



STATEMENT OF

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INTRODUCTION

Mr. Chairman and Members of the Subcommittee, it is a pleasure to appear before you today to discuss an issue close to my heart: the development of new models of comprehensive care for the frail elderly. Specifically, I have been asked to talk about two important demonstration projects in which HCFA has invested years of thought and effort: the Program of All-inclusive Care for the Elderly (PACE) and the Social Health Maintenance Organization (S/HMO) projects. These two projects provide, we believe, important initial building blocks in our effort to develop high quality, locally sensitive, customer-oriented, community-based services for those in need of long-term care.

It is important to begin by talking for just a moment about community-based long-term care. Both PACE and S/HMO emphasize home and community-based services. Most beneficiaries and their families greatly prefer home and community-based care to institutional care, and we want to continue to explore how to best serve their needs. We have come a long way since the early 1970s, when home and community-based care was a fairly new idea and was considered largely as a way to reduce the length of hospital stays or as an alternative to institutionalization in a nursing home.

Today, Medicare and Medicaid each provide substantial amounts of home and community-based care. More than 250,000 people receive long-term care services in a home or community setting under Medicaid's home and community services waiver program alone. More than 2.5 million beneficiaries annually receive services through Medicare's home health benefit. Because of the breadth of services and the capitated payment approaches of the PACE and S/HMO programs, these programs differ from standard home health benefits of Medicare and Medicaid. Both PACE and S/HMO emphasize reducing the burden on informal caregivers, improving social and psychological well-being, improving health status and functional independence, and increasing longevity. Our experiences with the PACE and S/HMO programs are providing us with important information about how best to provide integrated acute and long-term care.

INTEGRATION

Integration of services is very important for the estimated five to six million individuals who are eligible for both Medicare and Medicaid. Many of these "dual eligibles" have multidimensional, interdependent and chronic health care needs. However, as currently structured, the Medicare and Medicaid programs are not sufficiently coordinated to serve many of these complex health needs.

Because the financing, administration, and delivery systems are fragmented, services are often duplicated and access to care can be limited. Further, since care is financed from different funding sources, there are insufficient incentives to integrate services. For example, increased emphasis on rehabilitation in the acute setting might reduce long-term care spending, but Medicare

providers do not have appropriate incentives to invest resources that could save Medicaid money

Integrating acute and long-term care involves coordinating and integrating the Medicare and Medicaid benefits. Integration and coordination should address both financing and service delivery. Integration of financing involves the pooling of funding from Medicare and Medicaid into a single funding stream. Current managed care models attempt to integrate services using capitated payments to providers, which gives managed care organizations flexibility to tailor benefits to the distinct needs of each beneficiary. However, integration of funding sources alone does not ensure integration of services. Today, various managed care plans coordinate the delivery of acute and long-term care services to differing degrees. Some plans simply facilitate patient transitions between the acute and long-term care settings. Others, such as the PACE demonstration, employ a multidisciplinary team of professionals who work together to manage both medical and social services across the acute and long-term care settings.

The goal of the PACE and the S/HMOs projects is to reduce fragmentation of services, contain costs, and effectively integrate acute and long-term care into a single, seamless system. Funds are combined into a common pool from which providers pay health care expenses. In S/HMOs, providers receive funds mostly from Medicare, although they also receive some Medicaid and private insurance funds. In PACE, providers receive funding from Medicare, Medicaid, and private insurance.

OVERVIEW OF PACE

In 1979, HCFA funded a three-year grant to On Lok, a program based in San Francisco, California, which provides health, nutritional, and recreational services to frail older adults in a day-care setting. On Lok also integrates the provision and financing of medical and long-term care services. Since the initial grant award, HCFA has supported On Lok through waivers for the past 16 years. On Lok is unique because it accepts only those ill enough to be eligible for nursing home care. Medicare and Medicaid pay all of the costs of care, and participants are assigned to an interdisciplinary team that meets regularly to assess their needs and assure that they receive the full range of needed services. This might include anything from housing to medical supplies to a microwave oven for someone who can no longer use a gas oven safely.

