UNITED STATES
HOUSE OF REPRESENTATIVES

COMMITTEE ON WAYS AND MEANS
Subcommittee on Health

TESTIMONY

by

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in

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Statement of Jennie Chin Hansen, M.S. R.N.
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Mr. Chairman and Members of the Subcommittee:

I am accompanied by Judy Baskins, the President of the National PACE Association and Project Director of Palmetto SeniorCare, the PACE site in Columbia, South Carolina. Also here is Dr. Chris van Reenen, the Executive Director of the National PACE Association, and Dr. Bob McCann, a primary care physician at our Rochester PACE site, from whom you will be hearing later on.

Thank you for the opportunity to comment today on the unique health and social service needs of frail older Americans. I am speaking on behalf of On Lok, a non-profit, community-based organization in San Francisco which has, since 1973, provided home and community-based care to thousands of frail elders. On Lok currently serves over 430 older persons. We currently are in the process of expanding our service area to make On Lok an option to frail elderly throughout the San Francisco Area. I also represent ten programs that have successfully replicated On Lok's experience in California, Colorado, Massachusetts, New York, Oregon, South Carolina, Texas and Wisconsin. Many more programs across the country, like On Lok's, are under development in states such as Florida, Georgia, Illinois, Maryland, Virginia and Washington.

Since 1973, On Lok has evolved from a single adult day health care program to a total system of care directly providing a comprehensive package of acute and long-term services on a fully integrated basis. On Lok was designed specifically to address the complex medical and social service needs of frail older adults. Congress has specifically supported and encouraged the On Lok program, virtually from its inception. Then, in 1986, Congress initiated a national demonstration of On Lok's cost-effective, managed care system called PACE -- the Program of All-inclusive Care for the Elderly. The objective of the demonstration was to determine the feasibility of making this unique program more widely, and ultimately, generally available.

All PACE programs share the same basic elements:

- **PACE programs enroll only the very frail** -- older persons who meet their states' eligibility criteria for nursing home care. This approach is fundamental and unique among managed care programs -- there is no mixture of "good risks" with "poor risks." All PACE enrollees are in immediate need of comprehensive and continuing chronic care. A key objective of PACE is to maximize the functioning and independence of enrollees in order to delay or prevent nursing home placement.

- **PACE programs provide their enrollees a comprehensive benefit package** including all necessary medical and long-term

care services, both in the community, and in hospitals and nursing homes without any limits on dollars or duration of service.

- **PACE programs fully integrate the delivery of acute and long-term care** through interdisciplinary teams consisting of physicians; nurses; social workers; physical; occupational and recreational therapists; dietitians; and home care workers.

- **PACE programs are reimbursed on a capitated basis**, at rates that provide payers savings relative to their expenditures in the traditional Medicare, Medicaid and private-pay systems. These payments are pooled by the program, enabling us to provide the most appropriate services in the most appropriate settings in order to best meet the needs of our enrollees.

- **PACE programs assume total financial risk** and responsibility for all medical and long-term care without limitation.

The typical PACE enrollee is an 83 year old widowed woman who lives alone and suffers from several chronic and acute medical conditions, and some degree of cognitive impairment. She requires assistance with various activities of daily living such as bathing, dressing and using the bathroom as well as help with other aspects of her personal care, housekeeping, and managing her medications. In the traditional system, frail older persons or their families or friends must coordinate the delivery of multiple services from

multiple providers, leading to fragmentation and duplication of care. In PACE, participants receive all their services through a single agency that assumes total responsibility for providing all care. In this way, integration, not merely coordination, becomes a realistic objective.

To explain what I mean by integration, it is important to describe a fundamental element of the PACE program. That is, the same people who deliver care meet together on a regular basis to discuss and develop an overall assessment and treatment plan for each enrollee. This degree of coordination and management leads to an example of a quick response to medical crisis, which, for example, so happens at 5:00 P.M. on a Friday afternoon. In the PACE system, the participant would be able to be hospitalized, monitored and stabilized by the PACE primary care physician and be discharged on Sunday -- yes, Sunday! -- to a knowledgeable PACE community team and system of services tailored to that person's specific needs at home. Such a response is seldom possible in a traditional world for the frail elderly.

