LONG-TERM CARE OPTIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

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CONTENTS

LONG-TERM CARE OPTIONS

THURSDAY, APRIL 18, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10 a.m., in room 1100, Longworth House Office Building, Hon. William M. Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 9, 1996
No. HL-17

CONTACT: (202) 225-3943

Thomas Announces Hearing On Long-Term Care Options

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on long-term care options. **The hearing will take place on Thursday, April 18, 1996, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

Oral testimony at this hearing will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee or for inclusion in the printed record of the hearing.

BACKGROUND:

Legislation was passed in 1983 authorizing the Health Care Financing Administration (HCFA) to establish the first demonstration of the Program of All-Inclusive Care for the Elderly (PACE). This demonstration program was initially developed by On-Lok, Inc., a community-based, long-term care program in San Francisco. In 1986, legislation was passed to replicate this model of integrating acute and long-term care services. PACE programs assume full responsibility for providing their enrollees a comprehensive package of medical and long-term care services, including primary and specialty medical care, adult day health care, home care, physical and occupational therapies, and inpatient nursing home, if necessary. Currently, On-Lok and 10 replication programs serve 2,200 frail, elderly enrollees, and 27 other States have expressed interest in setting up programs. Congress has expanded and extended the program three times since its inception. In 1994, total Medicare and Medicaid reimbursements to PACE programs were $23 million and $51 million, respectively.

The Social Health Maintenance Organization (SHMO) is a public-private health care model that integrates acute care and long-term care services for senior citizens. These SHMO's pool premiums from Medicare, Medicaid, and members to create prepaid, managed health and long-term care systems that are competitive in the Medicare supplement market. These organizations combine primary care services with expanded coverage for community-based long-term care designed to keep functionally impaired older people living at home as long as possible.

HCFA originally selected four organizations as the original demonstration sites in 1984, and they began operating in 1985. More than 50,000 seniors have been served by the program. Congress has extended the demonstration program three times with the latest action extending the program until 1997.

FOCUS OF THE HEARING:

The hearing will focus on these two integrated acute and long-term care models and explore how these two approaches can be expanded to increase choices for Medicare beneficiaries.

(MORE)

WAYS AND MEANS SUBCOMMITTEE ON HEALTH
PAGE TWO

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Thursday, May 2, 1996, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

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Chairman THOMAS. The Subcommittee will come to order, please. Today's hearing highlights efforts under Medicare and Medicaid to find ways to remedy problems resulting from divisions between acute and long-term care. These innovative remedies work by bringing these two sectors together in a single, integrated system. While the best known of these demonstration projects are On Lok and its program of all-inclusive care for the elderly called PACE and the social health maintenance organizations, Social HMOs or SHMOs, there are at least a dozen other initiatives underway or in the planning stage.

This hearing will focus on the experiences of the PACE and the Social HMO programs primarily. In addition, we will also hear testimony on other creative alternatives that are being demonstrated across the country. These integrated models of Medicare beneficiaries' additional options for receiving medical care under the Medicare Program create a public/private partnership that offers quality care at potentially lower costs for an increasingly frail elderly population.

We should explore these integrated acute and long-term care models to determine how they would fit into the Medicare Plus structure included in legislation passed by the Congress and provide increased private-sector choices for our Medicare beneficiaries.

I had the pleasure of meeting Jennie Chin Hansen, executive director of On Lok, in my district office in Bakersfield earlier this year. I was very impressed with the success On Lok has achieved in caring for the frail elderly at home and in the community as an alternative to nursing homes, and I in particular look forward to her testimony today. I would just say parenthetically, we could have held this as a field hearing in California and have gotten a pretty good cross section of most of the programs that are going today.

I might add that Senate Majority Leader Dole, who would be with us this morning as our initial witness were he not at a press conference over on the Senate side, is a strong advocate of the On Lok and PACE programs and has introduced legislation, Senate bill 990, to expand the program beyond the current 11 sites and to make the demonstration program permanent within the Medicare Program. This may be an area where the administration and Congress can find some common ground.

It is also important to highlight the Social HMO program as an additional option for Medicare beneficiaries. It is currently a smaller program than PACE, with only three sites up and running. However, such additional sites are in the planning stages.

As our population continues to age, we will need to pursue additional delivery and financial options for providing medical and personal care services at home and in the community, not only for cost savings but for increasing the quality of life of our most vulnerable Medicare population. Today, I am confident we will receive new insights into the lessons learned and greater potential of these private-sector options.

At this time, I yield to the gentleman from California, Mr. Stark, Ranking Member.

Mr. STARK. Mr. Chairman, thank you for calling attention to these alternative methods of care for American people. I wish ev-

eryone in America could participate in a Social HMO or a PACE-type program. I think we could pass an extension of these programs on the suspension calendar.