PACE is an outgrowth of On Lok. It was authorized by Congress in the Omnibus Budget Reconciliation Act of 1986. PACE was established partly as a result of the success of the On Lok program, but the PACE program is separate from On Lok. Each of the current ten nationwide PACE sites is reviewed at least annually. PACE sites continue to operate under the Secretary's discretionary authority.

PACE specifically targets frail elderly persons eligible for nursing home care, but who are living in the community. PACE seeks to help individuals continue to live at home and not in a nursing home facility. PACE integrates social and medical services through adult day health care. It uses a multidisciplinary team approach, with care provided by physicians, nurses, social workers,

nutritionists, occupational and speech therapists, and health and transportation workers. Through preventative and rehabilitative services, participants' chronic conditions can be stabilized and medical complications prevented. Community living is usually the overwhelming choice of participants. However, should nursing home placement become necessary, PACE also provides that service. PACE enrollees receive all health services through PACE, including physician services, hospitalization, therapies, pharmaceuticals, and equipment.

Currently, there are approximately 2,700 enrollees who participate in the ten PACE sites and On Lok. As many as 48 additional organizations are in various stages of developing PACE sites. The ten operating PACE sites are in the following locations.

- East Boston, Massachusetts;
- Portland, Oregon;
- Columbia, South Carolina;
- Milwaukee, Wisconsin;
- Denver, Colorado;
- El Paso, Texas;
- Bronx, New York;
- Rochester, New York;
- Oakland, California; and
- Sacramento, California.

An additional noteworthy characteristic of PACE is the way in which it has responded to the diversity of populations in need of services. The ethnic and racial distribution of beneficiaries served reflects the communities from which PACE draws its participants. From January 1993 through December 1993, of the beneficiaries served in the PACE program:

- 38 percent were Caucasian,
- 28 percent were African-American,
- 20 percent were Hispanic-American, and
- 13 percent were Asian-American.

PACE FINANCING

PACE providers receive a fixed monthly fee for each participant. This fee is set to account for the frailty of PACE enrollees, but it does not vary based on the degree of frailty or the services used by the individual participant. PACE providers receive most of their financial support from Medicaid and are paid on a capitation basis. The Medicaid capitation rate is determined by the rate-setting methodology of the state in which PACE operates.

Medicare, Medicaid and private insurance funds are pooled to achieve maximum efficiency and flexibility in the use of resources. The Adjusted Average Per Capita Cost (AAPCC) methodology

used by Medicare to pay for at-risk health maintenance organizations is modified for Medicare capitation payments in PACE. The basic AAPCC rate is multiplied by a "frailty adjustment" of 2.39 to reflect the costs Medicare would bear in caring for the frail elderly in the fee-for-service system.

In order to protect against unanticipated costs, unanticipated disenrollment rates, and the unavailability of stop-loss insurance coverage, PACE demonstration sites share risk with Medicare and Medicaid. During the first three years of operation, sites assume progressively increasing risk, and at the start of the fourth year assume full risk. Currently, special demonstration waivers permit the integration of Medicare and Medicaid funds.

PERFORMANCE OF PACE

A preliminary evaluation of PACE should be available later this year. State participation in PACE is voluntary, and continued states have shown a great deal of interest in continuing their participation. Based on enrollees' low disenrollment rates, enrollees appear satisfied with PACE: the combined rate of voluntary and involuntary disenrollment from PACE is considerably lower than the voluntary rate of disenrollment from other Medicare risk-based health plans. Other states are interested in developing their own demonstration sites.

