



PACE IN NEW JERSEY

Introduction to the PACE Model

The goal of PACE is to keep low-income, nursing home eligible older people living in their communities, rather than in facilities, by providing all the services needed to support and promote their independence.

PACE OVERVIEW

- PACE stands for Program of All-inclusive Care for the Elderly
- PACE is a joint Medicare-Medicaid program that started in the 1970s and operates in 33 states
- A PACE organization is **both the payor/health plan and provider**, partnering with a network of community specialists, hospitals, mental health and other providers.
- New Jersey is expanding PACE to all counties in the state (currently 13 counties are operational; remaining counties have been awarded to a PACE organization)

PACE PARTICIPANTS

- Age: 55+ (average age 75)
- Frail: Meets NJ requirements for nursing facility level of care
- Able to live safely in the community with PACE services at the time of enrollment
- Complex: Average participant has 6 chronic conditions and 46% diagnosed with dementia
- Financial status: Virtually all qualify for Medicaid

Source: National PACE Association

Where is PACE?

9 operational programs/sites in 13 New Jersey counties serving 1500+ participants and growing.

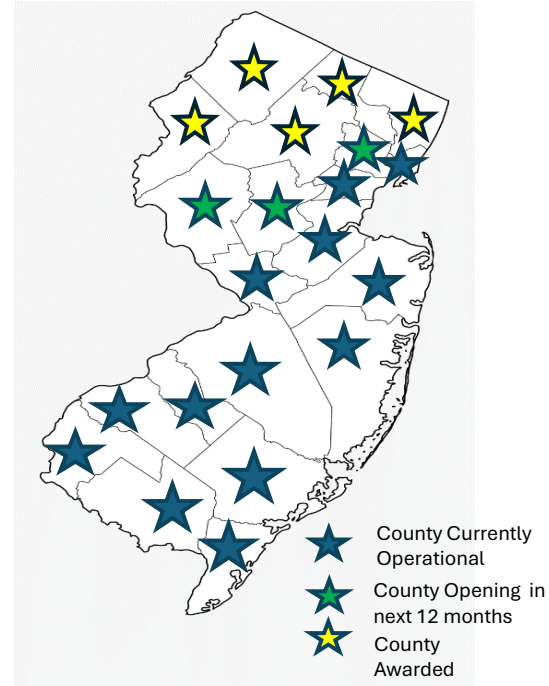
5 PACE organizations slated to become operational Essex (2026), Somerset (2026)/ Hunterdon(2026), Passaic (2027), Bergen (2027), Morris/Warren/ Sussex (all in 2028).

198 PACE organizations nationally with 380 centers, up from 2021 when there were 130 PACE organizations nationally with 275 centers in total.

More than 90,000 enrolled in 33 states nationally, up from 51,000 in 2021.



