



PACE in Western Colorado

Effectively Serving Medicare/Medicaid Dual Eligible Patients in Rural America

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Introduction

Chairman Kohl, Ranking Member Corker and members of the Committee, my name is Dr. Dory B. Funk and I am the medical director for Senior Community Care, a Program of All-inclusive Care for the Elderly, or PACE program, operated in a rural area of western Colorado by Volunteers of America. PACE is a fully integrated interdisciplinary model for delivering comprehensive health care to frail older adults who meet the state's criteria for nursing home level of care. Our objective is to maximize our program participants' independence in the community and to delay or avoid entirely permanent nursing home placement. It is my honor to testify today on behalf of the 86 PACE programs in 29 states across the country, on ways to better integrate care for individuals with complex health and long term care needs – something that PACE programs have been doing for more than 25 years.

PACE History

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 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.

Today, eighty-six PACE providers serve approximately 25,000 enrollees in 29 states. Ninety percent of our participants are dually eligible for both Medicare and Medicaid. On any given day, PACE enables over 90 percent of its participants to remain living in their homes, rather than residing permanently in nursing homes.

In the Deficit Reduction Act (DRA) of 2005, Congress established a program to expand PACE to rural areas of the country. Thanks to this law, 13 rural PACE programs – including Senior Community Care -- have been developed. States' interest in PACE 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.

Key Features of the PACE Program

PACE organizations have three fundamental characteristics: (1) they are community-based care providers, not health plans; (2) they provide comprehensive, fully-integrated care; and (3) they are fully-accountable and responsible to their enrollees, their families and federal and state governments for the quality and cost of care provided.

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 and in their community, an option many families do not think is even possible. Without PACE, many of these frail adults would be in nursing homes. 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. Services are typically provided at a PACE Center – a full-service delivery site where participants can receive a broad range of services including primary care; nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work, personal care, and transportation.

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.

History of Senior CommUnity Care

Volunteers of America applied for and received a federal grant in 2006 to develop a rural PACE program in Delta and Montrose Counties of western Colorado. Our service area is home to approximately 77,000 people living across 3,383 square miles, or just under 23 people per square mile. Sixteen percent of the population

is eligible for Medicare. There is a 49 bed hospital in Delta County and a 75 bed hospital in Montrose County, each with fulltime emergency rooms, radiology services, and surgical services. In addition to a broad cadre of specialists, there are 44 primary care physicians and nurse practitioners practicing in the region.

Senior CommUnity Care opened in August 2008. By utilizing some operational flexibility within the PACE model as granted by waivers from our state and the Centers for Medicare and Medicaid Services (CMS), SCC became the fastest growing PACE organization in the nation. Growth has slowed but remains robust. We currently have 225 participants, 95% of whom are dual eligibles. SCC is the largest of any rural PACE organization in the nation, serving more than 23% of the PACE eligible population in our service area. Nationally, PACE organizations generally see market penetration from 6 to 8 %. Furthermore, our quality measures consistently are equivalent to or better than National PACE Association benchmarks.

Applying Operational Flexibilities in PACE

Senior CommUnity Care growth can be attributed, in part, to three waivers that gave us some flexibility in providing PACE services to our rural population. First is our ability to contract with community based primary care physicians, allowing them to remain their patient's doctor when they join PACE. Typically, PACE organizations hire staff physicians to provide primary care in our centers. At Senior CommUnity Care, however, we also utilize community based primary care physicians to be primary care providers for a number of our PACE participants. The physician-patient relationship is very durable, perhaps more so in rural America. By allowing patients to maintain long-standing relationships with their primary care physicians, we were able to remove a significant barrier to enrollment in the program, i.e. their reluctance to leave a usually trusting relationship with a long-term care provider. Contracting with community-based physicians also has helped us serve a geographically remote region, building our capacity to reach individuals in several small communities and unincorporated areas.

The community based physicians actively participate on Senior CommUnity Care's interdisciplinary teams (IDTs) via monthly conference calls involving the entire IDT. Each of their patients is fully reviewed and

care plan issues are discussed during these calls. They also participate in an ad hoc fashion when acute medical issues arise. The community based physicians are educated about PACE philosophies of care including notions like ‘the dignity of risk’ and focus on elder independence.

We use the NPA Model Practices to orient the doctors to providing evidence based medical care for our geriatric population. The NPA Model Practices were developed by the NPA Primary Care Committee to provide guidelines for preventative care and specific common medical conditions (diabetes, chronic lung disease, congestive heart failure, and chronic kidney disease) based on participants chosen pathways of care or advanced directives.