We do not legislate in vacuums, and I would be interested in hearing Dr. Vladeck talk to us about the realities of Medicare changes that would remove guarantees for low-income seniors or Medicaid and weaken nursing home quality if the Social HMOs or PACEs can make up for that. But we have a program proposed that will turn Medicare into a program where providers are able to charge seniors extra for the basic Medicare benefits. What good does it do them? Can Social HMOs and PACEs make up for the harm that is being done to the Medicaid and Medicare Programs with a few demonstration projects?

My guess is that the net result of the actions of this Committee this year will be harmful to seniors. I wish that indeed, programs like On Lok, which is about to expand, I understand, into my district will continue. It seems somewhat disingenuous, however, and I hope that Dr. Vladeck can explain to us that on the one hand, we can help with a few modest programs like On Lok, yet we make huge cuts in the increase in revenues needed to run a Medicare Program. It is even more difficult when we destroy a Medicaid Program and nursing home quality standards, which are so vital to the health of seniors.

Thank you, Mr. Chairman.

Chairman THOMAS. Well, we almost made it to you, Bruce, in a bipartisan way. Nice to have you with us. I look forward to your testimony.

STATEMENT OF HON. BRUCE C. VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman, Mr. Stark, Members of the Subcommittee. I am really particularly pleased to be here to discuss the development of new models of comprehensive care for the frail elderly. It is an issue that has been close to my heart for many years and one in which I have been professionally involved for many years. In fact, I am pleased to count myself among the earlier admirers of On Lok, having first visited the program in 1977 and having helped arrange some of their first national foundation funding.

I want to talk today about the program that we have built on top of the On Lok example, the PACE program or Program of All-Inclusive Care for the Elderly and the social health maintenance organization projects or SHMOs, as well as some of the other things that we are either doing or are in development. We are putting in place building blocks for high-quality, locally-sensitive, customer-oriented, community-based services for those in need of long term care and for better integrating acute and long-term care in Medicare and Medicaid financing.

Before talking specifically about PACE and SHMOs, however, let me just very quickly point out that we are in the midst of a transformation of our long-term care system that has been going on for more than a decade now, increasingly reflecting the preference of clients and their families to receive services at home whenever possible. And while the distribution of services is probably still more

heavily oriented toward an institutional side than many bene ficiaries and advocates would like, in fact, most of the growth i services over the last decade has been on the community-base side.

We are running an average daily census now of a quarter of million frail elderly people in Medicaid home- and community based waiver programs. The Medicare home health benefit is nov providing increasingly long-term care services to more than 2 mil lion beneficiaries a year. For those benefits, the issues of integra tion continue to be significant, but we are building a base in term of a community services infrastructure that will be important as w move forward in the development of more comprehensive service in the future.

HCFA's relationship to the PACE program goes back to 1979 when we first funded On Lok as the model program for providin health, nutritional and recreational case management services t frail elderly adults based upon an adult day care program. On Lo has always been committed to the integration of both financing an of acute and long-term care services, and we have been in the busi ness of supporting On Lok, first through grant funds, and throug waivers of different program requirements ever since.

Now, the PACE program was designed to replicate the On Lo model to specifically target frail elderly persons who are eligible fo nursing home care by reason of the degree of their medical and so cial needs, but who prefer to remain in the community. It is a full capitated program in which all covered services are provide through a single organization or a single provider of care, includin not only the long-term care services and inpatient hospitalizatio but physician services, therapies, prescription drugs and equipmen as well. And while the PACE programs seek to discourage the us of nursing home care, when their enrollees need nursing hom care, PACE also pays for that service.

We currently have about 2,700 enrollees in these programs, i On Lok and 10 additional PACE sites. We have as many as 45 o 50 additional organizations in the process of developing such sites Basically, we pay them the Medicare capitation rate, established a 2.39 times the basic AAPCC in the community for Medicaid. PAC then negotiates capitation rates with each of the states in which i operates, and we have a series of waivers of our HMO require ments, to permit them to operate in such a capitated environment

We have not completed our formal evaluation yet, but we hav done a number of studies, both of quality of care and of custome satisfaction with the PACE programs, and both are quite high. W continue to work on some of the issues of appropriate financin mechanisms and longer term requirements. We have been in th business of SHMOs since 1984, when Congress mandated a test o this notion. Again, the idea was that one could save money and im prove services by providing both the full range of Medicare acut benefits and long-term care benefits through a single, capitated or ganization. SHMOs, as opposed to the PACE program, seek to en roll a cross section of elderly Medicare beneficiaries in their com munities, and while they have relationships with the Medicai Program, they also have a significantly higher proportion of pa tients who are paying additional premiums from private resources

As opposed to PACE, the long-term care benefits in the SHMO programs are generally capped at some dollar maximum and are somewhat more limited in scope. We have had extensive evaluations of the first generation of SHMOs. I think they show very high levels of customer satisfaction, good to excellent levels of quality of care and somewhat equivocal results on cost savings having to do with differences between the SHMOs themselves and over time in the course of the life cycle of any particular SHMO.