Enrollees attend the PACE Center, on average, two to three times a week. There they receive primary medical care, nursing and social work services, rehabilitative and restorative therapies, personal care, meals and an opportunity to participate in various activities. Participants see their physician an average of twice a month and more frequently if necessary. When enrollees do not come to the Center, services are provided in their homes. An enrollee who

requires hospital or nursing home care remains in PACE and care continues to be coordinated and monitored by PACE staff, thus assuring continuity of care between services provided in the Center, at home and in institutions. Under contracts with hospitals and nursing homes, PACE's medical teams follow our patients right into the hospital or nursing home to both monitor their care as well as to formulate appropriate plans for ongoing care, either in the institution or community.

I would emphasize that by expanding the availability of community-based long-term care services, tightly integrating all aspects of PACE enrollees' care, and emphasizing preventive and supportive services, PACE programs have substantially lowered the utilization of high-cost, inpatient services. In turn, dollars that would have been spent on hospital and nursing home services are used to expand the availability of community-based long-term care which, again, reduces the need for high-cost services.

Hospital utilization rates for PACE enrollees are at or below levels for the general older population, and nursing home rates are way below levels for a comparably frail group. Analyses of costs for individuals enrolled in PACE show that Medicare and Medicaid save between 5% and 15% relative to expenditures for a comparably frail population in the traditional Medicare and Medicaid systems. These savings are apart from the humane aspects of the program to maximize and prolong the capacity of an individual to function independently in his community. It should be emphasized that where

a PACE site generates income in excess of program expenditures, these funds are placed in reserve so as to smooth out fluctuations in utilization or reimbursement.

Quality of care at PACE sites is monitored at both federal and state levels -- by HCFA and through states' review processes. In 1993, an independent review by the Community Health Accreditation Program found quality and coordination of care at PACE sites surveyed to be exceptional. And, importantly, the National PACE Association recently received a grant from the Robert Wood Johnson Foundation to develop standards of care for PACE programs and an accreditation process which we believe will help enormously to maintain PACE's present quality of care in the future.

On Lok and PACE have always enjoyed bipartisan encouragement and support which has culminated in the introduction by Senators Dole, Inouye and others of "The PACE Provider Act of 1995." The legislation would: 1) expand the number of PACE programs; and 2) move qualified existing and future PACE sites from demonstration to provider status. Based upon the years of experience of the PACE demonstration, CBO has found S. 990 budget neutral. However, the legislation includes a specific provision limiting provider status to only those programs which the Secretary finds generate cost savings to Medicare and Medicaid.

Since S. 990 was introduced last June, HCFA had raised a couple of concerns regarding its specifics, concerns which we found

reasonable and consistent with the overall thrust of the proposal. We support changes designed to address those concerns in a modified version of S. 990 which has been made available to Members and their staffs. We want to note that the relationship between PACE and HCFA has been collaborative and constructive over some 15 years, and surmise that HCFA may have encouraged the specific recommendation to expand the program in the President's budget.

The urgency to expand PACE is generated not just by widespread unmet needs but also by the managed care focus of Medicare and Medicaid reform legislation. Today, PACE is the only managed care program providing services exclusively to enrollees whose health status qualifies them for long-term institutional care. Again, PACE programs have already proven they can effectively meet the needs of the frail elderly, a population considered by many to be increasingly vulnerable in the context of expanded managed care. The frail elderly are not sought after by managed care plans which prefer to avoid the risk and often do not have the capability, interest or focus to address the needs of this high-risk, high-need, chronic care population. In that regard, I would like to point out that provider status for qualified PACE programs is vital to assure that frail individuals have direct access to enrollment in a program designed to fully address their unique needs. Further, provider status would facilitate subcontracting arrangements with managed care plans and other insurers for the provision of PACE services. Parenthetically, without ultimately affording provider status to successful PACE

