

**UNITED STATES
HOUSE OF REPRESENTATIVES**

**COMMITTEE ON WAYS AND MEANS
Subcommittee on Health**

TESTIMONY

by

Judith Pinner Baskins, R.N., B.S.N.

**President, National PACE Association
Director of Geriatric Services, Richland Memorial Hospital,
Columbia, South Carolina**

Tuesday, April 29, 1997

in

Washington, D.C.

Statement of Judith Pinner Baskins, R.N., B.S.N.
President, National PACE Association
Director of Geriatric Services, Richland Memorial Hospital,
Columbia, SC

Mr. Chairman and Members of the Subcommittee:

Good morning. My name is Judy Baskins; I am the Director of Palmetto Senior Care, a PACE program that has operated in Columbia, South Carolina since 1990 under the auspices of Richland Memorial Hospital, a 649-bed regional community teaching hospital. "PACE" as you know is the acronym for "Program of All-inclusive Care for the Elderly." I also am the President of the National PACE Association and am pleased to testify today on behalf of its members, community and public organizations committed to meeting the unique medical and social service needs of frail, elderly Americans. The current PACE model was developed and first implemented in 1983 by On Lok Senior Health Services in San Francisco. On Lok originated the essential components of the program in 1972. Today, 11, soon to be 12, PACE programs across the country oversee and essentially provide the entire spectrum of health and long-term care services to their enrollees without limit as to duration or dollars. Since 1983, PACE programs have served a total of approximately 6,000 frail, older people.

Attached to my statement is a list of current PACE programs operating under waivers as well as a list of organizations that are in various stages of formal development of PACE.

Before I explain more about PACE, I want to express our appreciation for the strong bipartisan support in Congress for PACE over the last 15 years, including concerned support from many members of this Subcommittee.

PACE programs differ from other managed care entities and long-term care providers in the following ways:

- PACE enrolls only individuals who meet their states' eligibility criteria for nursing home level of care, thereby totally focusing on and **servicing a very frail, high-cost subset of the elderly population**. The average age of our enrollees is over 80; and they have an average of 8 serious medical problems each, including heart disease, peripheral vascular disease, diabetes, hypertension and dementia. The principal objective of PACE is to maximize the function and independence of enrollees. By doing this, PACE is able to minimize institutional placement, that is, to delay or prevent it altogether.
- **PACE provides a comprehensive range of primary, acute and long-term care services**. We provide the majority of services, including medical care, adult day care, home care, rehabilitative therapies, personal care, transportation, meals and prescription drugs, to enrollees in the community -- either in the PACE Center or in individuals' homes. If, ultimately, institutional care is required, PACE participants are not dropped from our program. We cover that care and, in all cases, closely follow the patient's progress in the institution to assure receipt of proper care at the proper time. We don't abandon our participants.

Our ability to weave medical and social services into a comprehensive health care delivery system allows individuals to remain in the PACE program, regardless of changing needs, and to continue to receive much of their care from providers with whom they have developed a long-standing, trusting relationship.

- **Interdisciplinary teams** consisting of physicians, nurses, social workers, physical, occupational and recreational therapists, dietitians and home care workers **integrate the delivery of acute and long-term care**. Within PACE, integration of services is achieved through daily, face-to-face interaction between program enrollees and the professionals and paraprofessionals who provide their care. This close personal attention contrasts with models which attempt integration via contracts and telephone contact. The PACE approach allows for health professionals to respond immediately to changes in enrollees' conditions which are frequent, sudden and often serious in the

case of the frail elderly. PACE's emphasis on preventive care and immediate response to change is integral to its success.

- **PACE programs receive capitated payments from Medicare, Medicaid and private-pay sources.** These payments are pooled at the program level, allowing health care providers enormous flexibility in developing treatment plans that respond to enrollees' needs rather than reimbursement regulations. Incentives inherent in the fee-for-service system to provide more and more, regardless of efficacy, do not exist within PACE. At the same time, because PACE programs retain complete responsibility for enrollees' care, usually until they die, the incentive to underserve -- a criticism of managed care in general -- is minimized. A further control on underservicing is our community and public sponsorship which affords high visibility and accountability.
- **PACE programs assume total financial risk and responsibility** for all medical and long-term care without limitation and without copayments and deductibles.

