of LTSS need that would qualify them for coverage of nursing home services under their state’s Medicaid program. They must also live within the service area of a PACE center. Once enrolled in a local PACE program, participants have access to a comprehensive range of services, including adult day care, medical care, physical and occupational therapy, dental care, nutrition counseling, prescription medications, and LTSS.\(^3\)

PACE enrollees receive many of these services at a PACE center in their community. The PACE center is a core feature of the program. At their local PACE center, participants receive such services as primary medical care, physical and other therapies, adult day services, and meals (see box 1). Among the LTSS

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**Box 1. What People Enrolling in PACE Can Expect**

Individuals enrolled in PACE receive integrated care from an interdisciplinary team of health care and social services professionals who deliver services at the PACE center and coordinate other health care and LTSS outside the center. With PACE, participants can expect the following:

- An initial comprehensive assessment, conducted by the PACE interdisciplinary team, that identifies the individual’s health and LTSS needs, including health conditions, physical and cognitive function, medications, availability of family caregiver support, and language and cultural needs.
- A care plan, developed by the PACE team, designed to comprehensively address the needs of the individual and enable them to live safely at home in the community or to transition to a nursing home if needed.
- Periodic review and updating of the care plan.
- Coordination by the PACE team of all services covered by Medicare and Medicaid as well as other services the team authorizes as necessary. Coordination includes services provided at the PACE center and services provided elsewhere, such as at home.
- Support for family caregivers, including caregiving training, support groups, and respite care.
- The right to voluntarily disenroll from PACE.

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services based at the PACE center is transportation to and from that center. In addition to services at the PACE center, participants may receive additional services authorized by their PACE program, such as appointments with specialists, hospital services, and home-based LTSS. For participants needing in-home support, PACE will arrange home-based services, such as personal assistance, home-delivered meals, and transportation to medical appointments. PACE also supports family caregivers by offering training, support groups, and respite care.

For PACE participants who transition from living at home to residing in a nursing home, PACE will continue to cover their care—including coordinating ongoing nursing home services and any medical care they may need.

The PACE model offers integrated care provided by an interdisciplinary team of health care professionals and social support staff. The team includes primary care providers, social workers, physical and occupational therapists, personal care attendants, and other staff (see figure 1). The PACE team regularly assesses each participant’s needs, including any changes in health or behaviors, and tailors and updates the individual’s care plan accordingly.

**FIGURE 1. THE MINIMUM PACE CENTER INTERDISCIPLINARY TEAM**

<table>
<thead>
<tr>
<th>Program Management</th>
<th>Primary Medical Care</th>
<th>Therapy</th>
<th>Nutrition</th>
<th>Social Support and LTSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PACE center manager</td>
<td>• Primary care physician</td>
<td>• Occupational therapist</td>
<td>• Dietitian</td>
<td>• Driver</td>
</tr>
<tr>
<td>• Registered nurse</td>
<td>• Physical therapist</td>
<td>• Recreation therapist</td>
<td></td>
<td>• Home care coordinator</td>
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<td></td>
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<td></td>
<td>• Personal care attendant</td>
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<tr>
<td></td>
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<td></td>
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<td>• Social worker</td>
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</table>


**Who uses PACE**

To enroll in PACE, individuals must be age 55 or older, certified by their state to need a nursing-home level of care, reside in the service area of a PACE organization, and be able to live safely at home with PACE support. Although some PACE participants move to a nursing home at some time after enrolling, the overwhelming majority of current participants (about 95 percent) live at home in the community.

PACE participants are, on average, in their late 70s. About two-thirds are women. Most PACE participants are age 65 or older (91 percent) and have chronic health conditions, such as vascular disease, congestive heart failure, and chronic obstructive pulmonary disease, along with functional or cognitive limitations. Nearly half of PACE participants (46 percent) have dementia.

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4 Medicaid.gov, “Programs of All-Inclusive Care for the Elderly Benefits.”