We reimburse our contracted physicians with a monthly stipend per participant, and office visits are reimbursed at rates matching the highest paying local private insurance (currently 148% of Medicare allowable). Probably the most important “buy in” factor for our local doctors is that they see their patients do well. We typically enroll their sickest and neediest patients who often are the greatest users of their services as well as the local emergency rooms and hospitals. The usual pattern is for these patients to dramatically reduce their use of the primary care physician’s office as well as the ER once they have a comprehensive care plan in place.

I would like to share an example of how care is provided by our PACE organization. David is an elderly gentleman with severe Chronic Obstructive Pulmonary Disorder who was notorious for not taking his medications as instructed. He lives in a senior subsidized housing unit about two blocks from Delta County Memorial Hospital. David was infamous in both of our community hospitals for walking in with his bags packed for a hospital stay. He was known on a first-name basis by radiology techs, nurses, administrative staff, you name it. He even went so far as to leave a sign on the door to his apartment during his sojourns that said “Gone to the ER.” Since his enrollment in Senior Community Care in December 2010, David has had only one unanticipated ER visit and hospitalization.

The second operational flexibility we enjoy is a waiver that allows an expanded role for nurse practitioners. Our nurse practitioners are able to perform the functions traditionally reserved for primary care physicians on the PACE interdisciplinary team. This includes performing periodic assessments and taking a bigger role in care plan development. In Colorado, nurse practitioners have unrestricted license to practice as primary care providers given the fact that much of the population lives in rural areas where access to primary care services are limited. Inasmuch, some of our participants have nurse practitioners as their attending care providers even before they enroll in PACE. Having this waiver allows us better support the role of the community based primary care physician in the PACE model and breaks down another barrier to providing needed medical care to people in need.

Considering our geography, the third operational flexibility is critical for the delivery of needed care. In addition to two full-service PACE centers in the towns of Montrose and Eckert, we obtained a waiver that allows us to maintain an alternate service delivery site in a senior center in the small town of Paonia (population 1639). . The site is open two days each week and provides meals, showers, and nursing services. A primary care physician is on site to see patients a half-day each week. Each of our sites is approximately 30 miles from the next closest one. Without the alternative delivery site, participants in that portion of our service area would have to endure up to an hour of one way van travel to the nearest center, sometimes longer during the winter months.

We have several success stories concerning the Paonia site. Sandra is an 81 year-old lady who joined our program in July 2011 after a prolonged hospitalization for new onset polymyalgia rheumatica (a severe, very painful inflammatory condition requiring treatment with steroids), new onset diabetes and out of control hypertension. She lives in Paonia with her disabled daughter. As you can imagine, she was discharged with a complicated medical regimen of pills, insulin shots, and blood sugar monitoring and wound up in a nursing home with her disabled daughter left to fend for herself. It turns out that our Paonia site is less than two blocks from her home. She was discharged from the nursing home to SCC. Given our proximity to her home, we were able to see her two times a week until her conditions stabilized. She has not returned to the

hospital or emergency room for her conditions since her enrollment and now her daughter is a member of our program as well.

Health Outcomes for the Participants

The aforementioned waivers have allowed SCC to integrate PACE services and philosophy of geriatric care into our community, resulting in better health outcomes for our dual eligible population. We “push the model into the community” through close involvement with community physicians, local hospitals, emergency rooms, skilled nursing facilities, assisted living facilities, personal care agencies, senior organizations, ambulance services, dialysis centers, and others. The hospitals, nursing homes, and physician offices all have access to pertinent electronic medical records, including a real-time medication list and basic demographic information. This effort has led to very low hospital readmission rates and low overall hospital days. The all-cause 30 day hospital readmission rate for Senior CommUnity Care is **6.8 %** for the last fiscal year. Nationally, the 30 day hospital readmission rate for the dual eligible population is **21.7 %**. For PACE overall the dual readmission rate is **19.3%**. Hospital days per thousand member months per year for SCC the last fiscal year is 2982. For PACE nationally the number is 3440. The national number for nursing home placed duals it is 5247 and for duals receiving home and community based services it is 6447.

Aligned Incentives under Medicare/Medicaid Capitation

PACE programs accept 100% responsibility for the cost and quality of care they deliver. By law, Medicaid pays PACE an amount equal to or less than what it would have otherwise spend on beneficiaries needing nursing home level of care. Because of the capitated payment to PACE organizations, financial incentives align with participants' wishes and needs. By emphasizing prevention and primary care, PACE programs help participants avoid unnecessary (and costly) nursing home and hospital stays.