Often in large health care systems the individuality of the patient is lost within that system. In contrast, in PACE the intimate relationship between the health care providers, participants and their families allows for autonomy in decision-making about health care issues ranging from polypharmacy to end of life decisions.

PACE can legitimately be called a "creature of the Congress." In 1986, Congress initiated authorization of waivers for up to 10 nonprofit, community-based demonstration sites with the objective of determining whether On Lok's experience in San Francisco could be replicated nationally. That number was expanded to 15 in 1990. The first of the demonstration programs to open their doors have now been operational for seven years. Together the 11 programs now under Medicare and Medicaid waivers have accumulated more than 60 years of operating experience. Here is some of what that experience has been and what it has taught us.

In short, the demonstration proved successful replication of On Lok's program based in San Francisco is indeed possible by non-profit entities operating under various auspices in a variety of communities

across the country. These programs have enrolled an exclusively frail population and succeeded at helping enrollees to maximize their function and independence in the community, thereby avoiding nursing home or long-term hospital placement. Again, unlike any other type of provider, these organizations have assumed complete responsibility for each enrollee's total needs without limit in terms of the type, number or intensity of services provided to any individual enrolled in the program. Further, notwithstanding an aversion among huge health systems to assuming risk for this subset of the Medicare population, PACE programs, among them comparatively small community-based providers, have proven their ability to assume full financial risk for not just Medicare-covered services, but for both Medicare and Medicaid benefits.

Among the more specific findings, PACE participants experience much lower rates of hospital admissions and overall utilization of hospital care, and lower utilization of nursing home services than do comparably frail individuals outside PACE. PACE programs use savings from reductions in inpatient utilization to expand the range and intensity of ambulatory care services in the community that in turn yield lower rates of inpatient utilization. Generally, any revenues in excess of costs are allocated to reserves to cope with unusual and unanticipated medical needs of our participants.

A dramatic example of PACE's efficacy is hospital utilization among PACE participants. As measured by hospital days per thousand per annum, the rate in PACE is quite comparable to that of the general Medicare population (approximately 2400 days/1000/annum). This is astonishing considering the level of frailty and medical complexity of the PACE population in relation to the general Medicare population. The general Medicare group includes a very large proportion of healthy individuals. These findings are substantiated in HCFA's evaluation of the PACE demonstration.

In South Carolina, utilization of hospital services is even lower than the PACE average. We have reduced hospital utilization among our enrollees to less than 1000 days/1000/annum. How? By substituting subacute care, home health and PACE Center services for care traditionally provided in the hospital. This has substantially improved the quality of care and quality of life for our participants

while maintaining clinical and functional outcomes comparable to, if not better than, more traditional institutional management.

For example, over the last two years, our average length of hospital stay for treatment of hip fractures has been only two and one-half days. Hospital care is followed by intensive rehab -- usually in a subacute setting, although sometimes in the PACE Center or at home -- overseen by the center-based PACE team. The transition back to less intensive services is individualized and based on participant, caregiver, environmental and medical circumstances and can be completed in as little as three weeks to as long as three months. In almost all cases, the functional ability has returned to at least the pre-event level. Clinical outcomes are not compromised by this shift from acute to community-based care; in many cases outcomes are actually improved.

The quality of care provided by PACE programs to date has been high and is never sacrificed in pursuit of lower costs. Federal and state review processes, an independent review by the Community Health Accreditation Program in 1993, ongoing consumer satisfaction surveys at individual PACE sites, and the findings of HCFA's evaluation verify the high quality of PACE care.

In South Carolina, for example, a recent survey of PACE enrollees and their caregivers conducted by the Department of Health and Human Services revealed that 83% of respondents found the health care provided by Palmetto Senior Care to be very good or excellent. The remaining 17% evaluated their care as fair or good. Perhaps even more importantly, 87% of Palmetto's participants believe their quality of life has improved as a result of enrollment in PACE.