Programs of All-Inclusive Care for the Elderly (PACE) in New Jersey by county

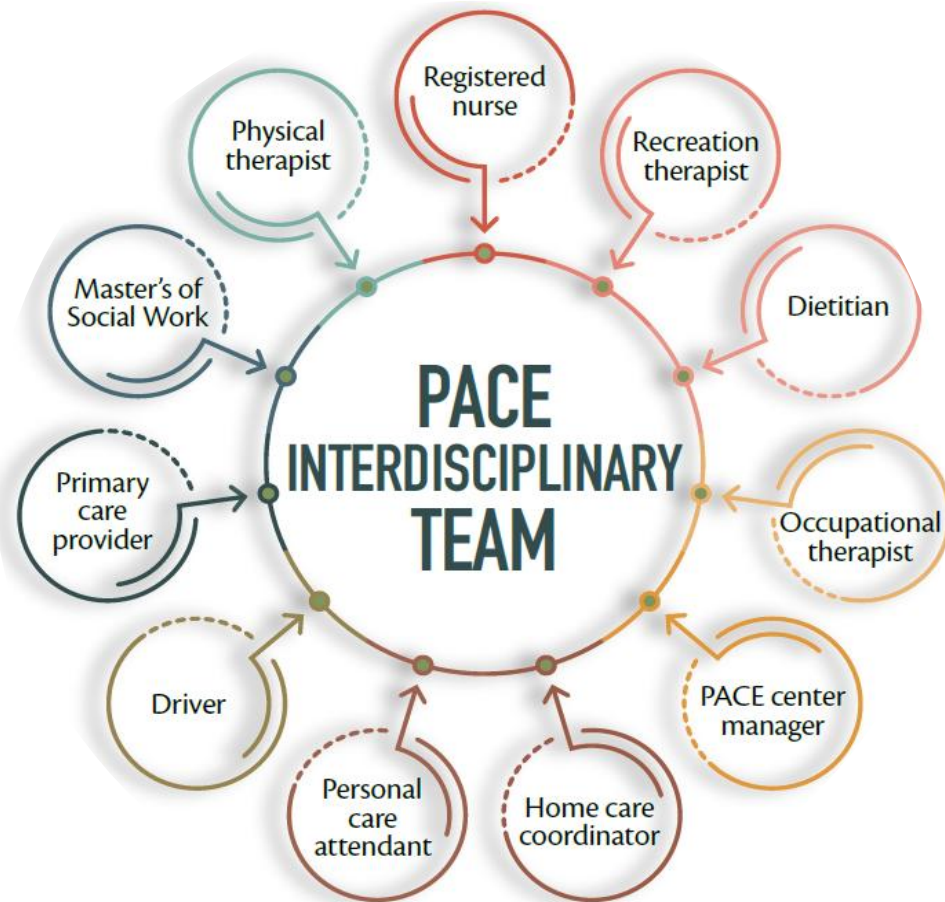


- | | |
|--|--------------------------------|
| ○ Atlantic – AtlantiCare LIFE Connection | ○ Mercer – Capital LIFE |
| ○ Bergen – WelbeHealth | ○ Middlesex – BoldAge PACE |
| ○ Burlington – Trinity LIFE, Capital LIFE and BoldAge PACE | ○ Monmouth – BoldAge PACE |
| ○ Camden – Trinity LIFE | ○ Morris – WelbeHealth |
| ○ Cape May – AtlantiCare LIFE Connection | ○ Ocean – BoldAge PACE |
| ○ Cumberland – Inspira LIFE | ○ Passaic – SeniorLIFE PA |
| ○ Essex – WelbeHealth | ○ Salem – Inspira LIFE |
| ○ Gloucester – Inspira LIFE | ○ Somerset – SeniorLIFE PA |
| ○ Hudson – Lutheran Senior LIFE | ○ Sussex – WelbeHealth |
| ○ Hunterdon – SeniorLIFE PA | ○ Union – Lutheran Senior LIFE |
| | ○ Warren – WelbeHealth |

For more information, please visit <https://njpaceassoc.org/>

How Does PACE Care for Participants ?

The heart of PACE is an interdisciplinary team (IDT) that builds individual care plans from diverse perspectives



- Collaborative care planning and goal setting that includes the participant, and as appropriate, their family/other caregivers.
- Services provided by the PACE organization include:
 - On-site clinical services including primary care, rehabilitation services, nutritional counseling, social work, case management, mental health, dental and vision care
 - PACE center for socialization, recreation and meals
 - Transportation – door through door to the PACE center and to/from appointments/activities in the community
 - Personal care and home health services at home
 - Medication, OTC supplies, and DME
- PACE utilizes a network of contracted specialists and facilities for additional care

The Impact of PACE in New Jersey

Keeping frail, nursing-home-eligible older people safely at home — at a lower cost with better quality of life

16%

fewer readmissions compared to other dually-eligible beneficiaries 65+

33%

increase in life expectancy, from 3.9 to 5.2 years for the same population without PACE services

\$655

saved per participant, per month (Medicaid)

~\$10M

saved annually for NJ Medicaid

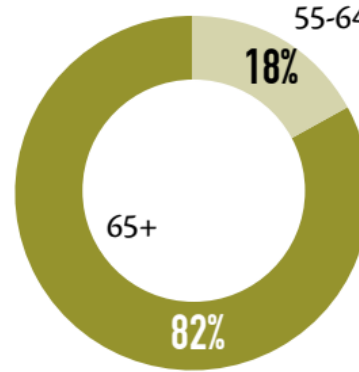
Source: National & NJ PACE Associations

National PACE Data Mirrors NJ PACE

94% Live in the community

75

Average age



65% WOMEN

MEN **35%**

PACE HELPS WITH ACTIVITIES OF DAILY LIVING



Dressing



Bathing



Transferring



Toileting



Eating



Walking

PACE Provides High-Quality Outcomes



LESS THAN

1

ER VISIT PER YEARⁱⁱ

- Lower Hospitalization Rate: A 24 percent lower hospitalization rate than dually-eligible beneficiaries who receive Medicaid nursing home services.^{vii}
- Decreased Rehospitalizations: 16 percent less than the national rehospitalization rate of 22.9 percent for dually-eligible beneficiaries age 65 and over.^{vii}
- Reduced ER Visits: Less than one emergency room visit per member per year.^{viii, x}