In response to the evaluation of the first generation, Congress authorized an extension and established a second generation, which we refer to as SHMO II. We have awarded grants to six organizations to develop SHMO II, delivery systems. The major difference with SHMO I in that regard will be a significantly higher emphasis on geriatric medicine and geriatric case management as the heart of the integration of the acute and long-term care services package.

We are aware of Senator Dole's bill. In fact, the President's balanced budget recommendations for this year contain very similar legislative provisions. There are some differences between what the President has supported and what Senator Dole has proposed, and we think all of them are quite resoluble. Ms. Hansen will speak about some of the specifics of the proposed legislation in her testimony, and we would very much support the enactment of legislation this year to expand and make permanent the PACE benefit as a benefit in the Medicare Program.

We would also support continued extension of the SHMO demonstrations, both the first and second generation projects, which are now set to expire at the end of 1996. But frankly, the broader expansion of the SHMO needs to be connected to and coordinated with other changes that are going on in Medicare and managed care more generally. We believe that if we had the kind of risk adjusters in which we are investing so much time and energy, and some of the other new developments in terms of the choices Medicare beneficiaries have and the way in which supplemental benefits are priced, much of what is now provided through SHMO demonstrations could be provided through existing risk contract statutes, as modified according to some of the President's proposal. It is not clear to us which is the better way to go in that regard.

So, since the existing SHMOs are doing a good job and have happy customers, and we are just starting with the second generation, we would support extension of the demonstration authority pending broader congressional action on changes in Medicare managed care legislation.

In my written testimony—and in the interests of time, I will not go through it—we identify another 8 or 10 initiatives that we are taking to deal with this integration of acute and long-term care under Medicare and Medicaid. I am happy to answer questions about any of them or about any of this testimony. But let me say, just by way of summary, that while it has taken quite awhile, we detect considerable progress in understanding how to provide higher quality, more satisfactory services to the frailest of our beneficiaries in a way that, at worst, is no more expensive than the existing benefit structure. We are committed to continuing to expand our demonstration and research efforts, but we believe we know

enough already to make the PACE model a permanent part of the Medicare Program. We will draw on what we have already learned about SHMOs as we seek to refine the legislative base of Medicare and managed care going forward.

Again, I appreciate the opportunity to share our views on these subjects with you, and, of course, I am happy to answer any questions you might have, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF
BRUCE C. VLADECK, ADMINISTRATOR,
HEALTH CARE FINANCING ADMINISTRATION

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 S/HMOs program would provide additional time necessary to establish a comparative study and to assess its performance potential.

OTHER INTEGRATED SERVICE MODELS

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

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

The Wisconsin Special Care Initiative is designed to provide Medicaid-covered medical services and additional social services such as respite care, family training, long-term planning, referral and medication services to up to 3,000 Medicaid eligible SSI 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 adult day care services. This model includes a physician panel of experienced providers, case management services provided by a multidisciplinary team, and specialized clinics. 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 supporting this initiative in conjunction with the Pew Charitable Trusts, Robert Wood Johnson Foundation, and the Medicaid Working Group. All participants are eligible for Medicaid, 40 percent of whom are dually entitled. Initiatives in Wisconsin, Missouri, 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 will be responsible for the management, coordination and integration of services, including multidisciplinary approaches to care planning and service delivery. Maine-Net includes a comprehensive package of primary, acute and long-term care services as part of a prepaid capitated health 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.

Chairman THOMAS. Thank you very much, Mr. Vladeck. What I heard was in essence, you support S. 990 as a piece of legislation that directly mirrors the President's budget proposal. Is that it basically?

Mr. VLADECK. We would support it, Mr. Chairman. We would support it on its own terms, with concerns about a couple of specific provisions, which we believe could be resolved relatively straightforwardly.

Chairman THOMAS. Let me say it this way. We do not have the perfect model. We have several that appear to work. You have decided that, perhaps, the administration would support making these permanent. What is it about supporting these and in making them permanent that would allow for other options? Where is the growth factor in what we might be creating in a permanent structure here?

Mr. VLADECK. In terms of the implications of making them both permanent? Well again, here, it is important to distinguish between PACE and the SHMOs. In terms of PACE, all of the existing programs have appeared to max out in terms of service delivery capacity, in the range of 300 or so beneficiaries. And even those that have been in business the longest time, given the stringency of the eligibility criteria tend to level off at a steady state in that range. One could envision, therefore, one or more PACE programs in every community in the United States, which would still be addressing only a fraction of our beneficiaries and perhaps only a fraction of those who are otherwise eligible for long-term care.