PACE SHOULD BE MADE PERMANENT

Based on our current knowledge of the success of PACE, we recommend that PACE be shifted from a demonstration project to a permanent program. We support legislation, such as the PACE provision included in the President's Balanced Budget Initiative for Fiscal 1997, to accomplish this goal. Under the President's plan, providers would be monitored closely, while progressively assuming full risk. The President's plan permits the Secretary to continue to set Medicare payments to ensure budget neutrality. We recommend that the budget neutrality language be retained. The President's proposal is supported by both On Lok and the National PACE Association.

OVERVIEW OF S/HMOs

HCFA's Social Health Maintenance Organization demonstrations were established by Congress in 1984 to test whether investing in some long-term care benefits for Medicare HMO enrollees could save money through coordinating care and providing services that might prevent more costly medical complications. The S/HMO demonstrations have provided standard HMO benefits, such as hospital, physician, skilled nursing home, and home health services, together with limited long-term care benefits to Medicare beneficiaries who voluntarily enroll. In addition, expanded benefits, such as eye glasses and prescription drugs, are available. S/HMOs enroll a cross-section of the elderly living in the community. S/HMOs' services range from community-based care to institutional nursing home care. Services provided include personal care aides, homemakers,

medical transportation, adult day health care, respite care, and case management in a community setting.

The S/HMOs program provides more limited long-term care benefits than PACE. S/HMO have a yearly dollar cap for the long-term care benefit, whereas PACE does not have such a cap. Financing is through prepaid capitation, by pooling funds from Medicare, Medicaid, and member premiums and copayments. The level of the beneficiary premium payments vary by site. Benefits and capitation payments vary by state; S/HMOs negotiate independently with respective states to determine financing and benefits.

In 1985, S/HMO projects became operational at the following four sites:

- Kaiser Permanente Northwest established Medicare Plus II in Portland, Oregon;
- Group Health and Ebenezer Society established Seniors Plus in Minneapolis-St. Paul, Minnesota;
- Metropolitan Jewish Geriatric Center established Elderplan in Brooklyn, New York; and
- Senior Health Action Network established SCAN Health Plan in Long Beach, California.

However, in January 1995, the Minneapolis site withdrew its participation because it believed the S/HMO was too costly to administer. Currently, nearly 20,000 Medicare beneficiaries are enrolled in the three remaining demonstration sites. Overall, the Medicare beneficiaries enrolled in S/HMOs were healthier than the average beneficiary.

PERFORMANCE OF S/HMO I

In 1996, HCFA prepared a status report, now pending final approval, on the implementation and evaluation of the S/HMO demonstrations. This report found that the S/HMO projects had lower levels of disenrollment than Medicare's risk contract HMOs. Healthy S/HMO enrollees also expressed overall satisfaction with their participation in the program.

Frail S/HMO enrollees were compared to frail fee-for-service enrollees, based on access to care, interpersonal relationships with their physician, cost and benefits of care, quality or competence of care, and an overall measure of satisfaction. Evidence that the S/HMOs were less costly than fee-for-service were mixed; only some sites demonstrated savings. Also, relative to fee-for-service, no improvements in mortality or active life expectancy were demonstrated. Moreover, frail S/HMO enrollees were more satisfied than their fee-for-service counterparts in only one category, cost and benefits of care.

DEVELOPMENT OF S/HMO II

In 1990, Congress authorized an extension of the demonstrations and established the second generation of the S/HMO demonstrations, known as S/HMO II. One purpose of S/HMO II is to test the effects of linking chronic care case management services and acute care providers. The primary components of the S/HMO II projects include:

1. An expanded case management system, with acute and long-term care linkages;
2. A long-term care benefit package; and
3. A risk-adjusted payment methodology.

S/HMO II will continue to provide many of the expanded benefits offered in S/HMO I. We also expect S/HMO II projects to address some additional goals. S/HMO II is designed to refine the financing methodologies and the benefit design of S/HMOs. The criteria used to target long-term care benefits will also be refined. S/HMO II will target enrollment to special populations such as minorities, beneficiaries eligible for both Medicare and Medicaid, and residents living in rural areas. In 1993, Congress mandated that one of the S/HMO II projects examine the feasibility of serving beneficiaries with end-stage renal disease (ESRD).

