



National
PACE
Association

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On behalf of the National PACE Association**

**Before the Ways and Means Health Subcommittee
U.S. House of Representatives
Hearing on Promoting Integrated and Coordinated
Care for Medicare Beneficiaries
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2:00 p.m.**

Chairman Tiberi, Ranking Member Levin, and distinguished members of the Subcommittee, thank you for holding today's hearing examining integrated and coordinated care. I am Cheryl Wilson, CEO of St. Paul's Senior Services, and St. Paul's PACE, located in San Diego, California. It is my privilege to come before you representing the National PACE Association, the 122 PACE organizations operating in 31 states, and the over 42,000 participants we serve each day. Having trained and worked in healthcare all over the world since 1966, I am convinced that case management care models for Medicare beneficiaries with complex medical and functional support needs are essential to supporting their quality of life.

PACE is shorthand for Program of All Inclusive Care for the Elderly. PACE is a proven care model delivering high-quality, comprehensive, integrated and coordinated community-based care to Medicare beneficiaries 55 years of age or older, who meet the criteria for a nursing home level of care, but wish to live at home. Multiple studies show that people receiving care from PACE organizations live longer, experience better health, have fewer hospitalizations and spend more time living at home than those receiving care through other programs.

My testimony will cover three main points: a brief discussion of the PACE program; the benefits of PACE to the people it serves; and recommendations to remove obstacles currently impeding the future growth of PACE and the number of Medicare beneficiaries that can be served.

Overview of the PACE Program

The PACE model has existed in Medicare since 1983, initially as a pilot program. PACE became a permanent part of the Medicare program and a Medicaid state option in 1997 through the Balanced Budget Act (P.L. 105-33). PACE is a comprehensive, fully integrated, provider-based health plan. It was deliberately designed to address the health care needs of a medically complex and costly subset of Medicare beneficiaries – adults age 55 and over who meet state eligibility requirements for a nursing home level of care. The PACE care model was first developed in 1971 by an organization called On Lok in San Francisco in my home state of California. PACE continues to operate based on the fundamental principle that it is preferable in terms of quality of life, quality of care, and costs to public and private payers for PACE-eligible individuals to be served in the community whenever possible.

PACE organizations enroll an exclusively high-risk, high-cost population comprised of seniors and people living with disabilities at a nursing home level of care. Of the approximately 42,000 individuals served by PACE organizations across the country, 85 percent are at least 65 years of age, with 15 percent between the ages of 55 and 64. The average age across all participants is 77. PACE enrollees live with multiple chronic, medically complex conditions. The most common conditions that PACE participants experience are: vascular disease; diabetes with chronic complications; congestive heart failure; chronic obstructive pulmonary disease; and major depressive, bipolar and paranoid disorders. Additionally, almost half of all participants have some form of dementia. A large majority of PACE participants (86 percent) are unable to carry out one or more activities of daily living (ADL) without assistance, such as bathing, dressing, eating, toileting, transferring, and walking. Almost 60 percent of PACE participants need help with at least three ADLs. Despite their frailty and medical complexity, PACE participants enjoy a high quality of care and quality of life. Ninety-five percent live at home in their communities. Fifty percent of the individuals we serve through St. Paul's PACE live alone at home.

At the heart of the PACE model of care is a unique interdisciplinary team (IDT) comprised of a wide range of health care professionals including primary care providers, nurses, social workers, rehabilitative and recreational therapists, dietitians, personal care aides, and drivers. The members of the IDT have a direct care relationship with the Medicare beneficiaries they serve. This enables the team to very quickly and effectively identify, plan for, and respond to the complex medical care and functional support needs of the people they serve. Meeting daily, the IDT works collaboratively with program participants and their families to develop individualized, person-centered care plans addressing the full spectrum of participants' medical, long term service and support, and other biopsychosocial needs. The PACE organization is responsible for implementing these care plans across all settings of care, including at home, in community-based settings, and in inpatient acute care and nursing facilities, on a 24/7 basis, 365 days a year.

PACE organizations operate PACE Centers where program participants receive a broad range of services from multiple professional practitioners with extensive expertise in geriatrics. At the PACE Center, participants receive primary medical care, nursing services, rehabilitative therapy services (including occupational therapy, physical therapy, and speech therapy), social work services, personal care and supportive services, nutritional counseling; engage in activities; and are provided with meals. Because PACE organizations provide care directly to program enrollees, PACE organizations expand and improve on other services available in the community, which often are lacking and inaccessible to PACE's frail, elderly population. In addition, PACE organizations provide care in the home and transportation services to other providers in the community to address the needs of their enrollees. PACE organizations contract for services that they do not directly provide, such as inpatient hospital, nursing facility, and specialist care.