We have a long way to go, given the size of the programs, before we make any very consequential dent in the total need in the population.

Chairman THOMAS. Well, in the PACE program, it clearly creates a defined universe which it intends to serve. One of the difficulties with these kinds of hearings is that there will be testimony down the line that I would like you to react to.

Mr. VLADECK. Sure.

Chairman THOMAS. So, I am going to do some of the cross-questioning. Dr. Wiener talks about the fact that if these programs are going to be made permanent, that one of the things we ought to do is to remove the targeted aspect of the programs. That makes some sense, I think, on the Social HMOs.

Mr. VLADECK. Again, that is why I said, Mr. Chairman, that I think we ought to look at making Social HMOs permanent in the context of broader legislation on Medicare and managed care. Clearly, to the extent that we are talking about a specific package of long-term care benefits to which one could attach a premium or an adjusted community-rate calculation, then much of what is being done by SHMOs at the moment is currently available: they are plans our current risk contractors could do under current law.

The two major differences are that the SHMOs get 100 rather than 95 percent of the AAPCC, and have somewhat greater discretion over enrollment processes, both of which, we believe, could be addressed through more sophisticated risk adjustment mechanisms, which we are going to begin to test in the next number of months.

Chairman THOMAS. Are we not all awaiting more sophisticated risk adjustment mechanisms so that AAPCC can be modified in the regular Medicare Program as well?

Mr. VLADECK. That is exactly what I am saying, Mr. Chairman. So, it is not clear whether once we do those things, it will be necessary to have special legislation for SHMOs. That is the point I was seeking to make.

Chairman THOMAS. This is an unfair question, but I would like you to at least spend some time on it anyway, because clearly, what we have done here is remove a lot of the bureaucracy and the preconditions to a lot of specific programs by virtue of the integration, and especially across Medicare and Medicaid. But at the same time, I think, we have taken an integrated approach in which we take a multidisciplinary team with a focus on geriatrics and produce a use of those facilities focused on the needs of the individual. In your estimation, what probably creates any savings? Is it primarily the integration, or is it the knowledge of the team and utilization of the services? Obviously, it is a combination of both, but I am trying to focus on the question of integration as we move toward new delivery systems, not just for defined elderly populations but for populations in general.

Mr. VLADECK. To a large extent, Mr. Chairman, I would defer to the practitioners on that issue. But my own instinct is that the key part of this is that we have loosely defined as the case management function the notion of an individual professional or a team, whose responsibility encompasses the full range of services for which the individual may be eligible, who knows the individual well, and is closely involved in the clinical service of that individual. One of the interesting intellectual questions about how to generalize from these models is how to define and replicate the model of good care management. We get into issues of what the professional training and skills ought to be, and all other like issues. In the On Lok and the best PACE programs, my impression is that is really the heart of what they do.

Chairman THOMAS. Well, I also still have some concerns, especially probably knowing more about On Lok than the others, that there may be some cultural tendencies within the recipient population that might lead toward at least initial receptance of this kind of an approach more so than the population in general. But as we get more into managed care, and people are more familiar with it at the workplace site, as they move into an aging population, they might be more receptive as well.

Mr. VLADECK. Mr. Chairman, one of the really interesting things about these demonstrations is the range of cultures and populations that are being served in the PACE program and in the SHMO program. Now, in many ways, the most interesting cultural variable in all of these programs is the physician culture in the communities in which they are operating and the change in the traditional role of physicians relative to their relationships to other professionals on the team and to long-term care services. And I know they are not among the witnesses today, but I think in some ways, the folks at Kaiser in Portland have had the most interesting experience, given the history of the Permanente groups in terms of the cultural changes among physicians.

Chairman THOMAS. One last comment. Again, I am going back to Dr. Wiener's study, because he does cite so many other studies that have been offered. And what caught my attention on page 3, having read some of the case profiles and the way in which they were handled, in a very humane way, he says: "Within the Social HMOs, at least some disabled groups had higher mortality rates than persons receiving fee-for-service care (Manton, et al., 1993)."

Based upon the way in which there was almost a nurturing hospice concept to this program and choices that were focused by loved ones and relatives, that is not necessarily a negative statement. You have to look, I think, at the individual situation, because oftentimes, strictly, mortality rate divided by dollars does not necessarily produce a quality profile, and what I like about this program is that although we are obviously focusing on the cost of the program, and the quantity aspect is something that is important, I think overall, most people would agree that all things being equal, the quality of these kinds of programs is significant.