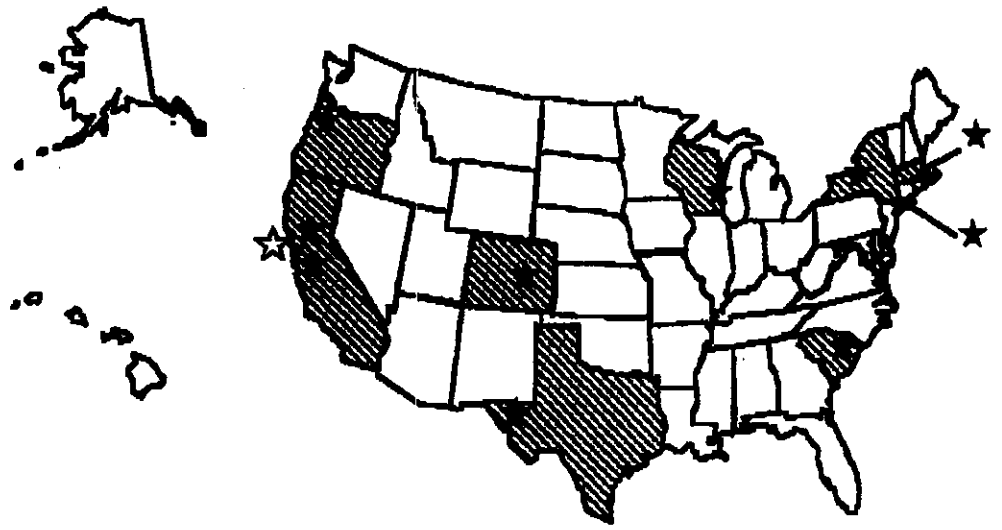
programs, they are almost condemned to demonstration in perpetuity!

S. 990 is consistent with efforts to provide states greater flexibility in administering Medicaid. Stemming from a commitment to develop viable alternatives to high-cost "bricks and mortar" institutionalization, over the last several years states have joined with community charitable and public organizations to develop PACE programs. S. 990 would provide states the option to pursue PACE development and, as under present law, state participation would continue to be voluntary. Thus, states would make their own evaluations of the need for and cost-effectiveness of PACE within their boundaries.

It should be emphasized that enactment of the provisions of S. 990 would not expand the number of individuals eligible for benefits. Rather, it would make more generally available a preferable, less costly, and more humane, community-based and community sponsored alternative to institutionalization for persons who are already or will be eligible for nursing home care. Implementation of the proposal would certainly contribute significantly, on a cost-effective basis, to the care and well-being of frail, older Americans on a basis not inconsistent with broader health care efforts. We urge your support and timely action in the near future on the provisions of S. 990.

Attachment: List of Sites in Development

PACE is replicating the On Lok model . . .



Organizations with Waivers to Operate PACE as of April 1996

CALIFORNIA
- ☆ On Lok Senior Health Services
  San Francisco
- ★ Center for Elders Independence
  Oakland
- ★ Sutter Health's Sutter SeniorCare
  Sacramento

COLORADO
- ★ Total LongTerm Care, Inc.
  Denver

MASSACHUSETTS
- ★ East Boston Neighborhood Health Center's
  Elder Service Plan
  East Boston

NEW YORK
- ★ Beth Abraham Hospital's
  Comprehensive Care Management
  Bronx

NEW YORK (Cont'd)
- ★ Rochester General Hospital's
  Independent Living for Seniors
  Rochester

OREGON
- ★ Sisters of Providence's
  Providence ElderPlace
  Portland

SOUTH CAROLINA
- ★ Richland Memorial Hospital's
  Palmetto SeniorCare
  Columbia

TEXAS
- ★ Bienvivir Senior Health Services
  El Paso

WISCONSIN
- ★ Community Care Organization's
  Community Care for the Elderly
  Milwaukee