To assure that PACE programs maintain quality of care and quality of life experienced by participants and their caregivers at its current level, the National PACE Association (NPA) is developing standards of care for the PACE program. A National Accreditation Advisory Committee made up of experts in the field of health care, quality assurance and accreditation is helping the NPA to complete a final set of standards by the end of this year. These standards will provide

the basis for an accreditation program which we hope to pilot at several existing PACE sites in 1998 and expand to all PACE sites in the future.

In terms of the cost-effectiveness of PACE to Medicare and Medicaid, a recent study commissioned by the NPA (undertaken by Dr. Leonard Gruenberg, President of the Long-Term Care Data Institute,) concluded that PACE generates approximately 12% savings to Medicare, relative to Medicare's expenditures for a comparable population in the fee-for-service system. With regard to Medicaid, each state participating in the demonstration establishes a Medicaid capitation rate for PACE based on the state's expenditures for comparable long-term care recipients in its traditional Medicaid long-term care system. States estimate savings of 5-15% relative to current per capita long-term care expenditures. None of the dollar savings measure the enhanced quality of life in terms of improved function and ability to remain in the community.

Building upon the years of experience and findings of the demonstration, it is time to expand the availability of PACE services to many more qualified frail, elderly individuals throughout the United States. Efforts toward this end began in the 104th Congress with legislation introduced by Senators Dole, Inouye and others. "The PACE Provider Act of 1995"--S.990-- sought to expand the number of PACE programs, and move qualified existing and future PACE sites from demonstration to provider status. Unfortunately, despite broad bipartisan support for the legislation, it was not enacted by the last Congress.

Consequently, we request your support now for legislation that would make PACE available to those Medicare and Medicaid beneficiaries who would benefit from PACE services. We propose a thoughtful, deliberate approach toward expanding PACE, one which builds upon the lessons learned over the course of the 11-year PACE demonstration. This approach includes mechanisms to insure that the expansion yields desired results. In particular, a key provision of S. 990 was that only programs found by the Secretary to be lower in cost than what would otherwise have been paid by Medicare and Medicaid could secure provider status. We strongly urge inclusion of

a similar mandate of cost-effectiveness in any implementing legislation.

Although we realize that PACE is not the only answer to meeting the needs of frail elder beneficiaries, it is one of just a handful of operational programs which integrate the entire spectrum of acute and long-term care services. It has withstood the scrutiny that comes with a high degree of visibility. We are very proud of the fact that not a single PACE program has throughout the years been accused of fraudulent or abusive practices by federal or state governments.

We believe PACE has proven itself in addressing the needs of beneficiaries, providers and payers. While it is not all things to all people, we are proud of its identity. We also are enormously concerned about the welfare of the very frail individuals enrolled in PACE and believe that concern warrants a careful and deliberate approach to expanding the availability of PACE. We strongly believe that efforts to expand PACE should build directly upon the demonstration experience. We must retain the distinguishing characteristics of the PACE model that have successfully addressed the needs of PACE enrollees. These include:

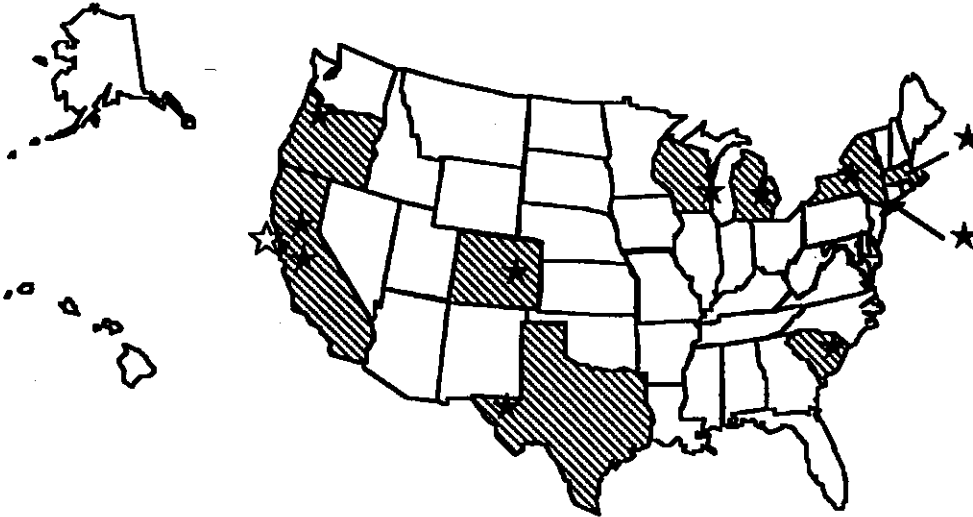
- **A staff model approach in which PACE staff deliver the majority of services provided to PACE enrollees**, as opposed to contract providers. The staff model is crucial to assuring the level of integration which is a trademark of PACE.
- **The community-based orientation of the program**, not only with respect to the location in which services are delivered but, equally as important, the active participation of community representatives on the governing bodies and key committees of PACE programs, such as ethics committees. PACE programs serve frail elderly individuals who are expected to die within three to four years of enrollment. It is essential that the program's operations be visible and accountable to members of the local community and subject to continuing public scrutiny.

- **The absolute distinction between service allocation decisions and financial considerations at the individual care planning level.** Care planning decisions must be made focusing on patient needs, not financial considerations.
- **Capitated financing which places the provider at risk for all services.** Unless the provider is required to assume risk for all services, the incentive always exists to utilize services for which one is not financially responsible, thereby shifting costs.

The question has been raised recently as to the possible ultimate inclusion of for-profit organizations among future PACE-type providers. To date, PACE programs have been limited to nonprofit or public entities. Consequently, all our experience under the demonstration has been with these types of organizations. For-profit organizations were never denied the opportunity over the years to propose PACE-type demonstration programs or to develop nonprofit subsidiaries within which PACE could be developed. We are not opposed to for-profit organizations ultimately entering the program, but we believe they should also be required to demonstrate, just as we have, their ability to focus effectively and exclusively on the frail elderly in terms of quality of care and cost-effectiveness.

We appreciate the interest that the subcommittee has expressed in PACE over a period of many years. We also appreciate the commitment to PACE by the Administration and HCFA. That commitment was evidenced most recently by the inclusion of language to expand PACE in the Administration's current budget. PACE, we hope, creates an opportunity to work together to improve the delivery of services to a subset of the most needy Medicare and Medicaid beneficiaries.

PACE is replicating the On Lok model . . .



Organizations with Waivers to Operate PACE as of May 1997

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

MICHIGAN

- ★ HENRY FORD'S HEALTH SYSTEM'S
CENTER FOR SENIOR INDEPENDENCE
Detroit

NEW YORK

- ★ BETH ABRAHAM HOSPITAL'S
COMPREHENSIVE CARE MANAGEMENT
Bronx
- ★ 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 May 1997

CALIFORNIA

ALTAMED SENIOR BUENA CARE
Los Angeles

HAWAII

PACE AT MALUHIA
Honolulu

ILLINOIS

CHICAGO REACH
Chicago

MARYLAND

HOPKINS ELDER PLUS
Baltimore

MASSACHUSETTS

ELDER SERVICE PLAN OF THE CAMBRIDGE HOSPITAL
CAMBRIDGE

ELDER SERVICE PLAN AT FALLON
Worcester

ELDER SERVICE PLAN - HARBOR HEALTH SERVICES
Dorchester

ELDER SERVICE PLAN OF MUTUAL HEALTH CARE
Roxbury/Dorchester

ELDER SERVICE PLAN OF THE NORTH SHORE, INC.
Lynn

(continued on reverse side)

Organizations Delivering Services under Medicaid Capitation as of May 1997 (continued)