Mr. VLADECK. I think it is particularly important, Mr. Chairman, to recognize that whatever the sort of conventional wisdom or stereotypes may be that, in fact, effective case management really empowers individual patients and their families, just as having to deal with a fragmented system can restrict choices. In fact, good programs of this sort like the PACE programs give the patients much greater control over the kinds of services that they receive than the so-called "unrestricted," and confusing array of benefits that might be available otherwise.

Chairman THOMAS. Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman.

Bruce, maybe you could clear up some definitional stuff here. I would preface this by saying that I think these programs are good, and they are certainly good for the beneficiaries. But the question of cost and which programs save and how much they save, we are not clear on. Let me see if I understand this. In the PACE programs, they are partly paid out of Medicaid and partly Medicare funded. Generally, most of the savings would come out of the Medicaid side, because there are lower long-term care costs. There is probably not a lot of savings in Medicare.

On the SHMO, however, it is mostly paid by Medicare and includes limited long-term care. In the SHMOs, we have seen nothing in the testimony here to say that they really save money. My guess is that the reason they do not save money is that they do not have a big nursing home potential cost to save from. Have I got that?

Mr. VLADECK. You know, it is one of the problems we have in all of the capitated programs under Medicare, since, in a sense, savings are invested in benefits.

Mr. STARK. OK.

Mr. VLADECK. And that is one of the reasons that it is so complicated to draw a conclusion. It is clear that Medicare is not saving money in the way in which it pays SHMOs. The question is, are beneficiaries getting more than they would, and the answer is probably, they are.

Mr. STARK. Medicaid is saving on the PACE side, because arguably, they prevent or postpone admissions to long-term care facilities.

Mr. VLADECK. I think that is fair, yes.

Mr. STARK. The SHMO does not have that opportunity to save. It does not get credit for it.

Mr. VLADECK. It does not get credit for it. It may well have it to a greater extent than we have been able to measure, because most of the folks who are served by SHMOs, or who are at risk for Medicaid-covered nursing home care, are not Medicaid beneficiaries at the time they are enrolled in the SHMOs.

Mr. STARK. OK; I think I have got it. Thank you very much.

Chairman THOMAS. Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you.

Good morning, Mr. Vladeck.

Mr. VLADECK. Good morning.

Mrs. JOHNSON. I am not quite sure that I understand your recommendation in regard to PACE. Are you recommending that only the programs that are in place now be permanent or that the program be made permanent and that new sites be eligible? And would you consider both for profit as well as nonprofit applications?

Mr. VLADECK. Mrs. Johnson, no. We believe that the PACE program should be made a permanent benefit in the Medicare Program. There has been some discussion among the sort of PACE-related community as to whether there should continue to be a limit or a ceiling on the total number of PACE sites or whether it should just become available to any qualified applicant. And my instinct is that that is a traditional issue, that long-term, we ought to have PACE programs in every community in the United States, and in bigger communities, we ought to have multiple PACE programs.

We have no experience with PACE program operators other than not-for-profit community-based organizations. And one of the things that Mr. Thomas alluded to and that I personally think is quite important as a contributor to the success of PACE programs has been how rooted they are in their specific communities and specific community organizations, and so forth. So, I do not have a prejudgment on the legal structure of ownership, but I do have some sense that we want to try to keep these as very much community-based, grassroots-based kinds of organizations, and there are a variety of ways one could seek to achieve that through legislation.

Mrs. JOHNSON. I asked the question because what I see happening out there in the real world, particularly since we have not been able to pass any policy changes, is an incredible change in the organization of medical services so that there are now hospitals that are developing relationships with long-term care facilities, with home-care capability as well as physicians, and they are going to be capable of an integrated care approach that has the same vision and is based on the same beliefs and assumptions as both the PACE and the SHMO programs. And I think it is imperative that we write the law as we make this permanent so that it can be integrated into the changes that are going on as rapidly as possible,

because whether it saves money or not, it certainly improves care. I have not quite focused on how many more services are available. But the breadth of services available make a lot of sense, and one knows that in people's lives, this makes a big difference. It also makes far better use of our Medicare and Medicaid dollars, and is the only avenue through which we can integrate them.

I would be interested in your office working with us on language in the bill that would make clear that these can become a part of HMOs that offer services to seniors, and it ought to be part of a package that the Medicare Select plans can offer as well through the additional benefit approach. It ought to be part of the supplemental insurance benefit that is available to seniors, because some of those supplemental insurance benefits are now coming in at zero premiums in order to enable the managed care plans to compete with the HMOs. And they are part of the package of benefits they are beginning to offer, and particularly as hospital and nursing home and day care facilities integrate. So, I think that we want to be sure that we do not write this too narrowly, because the whole sector is changing so rapidly. We want to be sure that this kind of integrated care benefit, this kind of case management approach, which is probably the very best approach, as we have more and more people moving into the frail elderly category, can be something that all HMOs can offer, that all managed care plans can offer if they want to. So, I would like to work with you and make sure that the legislation is broad enough to not only allow that development but also encourage that development.