With the responsibility to provide and pay for the entire continuum of medical care and long-term services and supports required by frail elders and those adults living with disabilities, PACE pays for all Medicare Parts A, B and D benefits, all Medicaid-covered benefits, as well as any other services or supports that are necessary to maintain or improve the health status of PACE program participants. Ninety percent of participants are dually eligible for Medicare and Medicaid.

For Medicare-funded services, PACE organizations are paid a capitated (per person, per month) monthly rate. This payment model rewards effective provision of preventive care, primary care, and community-based long term services and supports to minimize the need for avoidable, high-cost institutional care. The PACE program has proven to be a good value to taxpayers. A recent study by Mathematica Policy Research (MPR) determined that PACE costs are comparable to the cost of other Medicare options, but that PACE provides better quality of care for this extremely frail, complex population. Notably, the MPR study determined that PACE enrollees had a lower mortality rate than comparable individuals either in nursing facilities or receiving home and community based services (HCBS) through waiver programs.

PACE at St. Paul's

St. Paul's has operated a PACE program serving the San Diego community since 2008. We currently serve over 600 individuals, with a new PACE center under development. In addition to our PACE services, St. Paul's Senior Services is a full-service, nonprofit retirement organization providing homes and care to generations of San Diego's seniors since 1960. We provide affordable, innovative and

comprehensive programs in a non-denominational environment with great value placed on optimal independence at all stages of life. With the changing needs of today's older adults, our services have expanded to bring innovative choices to those seeking active retirement living, personal care, memory support, and medical care.

We continually provide for excellent, cost-effective and affordable services that will encourage and enrich independent living, including PACE. Through its interdisciplinary approach, which is the hallmark of PACE, St. Paul's seeks to provide care that addresses the varied social, physical, and spiritual needs of those we serve. St. Paul's Senior Services started with HUD housing, and this week opened our third Homeless Senior Housing project where PACE provides all the medical and social care. Our retention rate in these programs is 97 percent. Significantly, the primary reason for seniors dis-enrolling from our PACE program is that their health has improved to the point where they no longer meet the state's criteria for a nursing home level of care, and therefore are not eligible to remain in the program. Regrettably, for some, when they no longer have access to our PACE services, this displacement results in a decline in their health.

Benefits of PACE

When individuals with chronic and medically complex conditions do not have access to care, their quality of life is diminished, which over time leads to increased expenditures. PACE deliberately was constructed to address the chronic care needs of individuals by providing timely and clinically appropriate treatments and social supports. Access to care in PACE results in our participants not only experiencing a higher quality of life, but also having medical outcomes meeting the highest standards. Moreover, by reducing the incidence of complications associated with chronic illness, PACE programs also reduce the high costs of specialists, emergency rooms, and hospitals incurred in response to these complications.

Two weeks ago, quite by accident, I had lunch with a lady enrolled in our PACE program. This lady had all her belongings wrapped securely in a plastic bag. She told me her other "stuff" was outside all wrapped up because of "bugs." As we ate lunch together she told me her story which included a description of her multiple, major medical conditions, and her inability to manage as she could not get out to grocery stores or to her doctors for visits. As a result, she had a history of visiting the emergency room every two to three months, which she hated because of the long waits on a "skinny" bed which were uncomfortable due to her weight, all the hubbub, and the fact that no one ever spoke to her—they spoke about her and over her. She said she was getting to like the PACE staff, but it was taking time to believe that they could be so nice and really mean it. Further conversations with staff revealed this lady had spent the first three weeks in PACE sitting outside the building with care being delivered either to her home or on the bench outside due to her paranoia and fear of exploitation. She had finally agreed to have her home treated for bed bugs and other infestations, to receiving personal care, such as bathing and grooming from nursing staff, and to having her belongings wrapped up until she was willing to give them up for three days of freezing to eliminate all infestations. In the meantime, this lady is provided with dietetically appropriate meals delivered to her, daily home care for medication management, twice weekly personal care treatments at the PACE center, weekly physician visits, social services and

psychiatric interventions, and many other ancillary services. In the four months she has been with PACE, this lady has not experienced a single emergency room visit.

This has been our general experience with our participants regarding hospital visits. A study we performed internally at St. Paul's showed that, once enrolled in PACE, visits and admissions to the hospitals were reduced by 73 percent in the first year of PACE enrollment. These results are for our elders who average seven major chronic conditions each and who live in poverty.