Organizations Delivering Services under Medicaid Capitation as of April 1996

CALIFORNIA
- Altamed Senior Buena Care
  Los Angeles

HAWAII
- Malulhia
  Honolulu

ILLINOIS
- REACH
  Chicago

MARYLAND
- Johns Hopkins Elder Plus
  Baltimore

MASSACHUSETTS
- ESP of The Cambridge Hospital
  Somerville
- ESP Fallon
  Worcester

MASSACHUSETTS (Cont'd)
- ESP Harbor Health
  Dorchester
- ESP of Mutual Health Care
  Roxbury/Dorchester
- ESP of The North Shore
  Lynn

MICHIGAN
- Henry Ford Center for Senior Independence
  Detroit

WASHINGTON
- Providence Elderplace of Seattle
  Seattle

WISCONSIN
- Elder Care Options
  Madison

Organizations Delivering Services under Medicaid Capitation by the End of 1996:

NEW MEXICO
SISTERS OF CHARITY HEALTH CARE SYSTEM/ST. JOSEPH'S HEALTH SYSTEM
Albuquerque

NEW YORK
EDDY SENIORCARE
Troy

LORETTO'S INDEPENDENT LIVING SERVICES
SYRACUSE

OHIO
BETHESDA HOSPITAL
Cincinnati

VIRGINIA
SENTARA LIFE CARE CORPORATION
Norfolk

Organizations Exploring Feasibility of PACE Development:

ARIZONA
MARICOPA COUNTY HEALTH CARE AGENCY
Phoenix

CALIFORNIA
ST. JOSEPH HEALTH SYSTEM
Fullerton

LIFE STEPS/DANIEL FREEMAN HOSPITAL
Los Angeles

VERDUGO HILLS HOSPITAL
Glendale

CONNECTICUT
MASONIC HOME AND HOSPITAL
Wallingford

DELAWARE
FRANCISCAN HEALTH SYSTEM
Wilmington

FLORIDA
FLORIDA HOSPITAL
Orlando

GEORGIA
CANDLER HEALTH SYSTEMS
Savannah

ST. JOSEPH'S HOSPITAL
Atlanta

WESLEY WOODS, INC.
Atlanta

KENTUCKY
CHRISTIAN CHURCH HOMES OF KENTUCKY, INC./ SANDERS BROWN CENTER ON AGING
Lexington

MARYLAND
DIMENSIONS HEALTHCARE SYSTEM
Landover

LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL
Baltimore

MASSACHUSETTS
ST. LUKES/CHARLTON HOSPITAL
Fall River

MISSOURI
HEARTLAND HOSPITAL
St. Joseph

NEBRASKA
ALEGENT HEALTH
Omaha

NEW JERSEY
BERGEN PINES COUNTY HOSPITAL
Paramus

COMMUNITY-KIMBALL HEALTH CARE SYSTEM
Toms River

CARING, INC.
Pleasantville

SOUTHERN NEW JERSEY VISTING NURSE SYSTEM
Runnemede

ST. FRANCIS MEDICAL CENTER
Trenton

NEW YORK
ARDEN HILL LIFE CARE CENTER
Goshen

OHIO
AKRON GENERAL MEDICAL CENTER
Akron

BENJAMIN ROSE INSTITUTE/UNIVERSITY HOSPITALS HEALTH SYSTEM
Cleveland

PENNSYLVANIA
LUTHERAN AFFILIATED SERVICES
Mars

PITTSBURGH MERCY HEALTH SYSTEM
Pittsburgh

ST. AGNES MEDICAL CENTER
Philadelphia

UNIVERSITY OF PENNSYLVANIA SCHOOL OF NURSING
Philadelphia

VIRGINIA
INOVA HEALTH SYSTEM/FAIRFAX COUNTY HEALTH DEPARTMENT
Fairfax

WASHINGTON
FRANCISCAN HEALTH SYSTEM–CARE CENTER AT TACOMA
Tacoma

WEST VIRGINIA
RALEIGH COUNTY COMMISSION ON AGING
BECKLEY