7 National PACE Association, “PACE by the Numbers Infographic.”
Nationwide, most PACE participants (87 percent) are dually enrolled in Medicare and full Medicaid (see box 2). About 13 percent are enrolled in full Medicaid but not in Medicare. Fewer than 1 percent have Medicare without Medicaid or neither Medicare nor Medicaid coverage.8

**Box 2. About Medicare and Medicaid and How They Work for People Enrolled in Both Programs**

**Medicare** is a federal government program that provides health insurance for nearly all people who are ages 65 and older as well as for some people younger than age 65 who qualify because of long-term disabilities. Medicare covers medical care provided by hospitals, doctors, and other clinicians and offers optional prescription drug coverage. Medicare also covers medically related care, including home health, some skilled nursing facility services, rehabilitative care, hospice services, and certain durable medical equipment, such as wheelchairs and hospital-style beds. Medicare does not, however, pay for most LTSS, such as assistance from a home care aide or a long-term stay in a nursing home or other residential care setting.

**Medicaid** is a joint federal and state program that provides health insurance for people of all ages with limited incomes and savings. Each state designs and administers its own Medicaid program within federal guidelines and with joint federal and state funding. Medicaid covers both medical care and LTSS. In all states, Medicaid covers nursing home stays and some other types of LTSS, but states vary in the extent to which they cover LTSS at home and in other community settings, such as assisted living facilities.

For individuals enrolled in both Medicare and Medicaid (often referred to as Medicare-Medicaid dual enrollees), Medicare is the “first payer” for services covered by both programs and therefore pays for most medical care. Medicaid supplants Medicare, usually paying for Medicare premiums and cost-sharing amounts and for things Medicare doesn’t cover but Medicaid does, such as LTSS and hearing and vision services. Most dual enrollees (about 71 percent) are “full duals,” meaning they are eligible for full Medicaid benefits in their state. The other 29 percent are “partial duals” who receive Medicaid help paying Medicare premiums and cost-sharing but are not eligible for other Medicaid benefits such as LTSS.*


**How PACE is financed**

For PACE participants dually enrolled in Medicare and Medicaid (with full Medicaid benefits), each program pays a monthly per-person amount to the participant’s specific PACE program. Medicare’s portion is based on the expected costs of the services Medicare covers, such as hospital care, clinicians’ services, and prescription medications. Medicaid’s portion is based on the expected costs of the services Medicaid covers for dually enrolled people, such as LTSS, dental care, and Medicare cost-sharing amounts. Dual Medicare-Medicaid enrollees have no out-of-pocket cost-sharing costs for PACE-provided services, including prescription medications.9 For individuals enrolled solely in Medicaid (and not Medicare), Medicaid pays for the full range of PACE-covered services with no out-of-pocket costs for the individual.

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8 National PACE Association, “PACE by the Numbers Infographic.”

Eligible individuals with Medicare but not full Medicaid coverage, or who are not enrolled in either program, can enroll in a PACE program by paying a monthly per-person fee—but few people choose this option. For people with Medicare but not full Medicaid, this fee covers the Medicaid portion of the PACE benefit (which is largely for LTSS) plus an amount for Medicare prescription drug coverage. For individuals not enrolled in either Medicare or Medicaid, the fee is the total monthly amount these programs would otherwise pay.

PACE programs have the flexibility to use the combined payments from Medicare, Medicaid, and other payers to support the range of medical and LTSS services they offer. Each specific PACE program is at financial risk of losses if the costs of providing care exceed the payments. Similarly, each program can financially benefit if it keeps the costs of care below its payments.

PACE’s prevalence

As of August 2023, 154 PACE programs operated about 300 centers nationwide, serving about 70,000 individuals. The availability and number of PACE programs vary by state, with programs in 32 states and the District of Columbia (see figure 2). Each state determines whether to support PACE and how many programs to authorize. A PACE program may consist of one to several centers.

Evidence of success

Research shows the PACE model has been successful at enabling adults with complex needs and chronic conditions to live at home and avoid or delay nursing home admission. Studies also show PACE participants have lower rates of hospital stays and readmissions, increased quality of care, improved quality of life, and lower mortality rates, when compared with similar individuals not enrolled in PACE. Family caregivers of participants report high satisfaction rates and lower caregiver burden because of PACE. A 2018 survey based on 30 PACE centers across the country found that 96 percent of family caregivers were satisfied with the support they received through PACE, and 98 percent would recommend PACE to others. More than half of family caregivers (58 percent) reported experiencing less caregiver burden after the care recipient enrolled in PACE.