These findings have been correlated by other studies of PACE programs across the country; in Massachusetts and Wisconsin, state level studies observed that PACE participants had fewer emergency department visits. Moreover, those same studies, along with others conducted in Texas and New York, reported fewer hospital admissions for PACE participants and shorter hospital stays for those who were admitted. Further, a study of PACE participants in South Carolina found that "PACE participants had a substantial long-term survival advantage compared with aged and disabled waiver clients." This finding is supported by a national study which found that PACE participants had a considerably lower mortality rate than individuals in nursing homes or home and community based services provided by state Medicaid waiver programs

Providing effective and timely chronic care helps people live longer, avoid hospitalizations, and experience a higher quality of life with better health outcomes. In a 2010 study by Chad Boulton and Darryl Wieland, PACE is highlighted as one of three chronic care models that include processes to improve the effectiveness and efficiency of complex primary care. In the PACE care model, we are achieving these results for less than, or the same costs as other programs. In Medicare, payments to PACE organizations are equivalent to the costs for a comparable population receiving services through the fee-for-service program. In Medicaid, states pay PACE programs on average 16.5% less than the costs of caring for a comparable population through other Medicaid services, including nursing homes and home and community-based waiver programs.

As a comprehensive and capitated model, PACE incorporates the features of value based insurance design (VBID). By being fully at risk for all care and the associated costs of that care, PACE's financial incentives are aligned with improving health and independence and reducing higher costs of care. By maintaining individuals at the highest possible level of health and independence through the provision of preventive and primary care, long term services and supports, and comprehensive care coordination, PACE organizations reduce the use of high cost acute care and institutional care settings. Equally, as a provider-based model, PACE organizations link personal assessments and care planning with the integrated delivery of services. This direct care relationship with the people PACE serves allows for continuous evaluation of participants' conditions and revisions to their care plans in response to ever changing medical needs.

The Center for Medicare and Medicaid Services (CMS) is currently in the process of specifying a national set of quality measures for PACE; NPA is supportive of this effort. In the meantime, we have proposed a core set of measures and undertaken several quality initiatives on our own. These NPA initiatives include the development of a national benchmarking data set, as well as two national quality improvement studies addressing behavioral health services and needs, and place of death for PACE participants.

At St. Paul's, I have seen new members come into the program who were living under squalid conditions and who had been wheelchair bound for 3-5 years. These people had no house cleaning or bathroom access, no access to grocery stores, not enough money to purchase medicines, no ability to return for routine physician visits, and no routine immunizations ('flu etc.). Our first member in 2008, was a university professor who had lost everything including his home, health, dignity and self-worth due to costs of cancer care. After enrolling in PACE, he lived happily within our PACE family for 8 years, often being a spokesperson at public meetings. Another homeless lady with multiple medical conditions was referred to us by the emergency room social worker as a "frequent flyer" and, after housing her in one of our facilities, her PACE team restored her health so much that she could fly to Sacramento, accompanied by a staff person, to advocate for affordable housing for seniors. She testified before the California legislature and was very well received.

Many PACE families have told me they can resume employment, and start to care for their own health as well as the well-being of their younger family members due to PACE services returning ambulation and managing the health for their loved one. Additionally, our family surveys show a 96 percent satisfaction rate with all care.

PACE Moving Forward

NPA and our member organizations wish to assist the Medicare program to address the expanding number of Medicare beneficiaries with complex medical and functional support needs. Demands on the American health care system and, in particular, Medicare will be drastically increased due to notable, impending demographic shifts. The Medicare Payment Advisory Commission (MedPAC) reported in 2015 that starting in 2011, roughly 10,000 baby boomers became Medicare beneficiaries each day with that growth rate projected to last until 2030. Furthermore, MedPAC estimated that these additional beneficiaries will cause a 50 percent increase in the Medicare program's population from 2015 to 2030, jumping from 54 million to over 80 million. Many of those beneficiaries are likely to be high cost and high need. An AARP estimate found that over the lifespan of those 65 years of age and older, there is a 68 percent probability of either experiencing cognitive impairment or requiring assistance with at least two ADLs. Leading Age observed that there is a 70 percent chance of Americans of Medicare age (65+) needing some form of long term services and supports. Americans have expressed clear preferences as to the setting in which they would like to receive this care. A 2016 poll conducted by the Associated Press and the NORC Center for Public Affairs Research found for adults 40 years of age and older, 77 percent prefer to receive any necessary long term care services in their home.

From its inception, PACE has incorporated many of the health care delivery system features that the Medicare program seeks to promote, including person-centered care, health homes, coordinated care, and integrated financing. Thus, PACE is a well-suited, sustainable option for meeting the care needs and setting preferences of medically complex Medicare beneficiaries who need a nursing home level of care. PACE's community-based, provider-directed, person-centered, and cost effective model of care is effectively serving many frail elders and individuals with disabilities today, and could serve many more in the future. However, challenges and obstacles exist, which inhibit the ability of the PACE program to expand and serve more Medicare beneficiaries.

