



**Testimony of Shawn Bloom  
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**Before the Committee on Energy and Commerce  
Subcommittee on Health**

**“Dual-Eligibles: Understanding This Vulnerable Population and  
How to Improve Their Care”**

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## INTRODUCTION

Chairman Pitts, Ranking Member Pallone, distinguished members of the Subcommittee, my name is Shawn Bloom. I am the President and Chief Executive Officer of the National PACE Association (NPA). On behalf of the 76 PACE organizations that are members of the NPA and more than 30 additional members actively working to develop PACE programs across the country, I am honored to appear before the Subcommittee today.

There are nearly 9 million individuals “dually” eligible for both Medicare and Medicaid. Dual-eligible Medicare and Medicaid beneficiaries often have multiple, complex health conditions. As a cohort, they are in poorer health and have lower incomes relative to other Medicare beneficiaries. They also happen to be one of the most expensive categories of beneficiaries served by federal health care programs. According to a June 2010 report by the Medicare Payment Advisory Commission (MedPAC), on average, annual fee-for-service spending on dual-eligible beneficiaries is 2.2 times higher than annual fee-for-service spending on beneficiaries who are not dually-eligible beneficiaries; \$15,384 for duals versus \$6,992 for non-duals.

We understand the dual-eligible population well. Almost 90 percent of PACE participants are dual-eligibles. PACE exclusively serves the frailest subset of the duals, older adults requiring nursing home level of care. Such frail older dual-eligible beneficiaries served by PACE are precisely those who have the most complex treatment needs, have the highest health care expenses, and have illnesses and needs that place the greatest demand on family caregivers. The vast majority of individuals enrolled in PACE have low incomes, significant disabilities and chronic illnesses, and are dependent on others to help them with at least three basic activities of

daily living, such as eating, bathing, transferring, toileting and dressing. About half of our program enrollees have some form of dementia. Approximately 90 percent of PACE participants are 65 years of age or older, averaging 81 years of age, 30 percent of which are age 85 or older.

My testimony will focus on three main areas. First, I want to briefly discuss the history of the Program of All-inclusive Care for the Elderly (PACE) and outline the PACE model of care, focusing on those elements that have made the program so successful in providing high-value, person-centered care to the oldest and frailest of the duals. Second, based on our experience, I will identify several barriers to PACE growth and expansion since PACE was established as a nationwide, permanent Medicare provider and state Medicaid option in 1997. Finally, I will propose several program enhancements and potential voluntary demonstration programs that could help expand the PACE program to a greater number of dual-eligibles and others who would benefit from receiving PACE services and benefits.

## **PACE HISTORY AND EXPANSION**

PACE was developed and first implemented in 1983 by On Lok Senior Health Services in San Francisco, California. On Lok originated in response to the local Chinese-American community's desire to provide comprehensive medical care and social services for its elders without placing them in nursing homes.

The success of PACE would not have been possible without the longstanding bipartisan support of Congress, including several members currently serving on the Energy and Commerce Committee. The PACE community-centered approach pioneered by On Lok proved so successful in enabling older adults to remain in their homes that the federal government extended

the program to additional sites across the country through a demonstration program beginning in 1986. Based on the demonstration's success, in the Balanced Budget Act of 1997, Congress authorized PACE as a permanent Medicare provider and Medicaid state option. In the Deficit Reduction Act (DRA) of 2005, Congress established a program to expand PACE to rural areas of the country.

With the support of Congress, the number of PACE organizations has doubled in the last five years to 76. Today, PACE providers serve 22,000 enrollees in 30 states. Since its inception, on any given day, PACE enables over 90 percent of its participants to remain living in their homes, rather than permanently residing in a nursing home. There also has been more diversity among the types of interested sponsors during the past few years. For example, several hospice organizations now sponsor PACE programs and several others are developing PACE. Additionally, 13 rural PACE programs have been developed in the last four years operated by a range of different types of health care providers such as Area Agencies on Aging and community-health clinics. States' interest in PACE also is growing, driven in large part by policymakers' desire to find better solutions to address dual-eligible beneficiaries' health care needs and, at the same time, to provide more predictability and control of their Medicaid payments to PACE.