Mr. VLADECK. Well, I understand that, and I agree with that. I think it is important to maintain the distinction between a financing mechanism on the one hand and a delivery system on the other, and that is why I said that I think the future legislation relative to SHMOs needs to be integrated with any legislation we eventually agree on about Medicare managed care. On the PACE side, I think we are all eager to find mechanisms through which folks who are not eligible for Medicaid by virtue of income, but who have the same degree of care needs as other PACE clients, could also receive services from PACE programs through a combination of Medicare and private payments, whether they are insured or not.

When you get into the relationships, the capitated plans, some of the economics and the mechanics of that get to be quite complicated. But I think if we can keep some clarity in the distinction between delivery systems on the one hand and the mix of financing sources on the other hand, we can work our way through that.

Mrs. JOHNSON. Now, does your proposal include enabling the states to merge Medicaid and Medicare dollars for this kind of care?

Mr. VLADECK. Well, we feel very strongly that we ought to encourage the expansion of provider types that are funded through some kind of joint Medicare and Medicaid funding. In our discussions with the states, including the New England states, we have continued to oppose the notion of permitting states to function, in effect, as intermediaries or as controllers of Medicare dollars.

Mrs. JOHNSON. But what I hear the facilities trying to get away from is moving people from this group to that group and all of the

administrative complexities involved in that as well as the problems for the individual associated with that. And where there have been those demonstration projects of merging those funds, they have been very fruitful. This seems to me an ideal moment at which also to deal with reducing the amount of administrative costs associated with this kind of care by dealing with the pooling of the resources the Federal Government provides.

Mr. VLADECK. Well, that is what we are doing. And as you know, we are in discussion with a number of states about new ways of doing this, and we believe you can pool funds and should pool funds at the level of the beneficiary or at the level of the provider. There is some question as to the mechanics through which that is done, but we are moving ahead on a number of experiments in that general vein.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Dr. Vladeck, let me thank you for your leadership in this area of expanding opportunities for our Medicare and Medicaid recipients for long-term care needs. The PACE program is a winner, and I hope that we can find some way to make that permanent and available to all of our seniors. I would like to move forward on that.

The alternative to a senior not having PACE if they are a Medicare beneficiary, is that there are very limited services available, and, therefore, the beneficiary needs to use his or her own resources. The beneficiary will probably spend down into Medicaid and then go into long-term nursing care, which is going to end up being more costly and not as beneficial to the beneficiary. So the PACE program, it seems to me, is one in which I would hope that we could handle separately and do something to expand the availability of this service to our seniors, because it is good for them, and it is good for the taxpayers of this country.

If I could just get you to respond a little bit on the SHMO program, because I am not sure I totally appreciate the adequacy of that particular benefit to our seniors. That plan requires seniors to go into an HMO to get limited long-term care coverage, which may or may not be adequate to the need of the senior, as far as the senior's long-term care concerns. In your statement, you indicate that the overall Medicare beneficiaries enrolled in SHMOs were healthier than the average beneficiary. My question is are you referring to the fact that the care that they are receiving in the SHMOs has brought up their health care status? Or is the type of selection of a person who is going to go into an HMO generally healthier than the average, and therefore, we are not accomplishing the diversity that we had hoped to in the SHMO program?

Mr. VLADECK. Mr. Cardin, I think in all fairness, it must be noted that the original designers of the SHMO concept really started from the notion that if you had a broad enough pool and a broad enough base of Medicare beneficiaries, and you used resources for all of your beneficiaries efficiently with some modest additional funding and good clinical and administrative management of the cases, you could, in a sense, insure against additional long-term

care expenses that were not ordinarily part of the Medicare benefit package.

And so, to the extent that much of the work in the development of SHMOs to this point has been an effort to define the size of that supplemental long-term care package in order to create an insurance package within 100 percent of AAPCC plus a market-sensitive premium, I think it has been very successful. Now, that is limited. It is limited compared to what Medicaid beneficiaries are entitled to; it is limited compared to what people who have very extensive long-term care needs require over a period of time. But it is more than is now currently available in conventional Medicare HMOs. So, I guess the question really comes down to one of continuing to identify the long-term care insurance product that can be delivered in conjunction with a more conventional HMO package of services. Then, as the Medicare Program evolves in terms of customer choices, we need to subject that to a market test in terms of how many beneficiaries find that important as opposed to, say, alternative supplemental benefit packages, and how much of a dent that makes over time in the demand for non-Medicare-covered long-term care service.