NEW YORK

EDDY SENIORCARE
Troy

OHIO

TRIHEALTH SENIORLINK
Cincinnati

VIRGINIA

SENTARA SENIOR COMMUNITY CARE
Norfolk

WASHINGTON

PROVIDENCE ELDERPLACE OF SEATTLE
Seattle

WISCONSIN

ELDER CARE OPTIONS
Madison

Organizations Delivering Services Under Medicaid Capitation Beginning in late 1997:

NEW MEXICO

ST. JOSEPH HEALTHCARE
Albuquerque

NEW YORK

INDEPENDENT LIVING SERVICES
Syracuse

PENNSYLVANIA

UNIVERSITY OF PENNSYLVANIA SCHOOL OF NURSING
Philadelphia

ST. AGNES / CHI-EAST
Philadelphia

Organizations Exploring Feasibility of PACE Development:

CALIFORNIA

HUNTINGTON MEMORIAL HOSPITAL
Pasadena

LIFE STEPS/DANIEL FREEMAN HOSPITAL
Los Angeles

ST. JOSEPH HEALTH SYSTEM
Fullerton

COLORADO

CENTURA/CHI
Colorado Springs

CONNECTICUT

HEBREW HOME AND HOSPITAL
West Hartford

MASONICARE
Wallingford

MC LEAN
Simsbury

DELAWARE

CATHOLIC HEALTH INITIATIVES - EAST
Wilmington

FLORIDA

FLORIDA HOSPITAL
Orlando

MIAMI JEWISH HOME & HOSPITAL FOR THE AGED
Miami

GEORGIA

CANDLER HEALTH SYSTEMS
Savannah

WESLEY WOODS, INC.
Atlanta

IOWA

MERCY HOSPITAL MEDICAL CENTER
Des Moines

KANSAS

VIA CHRISTIE HEALTH SYSTEM
Wichita

KENTUCKY

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

MASSACHUSETTS

ST. LUKES/CHARLTON MEMORIAL HOSPITAL
Fall River

MISSOURI

HEALTH MIDWEST
Kansas City

HEARTLAND HOSPITAL
St. Joseph

ST. LOUIS REGIONAL MEDICAL CENTER
St. Louis

NEBRASKA

ALEGENT HEALTH
Omaha

NEW JERSEY

BERGEN PINES COUNTY HOSPITAL
Paramus

CARING, INC.
Pleasantville

COMMUNITY-KIMBALL HEALTH CARE SYSTEM
Toms River

CATHOLIC HEALTH INITIATIVES - EAST
Trenton

ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER
Patterson

VISTING NURSE SERVICE SYSTEM
Runnemede

NEW YORK

ARDEN HILL LIFE CARE CENTER
Goshen

CATHOLIC CHARITIES OF BUFFALO/
SISTERS OF CHARITY HOSPITAL
Buffalo

MERCY HEALTH SYSTEM OF WESTERN NEW YORK
Cheektowaga

WEINBERG CAMPUS, INC.
Getzville

NEVADA

WASHOE COUNTY SENIOR SERVICES
Reno

(continued on next page)

Organizations Exploring Feasibility of PACE Development (continued)

NORTH CAROLINA

CAPE FEAR VALLEY MEDICAL CENTER
Fayetteville

OHIO

AKRON GENERAL MEDICAL CENTER
Akron

CONCORDIA CARE, INC.
Cleveland

PENNSYLVANIA

ALLEGHENY GENERAL HOSPITAL
Pittsburgh

DOYLESTOWN HOSPITAL
Doylestown

FORBES HEALTH SYSTEM
Pittsburgh

LUTHERAN AFFILIATED SERVICES
Mars

PENNSYLVANIA (cont'd)

PITTSBURGH MERCY HEALTH SYSTEM
Pittsburgh

VISITING NURSE ASSOCIATION OF GREATER PHILADELPHIA
Philadelphia

TENNESSEE

ALEXIAN BROTHERS HEALTH SYSTEM
Signal Mountain

TEXAS

PARKLAND MEMORIAL HOSPITAL
Dallas

VIRGINIA

INOVA HEALTH SYSTEMS
Fairfax

WEST VIRGINIA

RALEIGH COUNTY COMMISSION ON AGING
Beckley