For example, Oklahoma is exploring a statewide expansion of PACE as a potential strategy to improve care for the state's dually-eligible population. There are 10 programs under development in North Carolina and in the next two years almost all eligible frail elderly will have access to a PACE program in New Jersey and Pennsylvania. Lastly, Texas just passed legislation intended to support the growth of PACE.

We also understand that the need and desire for PACE likely will increase as the population ages and increasingly understands the benefits of integrated care.

## **KEY FEATURES OF THE PACE PROGRAM**

The PACE program has three fundamental characteristics: (1) it is a community-based care provider, not a health plan; (2) it provides comprehensive, fully-integrated care; and (3) it is fully-accountable and responsible to its enrollees, their families and the government for the quality and cost of care it provides.

PACE is a community-based provider of care. Since its beginning as a demonstration program more than 25 years ago, PACE has provided innovative person-centered care for frail older adults that allows them to stay in their homes in the community, an option many families do not think is even possible. Without PACE, many of these frail adults would be in a nursing home. PACE is the recognized gold standard for older adult care and a model for how others looking to improve the system could succeed.

PACE provides comprehensive and fully integrated care. The PACE financing model bundles fixed payments from Medicare and Medicaid or private sources into one flat-rate payment to provide the entire range of health care services a person needs – including paying for hospital and nursing home care, when necessary. While a number of ideas are circulating about possible ways to coordinate care, PACE is a “real” program that has a long history of combining care into one seamless delivery package. Our programs are not large insurers primarily involved in approving and paying medical claims. Rather, they are the primary caregivers for the beneficiaries they serve. At the heart of the PACE delivery model is an interdisciplinary team (IDT) comprised of doctors, nurses, therapists, social workers, dietitians, personal care aides, transportation drivers, and others who meet daily to discuss the needs of PACE participants. Through PACE’s unified financing system, older adults receive individualized care that revolves around their unique needs and at a fixed payment amount.

PACE is accountable to its enrollees, their families and government, accepting full responsibility for the cost AND quality of care it provides. The result is better health outcomes, controlled costs and better value. PACE participants utilize, on average, about three days of hospital care annually. A 2009 interim report to Congress from the Department of Health and Human Services (DHHS) examined the quality and cost of providing PACE program services and found that PACE generates higher quality of care and better outcomes among PACE enrollees than the comparison group. PACE enrollees reported better health status, better preventive care, fewer unmet needs, less pain, less likelihood of depression and

better management of health care. PACE participants also reported high satisfaction with their quality of life and the quality of care they received.

The bottom line is that PACE providers accept 100 percent responsibility for the cost and quality of care they deliver. The focus on prevention and wellness means avoiding unnecessary care and the escalating costs that go along with it. Through PACE's integration of all services, not just financing, costs are controlled and health care outcomes are high.

Perhaps the best way for the members of this Subcommittee, and the American public, to understand what PACE does and what it means to the participants and families that it serves, is to share the experience of one of our enrollees.

George is a 69 year-old who lives in the Southern Bay Area of Northern California. He has severe lung problems, heart failure and kidney disease. He lives alone in a single room occupancy hotel. He walks with a cane and has had several falls. He has short-term memory problems, needs help with bathing, meal preparation, housekeeping and shopping. By his own admission he "isn't good with taking his meds."

In the year prior to his enrollment in PACE, he had been admitted to the hospital four times. During the five-week period prior to enrolling in PACE, he had made three trips to the emergency room—usually complaining of shortness of breath or chest pain. He is on Medicare and Medicaid. He rarely makes it to doctors, primarily because he lacks access to reliable transportation. During his last emergency room visit, the physician who treated George discussed his concerns over George's progressive kidney disease and said George would "likely" need dialysis treatments. Nevertheless, George did not keep his follow-up appointment with the

kidney specialist. The hospital case manager made an entry into his record to “pursue nursing home placement with his next admission.”