Mr. CARDIN. The alternative, of course, is that if you do not have a representative group, and it is actually costing Medicare more money to provide the SHMO type of a program, we should be looking at alternatives within traditional Medicare to expand the coverage for all beneficiaries that could save unnecessary utilization on nursing home care.

Mr. VLADECK. Well, I think that is a very good point. And one of the things we are doing a lot of work on at the moment has to do with the notion of case management, which again is, in many ways, the key to these effective integrated programs. If you look at what is happening in the private sector, there are a number of nontraditional so-called managed care plans, which are still very much fee-for-service oriented, or even look more like indemnity plans, except for formal case management functions somewhere in the system.

And one of the questions is the extent to which within the Medicare fee-for-service program we could build in that kind of case management, and the extent to which it would provide an additional benefit for beneficiaries and produce better outcomes and, thereby, produce savings to at least offset the additional costs.

Mr. CARDIN. I hope you will continue to explore that.

Mr. VLADECK. We are working on that very aggressively.

Mr. CARDIN. Good.

Chairman THOMAS. Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Thank you, Mr. Chairman.

Mr. Vladeck, nice to see you. Tell me once again what it is we need to do in order to expeditiously extend PACE and SHMO this year.

Mr. VLADECK. We need legislation, Mr. Houghton. We have specific statutory authority to operate our existing levels of demonstration activity. Actually, we have 10 PACE sites; we have authority to go to 15. We are operating all of the SHMOs that are permitted under existing authority, which is going to expire in another 20

months or so. So, we need a statutory basis to expand either or both programs beyond the point at which they are now based.

Mr. HOUGHTON. So, you feel that you could explain to people like myself, who have not been intimately involved in this process, that not only is the program good, but there have been significant in-depth reviews to prove your point?

Mr. VLADECK. I think on the PACE issue, there have been significant, in-depth reviews of the quality of services being provided and of customer satisfaction with those services. There are some issues that still are being very actively studied, including some of the economic issues. But given the pace at which implementation of statutory change works, we believe that even if the Congress were to enact Senator Dole's bill tomorrow, we would have the evaluation results in time. The evaluation results are not going to say yes or no to PACE. They are going to teach us more about standards for PACE programs, about what the essential characteristics are, and about payment levels. We would still have time to incorporate that into the process of expanding the program. The SHMOs have been sort of "studied to death."

Mr. HOUGHTON. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman.

Dr. Vladeck, I want to talk a little bit about a program in my state which you have currently awarded one of the demonstrations in the SHMO IIs that is supposed to start this summer, but first, let me just brag a little bit about it. I was pretty proud of it. Sierra Health Plan of Nevada is a very innovative company in Southern Nevada. It is basically HPN–SHMO II provided by Sierra Health Services. They were in my office yesterday, and it sounds to me like there are some dramatic improvements in SHMO II or SHMO I. One of the concerns that they raised to me was simply that the Medicaid and Medicare waivers be ready on time. Do you think that they will be ready by July 1, when they are scheduled to start up?

Mr. VLADECK. I checked yesterday, sir, and as of close of business yesterday, we are right on schedule for that. Again, the Medicaid waivers require working with the state as well as with our folks, and we have had a very good relationship with the state on this one.

Mr. ENSIGN. OK.

Mr. VLADECK. So as far as I know, we are exactly on track for that.

Mr. ENSIGN. OK; could you explain some of the concepts? Everywhere you go, long-term care with seniors across the board is always one of their biggest concerns. You know, they are the people who have to go through all of their assets before they can get on Medicaid. Certainly, the amendment that I offered to the recent health care reform bill that, in fact, Barbara Kennelly had commented that she has been trying to get passed for the last 12 years, that deals more with people with money, whereas the SHMOs seem to be addressing more the end of the spectrum where the people have fewer assets.

And the whole idea of SHMO II versus PACE would seem that it is much more of a complete program and not just a day care type of a program. Basically, you are talking about building ramps for homes that need a ramp. It involves taking a complete look at the elderly health care wise, mental health care status, the whole thing, to keep them as healthy as possible, because the bottom line is that obviously, that is better for the elderly, and the win-win situation is that the company is going to save money on it in the long run.

Mr. VLADECK. I think that some of the folks from PACE might be concerned about the characterization. I think the PACE programs are very complete in the range of services that they provide as well. They provide them to a more limited population, however.

Mr. ENSIGN. Right; it is more the frail population.

Mr. VLADECK. A more targeted population.