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10 Medicare.gov, “PACE.”
Research suggests PACE yields overall savings for Medicaid (such as by reducing nursing home spending) while keeping Medicare spending similar to expected spending without PACE. A 2022 report by the National PACE Association estimated that state Medicaid programs spent 15 percent less, on average, for PACE participants ages 65 and older (with dual Medicare and Medicaid coverage) than they would otherwise have spent if these individuals were not enrolled in PACE.\textsuperscript{15} With respect to Medicare, an evaluation of PACE programs in eight states concluded that Medicare payments to PACE organizations were equivalent to the predicted Medicare costs for a similar population not enrolled in PACE.\textsuperscript{16} That study also found that the effect of PACE on Medicaid spending varied among states.


\textsuperscript{16} Ghosh et al., \textit{Effect of PACE on Costs, Nursing Home Admissions, and Mortality}.
some states, Medicaid spending was lower for PACE enrollees than for a comparison group, while in other states, PACE spending was similar or higher.

The COVID-19 pandemic presented a multitude of problems for health care and LTSS providers nationwide, challenging efforts to deliver quality care and services for older adults. PACE programs, like other providers, needed to address infection control and safety concerns, workforce shortages, and the needs of family caregivers. Many PACE organizations pivoted from offering care and services at their centers to providing them in participants’ homes. While the long-term impact of the pandemic on PACE has yet to be fully understood, preliminary findings show PACE organizations implemented key adaptations that enabled them to continue to reach and serve individuals.\(^{17}\)

**Challenges and opportunities to scale and enhance PACE**

Although PACE has been a permanent part of Medicare and Medicaid for more than 25 years, its growth has been slow. Currently, one-third of states have no PACE programs, and among states that do, there are a relatively small number of centers.

While the limited availability of PACE centers is a key constraint in people enrolling in PACE, other barriers limit participation, such as affordability for individuals without Medicaid coverage. A range of efforts by federal programs, states, and provider organizations could expand the availability of PACE and its reach in supporting individuals and their families.

**Expanding availability of PACE centers**

Establishing a PACE center requires sufficient infrastructure and resources, including initial capital investment, staff, and equipment. Start-up costs have been estimated to be between $10 million and $20 million.\(^{18}\) Additionally, organizations may have difficulty hiring sufficient numbers and types of professionals needed to support PACE’s comprehensive range of services, especially in rural areas.\(^{19}\)

Further growth in PACE could come through increased investment by the public sector and private organizations. At the state level, some states earmarked COVID relief funds for starting or expanding PACE programs to make them available to more individuals.\(^{20}\) To increase PACE availability, states could also consider ways to use their Medicaid policies, including payment rates, to encourage more organizations to establish PACE programs.\(^{21}\) In addition, states could examine current health care infrastructure regulations to determine whether they could be modified to encourage more provider organizations to invest in PACE.

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\(^{20}\) Eastabrook, “PACE Gains Speed as States Seek Nursing Home Alternative.”

To broaden investments in PACE, federal and state agencies could consider outreach to private organizations, particularly entities interested in investing in home and community-based care options for older adults.

**Addressing workforce shortages**

A shortage of workers has significantly affected health care and LTSS, making it challenging for providers, including PACE organizations, to hire needed staff. In a 2022 survey of PACE directors, almost all (97 percent) reported experiencing a workforce shortage, with most citing difficulty filling open in-home personal care positions and more than half of respondents reporting higher-than-usual turnover.22 Labor force shortages may make it difficult to hire a qualified team with the required range of skills and qualifications.

Long-standing challenges, including issues in worker recruitment and retention, have been exacerbated by COVID-19. Studies find that many factors cause experienced workers to leave the LTSS field and discourage potential workers from joining it. These factors include poverty-level wages and minimal fringe benefits (such as paid family and medical leave, and retirement plans), demanding work conditions, and limited career advancement opportunities.23 Strategies to improve pay and benefits, address working conditions, invest in quality training programs, and offer career ladders and other advancement opportunities could help alleviate the workforce shortage.24

Many PACE organizations have implemented various strategies to attract and retain employees, such as increasing wages and retention bonuses, providing staff overtime opportunities, and offering career advances and skills training.25

**Making PACE affordable for more people**

The PACE model, as currently designed, is affordable for people with Medicaid, including those who are dually enrolled in Medicare and Medicaid, because these individuals have no out-of-pocket costs for PACE services. Although individuals without Medicaid may join a PACE program, the cost is likely to be a barrier for most people.