ONLY
6.6%

of nursing home-eligible PACE participants currently reside in a nursing homeⁱⁱ

- Fewer Nursing Home Admissions: Despite being at nursing home level of care, PACE participants have a low risk of being admitted to a nursing home.^{xi}
- PACE participants receive better preventive care, specifically with respect to hearing and vision screenings, flu shots and pneumococcal vaccines.^{xii}



PACE Programs are Health Plans and Care Partners

PACE programs contract with local specialists and facilities – then wraps around every visit to make care meaningful, seamless and easy

Before & during the visit

We get the participant to you



Transport & Escort Support

PACE transports to appts and, if needed, aides stay for the visit



Visit Prep

PACE clinicians help participants complete pre-visit instructions



The specialist visit

You deliver expert specialty care



After the visit

We carry out your plan



Consult-note review

Our PCP reviews your notes and recommendations.

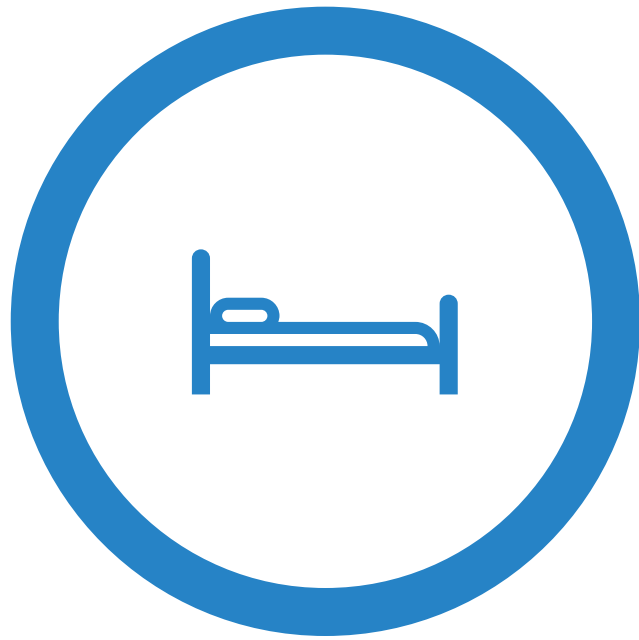


Orders effectuated

We arrange the labs, imaging, and follow-up care or services you order.

PACE Supports Hospitals with Complex Patients

The PACE interdisciplinary team, including rehabilitation and in-home care, is positioned to help hospital discharge planners keep participants safe and thriving at home after a hospital stay



Hospital Discharge Support

Keeping complex patients safely at home



Built-in Discharge Destination

PACE has the resources for safe, timely discharge – medication management, DME supply, and home care / home health.



Lower Readmission Rates

Managing medications, coordinating follow-up care, and supporting the person means high-risk older people are less likely to be readmitted.



Streamlined Claims

PACE is the sole payor – wrapping Medicare and Medicaid into one.

There is No PACE Without Health System Partners

CMS and NJ Dept. of Human Services require PACE to contract with an adequate network to operate

Category	Required Specialists
High Frequency Specialty*	Podiatry, Optometry, Dentistry, Audiology
Specialty	Cardiology, Pulmonology, Nephrology, Gastroenterology, Neurology, Dermatology, Ophthalmology, etc.
Acute and Surgical	Orthopedic Surgeons, General Surgeons, Oncologists, Hematologists, Urologists, Thoracic and Vascular Surgeons, etc.
Mental Health	Psychiatrists, Psychologists, Behavioral Health Clinicians.
Emergency and Inpatient	Hospitals, ASCs
Other Facilities	SNFs, Assisted Living



PACE Contacts

Sandra Festa, AVP & Executive Director
AtlantiCare LIFE Connection
sfesta@atlanticare.org

Dr. Melissa Gagliano, Executive Director
BoldAge PACE
mgagliano@boldagepace.com

Mary John-Williams, Executive Director
Capital Health LIFE
Mjohn-Williams@capitalhealth.org

Dr. Ankur Patel, Executive Director
Inspira LIFE
patela16@ihn.org

David Chau, Regional Director
Lutheran Senior LIFE
dchau@lsmnj.org

Mark Irwin
Senior LIFE
mirwin@pace-cs.com

Sr. Margaret Sullivan, Executive Director
Trinity LIFE
Marge.Sullivan@trinity-health.org

Jeff Darragh, VP Operations
Welbe Health
Jeff.darragh@welbehealth.com

Thank you!

CONTACT US AT: ADMIN@NJPACEASSOC.ORG