IMPLEMENTATION OF S/HMO II

In January 1995, HCFA awarded developmental grants to the following six S/HMO II project sites:

1. CAC-United HealthCare Plans of Florida in Coral Gables, Florida;
2. Contra Costa Health Plan, in Martinez, California;
3. Fallon Community Health Plan in Worcester, Massachusetts;
4. Health Plan of Nevada, Inc. in Las Vegas, Nevada;
5. Richland Memorial Hospital in Columbia, South Carolina; and
6. Rocky Mountain HMO in Grand Junction, Colorado.

We expect the Nevada and Florida sites to begin implementing the S/HMO II programs in the summer of 1996. The remaining four sites should begin operation by January 1997.

S/HMO (I and II) DEMONSTRATIONS SHOULD BE EXTENDED

The second generation of S/HMOs are building upon what we learned from the first generation. However, we need to learn more about the capitation payment structure and providing integrated services to the acute and long-term population. To assure that the S/HMO program is cost effective, we recommend that both generations of the S/HMO projects be extended until December 31, 2000, but not expanded. Authorization for both the first and second generation

S/HMOs is now set to expire on December 31, 1997. An extension of the program would provide additional time necessary to establish a comparative study and performance potential.

OTHER INTEGRATED SERVICE MODELS

HCFA is also testing other approaches to achieve integration. The projects focus on how care is integrated, the way in which care is coordinated, and in the use of case management program elements. Among these projects are the following examples that vary in the way they deliver care.

EverCare is a demonstration designed to study the effectiveness of meeting the needs of nursing home residents by pairing physicians and geriatric nurses who function as primary medical caregivers and case managers. EverCare reduces hospital care when patients can be managed safely in nursing homes if appropriate services are available. Three sites are operational in Georgia, Maryland and Massachusetts.

The Wisconsin Special Care Initiative is designed to provide Medicaid medical services and additional social services such as respite care, family care, long-term planning, referral and medication services to up to 3,000 Medicaid recipients in Milwaukee County. About 75 percent of projected enrollees are between 21 and 64 years of age, most are unemployed, and many receive some form of long-term care services. This model includes a physician panel of experienced providers, case management services provided by a multidisciplinary team, and special services for the elderly. Enrollment in the three-year demonstration began in July 1994.

Other projects target particular populations.

The Project for Non-Elderly Disabled is a demonstration to develop integrated care models primarily for non-elderly persons with disabilities. HCFA is sponsoring this initiative in conjunction with the Pew Charitable Trusts, Robert Wood Johnson Foundation, and the Medicaid Working Group. All participants are on Medicaid, 40 percent of whom are dually entitled. Initiatives in Wisconsin, Michigan, New York, and Ohio are in various stages of development.

MAINE-NET emphasizes care to rural populations by promoting the development of regional service delivery networks or health plans. These networks vary in the management, coordination and integration of services, including different approaches to care planning and service delivery. Maine-Net includes a package of primary, acute and long-term care services as part of a program plan. Maine plans to implement the program in January 1997.

CONCLUSION

Our primary goal in PACE, S/HMO, and the other integrated service projects being tested by HCFA is to find the best approaches to coordinating acute and long-term care services. We need to facilitate and advance a beneficiary-centered continuum of care for people who need long-term care, recognizing that people in long-term care have significant acute care needs, as well as chronic care needs. Since Medicaid and Medicare represent over half of all long-term care spending, we recognize the central role our programs must play in developing a more beneficiary-centered system. What we have already seen of PACE warrants shifting PACE from a demonstration to a permanent program. We look forward to working with Congress on legislation which makes this a reality.

We also think there is much to be learned from the S/HMO projects. Because of the importance of implementing an effective managed care program for the chronically-ill and elderly in need of long-term care, we recommend an extension of the S/HMO demonstrations authority.