The specific PACE fee for people without full Medicaid coverage varies by location and whether the person has Medicare. For people with Medicare but not full Medicaid, the average monthly fee in 2023 is $4,490 for the Medicaid-covered services, plus $930 for the PACE Medicare Part D (prescription drug) premium, totaling about $5,420 a month, according to estimates by the National PACE Association.26 For people with neither Medicare nor Medicaid coverage, the average fee in 2023 is about $8,710 a month.

Making PACE more affordable for people who do not have full Medicaid coverage could increase the number of individuals who would be interested in participating in the program. This might, in turn,
encourage more organizations to offer PACE. For example, instead of a single monthly amount, the fee could vary by a person's level of need and service use.

Policymakers have considered ways to make PACE more affordable. Most recently, federal legislators introduced the PACE Part D Choice Act, aimed at reducing Medicare Part D (prescription drug) premiums for Medicare-only PACE participants.27 The proposed legislation would allow Medicare-only PACE participants to purchase a stand-alone Part D plan—with an average premium of $43 per month in 202328—instead of paying the PACE Part D premium, which averages $930 per month.

Other solutions may also be possibilities. As states explore strategies to make PACE more affordable to more people, they could consider ways to offer financial assistance to individuals with high LTSS needs who do not currently qualify for full Medicaid benefits but would soon qualify if they moved to a nursing home and used up their savings. By enabling individuals in this situation to join a program like PACE, this financial assistance could help them avoid or delay an expensive nursing home stay and could be cost-effective for the state.

**Ensuring equitable access**

In expanding the reach of PACE, it is essential to ensure equity in both access and quality of care.29 Reflecting issues that span the health care system as a whole, a 2022 study highlighting factors that influence diverse older adults’ use of PACE programs cited barriers such as poor distribution of information to potentially eligible individuals, language barriers between older adults and staff, and inadequate emphasis on staff members’ sensitivity to enrollees’ cultural and disability differences.30 Addressing such barriers is key to achieving equitable access to PACE, which itself has the potential to reduce disparities by improving outcomes across racially and ethnically diverse groups.31

Efforts to expand access and use should focus on increasing PACE programs in geographically diverse and underserved locations. Strategies to enhance equity should also incorporate targeted outreach efforts to raise awareness of program availability, and such outreach efforts should be culturally and linguistically responsive. Provider organizations could partner and collaborate with community organizations (e.g., senior centers, senior housing libraries, pharmacies, clinics, and primary care offices) and faith-based groups as trusted sources to spread information about the availability of a PACE program in their region. To ensure PACE programs are responsive to participants’ needs and preferences—and ultimately drive equitable PACE access—collecting and reporting data on use and experiences by race/ethnicity and other demographic factors will be essential.32

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29 Reinhard, Tilly, and Flinn, LTSS Choices: From Ideation to Standard Practice.


31 Travers et al., “Minority Older Adults’ Access to and Use of Programs of All-Inclusive Care for the Elderly.”

Leveraging technology to enhance PACE

Technology could also be key to both increasing participation and diversity as well as enhancing what PACE centers offer participants and their families. States and PACE organizations could explore ways to use technology to reach a wider population of potential participants and simplify enrollment. For example, technology could assist enrollment by translating program-related information into multiple languages for prospective participants and their families. Technology could also streamline the completion of eligibility forms.

In addition, technology could enhance services available to participants and their families. Technology could help PACE organizations offer an array of services in individuals’ homes through, for example, telehealth platforms, remote monitoring, smart-home technologies, and wearable devices that promote safety at home. With an expanded set of home-based services, PACE could potentially attract the participation of individuals for whom traveling to a PACE center is difficult. And individual PACE centers might be able to expand the size of the geographic area they serve.

By leveraging technology, policymakers and provider organizations could both increase access to PACE and drive better outcomes for individuals and their families.

Conclusion

Access to quality home and community-based care options is a key priority for adults with LTSS needs and their families. The PACE program has demonstrated its ability to achieve positive health outcomes and improve the well-being of participants and their family caregivers—while enabling the well-documented preference among older adults to live independently to the extent possible. Efforts to expand the availability of PACE should promote investment in the program and address workforce challenges. Additional approaches to expanding the reach of PACE include making it affordable to more people, ensuring equitable access, and leveraging technology to reach more people and enhance the services available to participants and their family caregivers.

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https://doi.org/10.26419/ppi.00205.001