George was referred by a community social worker to the PACE program in the area. With the integrated payments of Medicare and Medicaid that are core to this program model, he now has access to a full team of on-site primary care physicians, clinic nurses, therapists, and social workers. The PACE program provides transportation to and from the center, as well as to outside specialists. His medications are directly managed by the clinic and home care team. He attends the center three times a week and on the other days a home care worker goes to his apartment to help with meals, medication and hygiene. He eats meals in the center and has meals delivered at home by the PACE program and his nutritional needs are directly overseen by a registered dietician.

Six months after enrollment, he has not been to the emergency room or to the hospital. His kidneys are functioning much better and there is no longer the concern of imminent dialysis. His blood pressure is also better controlled. He has had dental care and his ability to eat is also improved.

Each emergency room visit, with ambulance, costs an estimated \$2,500 and each hospital admission was close to \$10,000. Based on just his six month stay, PACE saved Medicare at least \$30,000. That does not even take into consideration the additional costs of dialysis that were likely avoided. A nursing home placement was avoided and the emergency room was no longer impacted by his frequent visits. Most importantly, George is more engaged with his own care, is more socially connected with other peers in the PACE program, and his quality of life has improved immeasurably.

As George's story shows, the existing PACE statutory and regulatory framework has allowed PACE organizations, together with CMS and states, to implement an effective model of care for dual-eligible individuals, over age 55, experiencing both major chronic diseases, and significant functional and/or cognitive impairments. We know this program works. It has a long track record of success and a nearly 15 year history as a permanent national program.

Just last week, in fact, the Medicare Payment Advisory Committee (MedPAC) released a report to Congress entitled *Medicare and the Health Care Delivery System* which stated that: "Fully integrated managed care plans and PACE providers offer the best opportunity to improve care coordination for dual-eligible beneficiaries across Medicare and Medicaid services."

## **BARRIERS TO PACE GROWTH**

The challenge facing policymakers now is to overcome barriers to PACE growth without compromising PACE beneficiaries' experience, quality of care, and PACE organizations' success at managing the full range of Medicare and Medicaid covered services and their associated costs.

In our view, there are four primary barriers to PACE growth:

1. Certain specific regulatory requirements, focused largely on required processes of care, have hindered growth and innovations to improve efficiency, program growth and meet the changing needs of PACE enrollees.
2. High capital costs and long lead times associated with program start-up and expansion.
3. Requirement that new PACE organizations assume full financial risk for all Medicare and Medicaid covered services on day one of program operations. In contrast to large Medicare Advantage organizations that are insurance entities, PACE organizations are small provider-based programs with less opportunity to distribute risk across their

enrolled population. This is particularly true during the initial years of PACE program operations when the total number of program participants is relatively small.

4. Enrollment in PACE is limited to individuals who are a minimum of 55 years of age and meet states' eligibility criteria for nursing home level of care. From states' perspective, this enrollment limitation prevents PACE from being a more comprehensive solution to addressing the needs of a broader population of high-need, high-cost individuals.

## **PROPOSED SOLUTIONS TO OVERCOMING PACE BARRIERS**

To overcome these barriers, we recommend the following modifications to the PACE statute and regulation:

1. Allow PACE organizations more flexibility in contracting with community-based primary care physicians.

Currently, PACE participants generally receive their primary care from physicians employed by PACE organizations. As a consequence, PACE growth is limited by PACE organizations' ability to hire additional primary care physicians who are often in short supply and PACE participants' choice of primary care physicians is limited.

2. Permit nurse practitioners (NPs) and physician assistants (PAs) to conduct certain activities that are currently assigned to PACE primary care physicians, in particular to perform participant assessments and engage in care plan development, consistent with state law and regulation governing their scope of practice.