Significant regulatory challenges need to be addressed. Updating the current PACE regulation, which is now over a decade old, must be done immediately. While CMS has issued a proposed rule that would provide PACE with more operational flexibility, it has yet to implement this rule in final form. As a result, PACE organizations face operational and administrative requirements that constrain growth. In its comments to CMS on the proposed PACE rule (CMS-4168-P), NPA has stressed the need for more flexibility to:

- Allow PACE organizations, in addition to operating a PACE Center, the option to offer and oversee services in other settings (e.g., adult day health centers, senior centers) that support the interaction of PACE participants with one another and with PACE interdisciplinary team members;
- Include community physicians as members of the PACE interdisciplinary team;
- Utilize Nurse Practitioners and Physician Assistants as primary care providers; and
- Provide operational flexibility to configure the PACE interdisciplinary team based on the needs of individual participants.

The proposed rule was issued on August 16, 2016 and the comment period for the rule closed on October 17, 2016. It now has been over seven months since the close of the comment period. We respectfully request CMS to conclude its consideration of the comments and move forward to implement a revised regulation that provides PACE organizations with the operational flexibility needed to grow and serve more frail seniors and those living with disabilities.

Similarly, CMS can support PACE growth by implementing the pilot authority provided by Congress to allow PACE to serve new populations with similar needs and medical complexities to the population currently served. On October 21, 2015, Congress passed the PACE Pilot Act with unanimous, bipartisan support. In response, on December 23, 2016, CMS released a request for information (RFI) to develop PACE pilots for new populations. Through the RFI, CMS requested information on the design and future implementation of a broad range of PACE pilots. The RFI provided the greatest detail regarding a five-year pilot (the Person Centered Community Care Model, P3C) for people with physical mobility impairments, while also seeking input on potential pilots for individuals with other needs, including but not limited to, people with intellectual and developmental disabilities, and individuals with complex medical and functional support needs who are at risk of needing a nursing home level of care. The comment period for the RFI closed on February 10, 2017. To date, CMS has not moved forward to incorporate those comments into an announcement of PACE pilots. We ask CMS to move forward with the PACE pilots.

Other obstacles to Medicare beneficiaries access to PACE require Congressional action. NPA recommends the following legislative changes to the PACE program to eliminate impediments and facilitate increased access to this proven model of care for Medicare beneficiaries.

- *Allow Medicare-Only Beneficiaries Who Enroll in PACE to Choose a Distinct Part D Plan, Rather Than Requiring Them to Enroll in the Part D Plan of the PACE Organization*

PACE is required to provide all Medicare and Medicaid benefits to a participant. Therefore, a Medicare-only beneficiary is limited to the Part D plan offered by the PACE program for prescription drug

coverage. Unlike dually-eligible beneficiaries, Medicare-only beneficiaries must pay a monthly premium for Part D coverage. As such, they should have the freedom to select the Part D plan of their choice. Greater selection and flexibility is critical so that Medicare beneficiaries may receive the Part D coverage best suited to their medical and financial needs.

- *Allow PACE Organizations More Flexibility in Determining the Premiums Charged to Medicare-Only Beneficiaries*

Existing regulations limit the ability of PACE organizations to establish the premiums charged to Medicare-only beneficiaries since the amounts must be set in accordance with the Medicaid rates paid for dual-eligible beneficiaries. This requirement unduly limits the ability of PACE organizations to set premiums accounting for differences in care needs existing among a nursing home-eligible population. With few exceptions, PACE Medicaid rates for dually-eligible individuals are not adjusted for risk or need.

- *Authorize PACE Organizations in States Without PACE to Move Forward Under a Contract with Medicare*

Currently, PACE organizations can operate only in states that have added the PACE program to their Medicaid plans and agree to enter into three-way PACE program agreements with PACE organizations, the State, and CMS. To date, 19 states have not elected PACE as a state option, so Medicare beneficiaries do not have access to the program in those states.

Conclusion

Thank you, Chairman Tiberi and Ranking Member Levin, and members of the Subcommittee for the opportunity to share the achievements of the PACE program today with the Subcommittee. St. Paul's and the 121 other PACE programs with 233 PACE centers across the nation have a proven track record of providing high quality, coordinated, integrated and cost-effective care to beneficiaries requiring a nursing home level of care-- one of the frailest and most medically complex segments of the Medicare population. NPA and its membership is committed to working with you to surmount the identified obstacles to growth, so that in the future more Medicare beneficiaries who would benefit from enrollment in PACE will have access to the program where they will receive cost-effective, comprehensive care.

In all my years in health care, I agree that PACE is the very best model of care as professed to me by HHS Secretary Tommy Thomson over 15 years ago.

I look forward to answering any questions.