These incentives resonate with our community based physicians as well. When the community docs “get it”, they practice with PACE philosophies in mind.

Moreover, we find that the adaptations we have made to the PACE model have had no impact on cost or quality. Clinical costs such as labs, diagnostics, community based primary care, specialists and hospital costs are \$711 for Senior CommUnity Care, compared to \$920 for the traditional model. The take home point is that appropriately oriented community physicians can be trusted to practice within PACE guidelines.

State Dual Integration Demonstrations

Colorado is a progressive state in the realm of health care delivery and is concerned with providing appropriate care for the dual eligible population. In the State of Colorado's dual eligible coordination demonstration, there existed a lock-in period that would restrict those dually eligible who met the care and age criteria for PACE to be unable to enroll. We were able to work in a variety of forums to highlight the concerns and limitations this lock-in would place on these complex and high-need individuals. Additionally, we participated in multiple stakeholder meetings with the state and, earlier this year, Pam Cook, the executive director of Senior CommUnity Care and representatives from InnovAge, a well-established and successful PACE organization in Denver, gave testimony at the Colorado State legislature. We have been fortunate in that leadership in both the state government and state legislature recognized the necessity of PACE and through enabling legislation has made it so that qualified potential enrollees are both educated about the option to choose PACE for their care, and that duals who are eligible for PACE are never locked out of enrolling in PACE. The bill modified Colorado Revised Statute §25.5-5-412, which is the state level PACE enabling statute. We are confident that SCC will remain a viable and attractive option for regional care organizations as they develop in western Colorado. That said, many of my fellow PACE organizations face a more uncertain environment. Several states have proposed lock-ins and auto-enrollment provisions that could potentially limit dual eligibles' access to PACE services. NPA has commented at the state and federal level on these proposals, and I know they continue to work with CMS to ensure that PACE remains a viable option alongside these demos. As supporters of the PACE program, I hope that you will use your position on this committee and as our elected leaders to ensure that our health and long term care delivery system maintains a robust role for the PACE program.

Moving Forward

Utilizing operational flexibilities within the PACE model, Volunteers of America has built a very effective PACE organization in rural western Colorado. Senior Community Care's operational differences within the PACE model has accomplished the following:

- 1) Quality and cost effective care to the dual population as demonstrated by low hospital days and readmission rates
- 2) A greater distribution of needed services to the frail elderly dual population in our rural area as demonstrated by an extraordinary market penetration percentage
- 3) Aligned incentives with this Medicare/Medicaid capitation system as demonstrated by low clinical costs while utilizing independent community based physicians

PACE programs are effective at serving the dual eligible population and their number is growing. However, the population of duals served by PACE could grow even faster if the operational flexibilities described in this testimony were encouraged and applied to a broader range of PACE organizations. To achieve this objective, the National PACE Association is pursuing legislative or regulatory solutions that would:

- 1) Expand PACE eligibility to include individuals under the age of 55 who meet their states' eligibility criteria for nursing home level of care, individuals with physical, intellectual and developmental disabilities, and high-need, high-cost beneficiaries who may not yet meet their eligibility criteria for nursing home level of care and currently are not well-served.
- 2) 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.
- 3) Offer greater flexibility around the composition of the interdisciplinary team.
- 4) Allow PACE organizations to contract with community based physicians.

- 5) Provide other flexibilities that would allow PACE organizations to serve more high-risk, high-need individuals.

Given the experience of Senior Community Care and other PACE organizations who have experimented with these flexibilities, we believe that PACE programs would be able to adopt these changes while still providing high-quality, cost-effective care to some of our nation's most vulnerable citizens.

CONCLUSION

Thank you, again, for allowing me the privilege of visiting our nation's Capital and the honor of reporting on our successes in western Colorado. Before becoming a PACE medical director, I practiced full spectrum family medicine in two of the smaller towns in Delta County for many years. When Volunteers of America approached me about being the medical director for this "experimental program," I was thoroughly skeptical about its potential benefits or viability. The great changes in SCC's participants' lives, as well as an uplifting of general geriatric medical care and social awareness in our communities has made me a true believer in the PACE model of care. I look forward to its continued recognition as a leader in providing care to the dual eligible population and whole heartedly encourage any actions the committee may take in supporting its growth.