This change, which would not alter state scope of practice laws in any way, would allow PACE organizations' access to an expanded pool of qualified primary care practitioners to help conduct certain activities.

3. Without compromising PACE participants' receipt of comprehensive assessment and care planning, allow for more flexibility in the composition and processes of the PACE Interdisciplinary Team (IDT).

We believe a smaller core team made up of the primary care practitioner, nurse and social worker, with requirements to add additional team members as determined necessary on the basis of participants' individual health care needs, would enhance program efficiency without compromising quality of care.

4. Encourage states to utilize PACE as a means for transitioning Medicaid eligible beneficiaries residing in nursing homes back to the community.

This could be accomplished, for example, under the Money Follows the Person demonstration by (1) allowing an enhanced federal match to apply to the PACE Medicaid capitation payment for PACE program participants who are nursing home residents at

enrollment and who, with the support of the PACE organization, transition to community residence; and (2) requiring states to make an enhanced payment to PACE organizations for these individuals.

## **DEMONSTRATIONS MAY BE AN IMPORTANT WAY TO EXPAND PACE AVAILABILITY**

NPA and its members are in the process of developing several demonstration proposals we will share with CMS and hope they will implement. These voluntary demonstrations will allow PACE organizations and their states to test significant modifications to current PACE requirements and evaluate their implications for participant and program outcomes. This series of voluntary demonstrations is designed with two goals in mind: (1) to foster PACE expansion without compromising quality, outcomes and accountability and (2) to identify specific opportunities for future, additional regulatory changes that will encourage many more prospective providers and states to pursue PACE. Following are the ideas that we are developing and plan to submit to CMS in the near future.

1. A demonstration allowing PACE organizations to enroll individuals under the age of 55 who meet their states' eligibility criteria for nursing home level of care.

Under this demonstration, PACE organizations would be required to provide comprehensive, coordinated, accountable care but would have substantial flexibility to implement modifications to current PACE regulatory requirements in order to best meet the needs of this younger population.

2. A demonstration to allow PACE organizations to enroll high-need, high-cost beneficiaries, as defined by states, who may not yet meet their eligibility criteria for nursing home level of care and currently are not well served.
3. A demonstration to reduce PACE organizations' reliance on the PACE Center as the primary location for the delivery of service and expanding PACE organizations' use of alternative care settings and contracted community-based providers.

A demonstration to test expanded use of alternative care settings and expanded use of contract providers would allow CMS, states and PACE organizations to evaluate the impact of these significant changes on a variety of participant outcomes, including quality of care and overall program viability.

4. A demonstration that would allow interested PACE organizations to implement alternative approaches to providing Part D drugs to their PACE participants.

The administrative requirements associated with Part D have been extensive, particularly in light of PACE organizations' size and core competencies as provider entities.

5. A demonstration with the objective of increasing Medicare-only beneficiaries' enrollment in PACE.

Currently, the vast majority of PACE participants are eligible for both Medicare and Medicaid benefits. The small number of Medicare-only participants enrolled in PACE pay a monthly premium equivalent to the Medicaid capitation amount and a Part D premium. We would like to test alternative approaches to PACE program design, use of community-based physicians, and premium-setting with the objective of encouraging Medicare-only beneficiaries' enrollment in PACE.

## CONCLUSION

In closing, we once again appreciate the opportunity to testify before the Subcommittee. As mentioned, PACE is a tangible program with a proven track record of providing high quality care to the frailest segment of the dual-eligible population. While not all dual-eligible beneficiaries require the intensive services provided by PACE, for the individuals who do, PACE is a good alternative to permanent nursing home placement. PACE is community-based, comprehensive, and fully accountable for all risk. The PACE community would like to contribute to state and federal governments' efforts to improve health care for more dual-eligible individuals, and we look forward to working with you on these activities.