Mr. ENSIGN. This is more of trying to keep people from becoming as——

Mr. VLADECK. We are enthusiastic about SHMO II and the evolution of some of the original SHMO plans, and again, I think Health Plan of Nevada is a very good example of this. One of the things we have talked about with this Committee on prior occasions is that as you have HMOs or other managed care organizations which have developed their organizations treating primarily a conventional, commercially insured population which begin to enroll large numbers of Medicare beneficiaries, the needs of those beneficiaries, the kinds of services they require, and the kinds of physicians you need to provide them with the range of services they need, are very different from that particularly of the typical, commercially insured population. This is particularly true in an area like southern Nevada, which has such a rapidly growing young population driving so much of the growth on the private side of the HMO market. Medicare beneficiaries do not use very much in the way of deliveries or pediatricians, as the simplest example of that.

So, our concern has been that as on the fee-for-service side, the providers of care to all Medicare beneficiaries, not just those who have already been labeled as long-term care clients, should develop the expertise and the skills and the relationship with different kinds of providers. This should be the case whether they are home care providers or community nutrition agencies that are necessary to provide real, high-quality continuing care to the elderly that are less of an issue in routine practice with other populations.

As you do that, the boundaries between what is good "acute care" and what is good "long-term care" start to dissolve altogether, we believe. But how to make that spectrum or that integration of issues where you cannot draw very hard lines is difficult, when you have two public programs with very rigid lines about what they pay for and what they do not, and who they cover and who they do not. This is really the challenge here, and that is the heart of the continued experimentation around these issues.

Mr. ENSIGN. And that is where the heart of the savings would come from, because sometimes, there is no incentive to do preventative care. If the other program is paying for it, there is not necessarily the incentive. But if you have the complete coordinated

type of care, there is the incentive. If this is the most costly end over here, and you put a little money in over here, the patient ends up with better care, and in the long run, you save dollars.

Mr. VLADECK. Mr. Ensign, every well-managed Medicaid Program in the United States has a group of its staff and a set of rules that in New York we were—New Yorkers being New Yorkers—more explicit about, but every other state does it, and we call it the Medicare Maximization Program. And, the basic rules were that for everybody in the long-term care system, both the providers and the state had to do everything that they could to bring in every Medicare dollar before Medicaid would pay something.

And in Medicare, we are not quite as good on the on-site management. We have a lot of policies that are designed either to prevent the shifting of Medicaid costs to us or to dump costs on the Medicaid Program. And, the net result is not only significant inefficiency and additional cost to the system as a whole, but we put our beneficiaries and our providers of service through some ridiculous hoops as a result.

Mr. ENSIGN. Mr. Chairman, I know my time has expired, but just one last comment. And, the comment that Sierra made to me yesterday is an example. CCU is the most expensive area in our health care system on a per-day basis. And obviously, if you are encouraging through preventative health, proper diets, exercise, and counseling in those areas, you are keeping somebody out of a CCU unit. The taxpayer through lower payments to Medicaid and Medicare is going to be better off. The patient is better off because they are healthier and this whole concept of a win-win-win situation is the way we should go, and I thank you for your efforts.

Thank you.

Chairman THOMAS. Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Dr. Vladeck, you are looking at a panel of proof that Tip O'Neill was right when he said that all politics is local. I think on this panel there are at least five of us up here who have a parent in their nineties. So, we all have more than a passing interest in this issue. There have been proposals made in this Congress for climatically changing the structure both of Medicare and Medicaid. Please tell me what the impact of those proposed policy changes would be on the PACE program and the SHMO program.

Mr. VLADECK. Well, I can do this in general terms, because I think there are a lot of specifics as well, for both SHMO and PACE and for other long-term care experiments. We use essentially the current system as the baseline or the template against which we both set prices and compare for standards of quality of care and for customer satisfaction and so forth. Any radical changes in the conventional baseline system are going to reverberate significantly through programs that are tied to that, even if the conventional system is only sort of a counter-example to them in one sense or another.

The most significant issue here, or I think the easiest and most straightforward is probably on the Medicaid side, given the nature of the proposed legislation.

Mr. MCDERMOTT. You mean the proposed legislation to make block grant Medicaid to the States?

Mr. VLADECK. The block grant legislation.

Mr. MCDERMOTT. So, we will have 50 different Medicaid Programs.

Mr. VLADECK. We already have 50 different Medicaid Programs.

Mr. MCDERMOTT. That's true.

Mr. VLADECK. But we cannot do the arithmetic in a way that makes the block grant proposals work out past the fourth or fifth year without a significant loss of coverage for lots of folks who are now getting Medicaid or who would be eligible for Medicaid in the future. We just cannot make the arithmetic compute. So, we are talking about building long-term care programs around folks who would be eligible for Medicaid, and taking the Medicaid and Medicare dollars and pooling them.

Our belief is that in the future under the Balanced Budget Act, a lot of those folks would not be eligible for Medicaid, nor would they be able to afford what would otherwise be paid for Medicaid in terms of a private premium. So these programs may be cheaper than existing Medicare and Medicaid. They are not cheap by any objective standard. And if you take the kinds of cuts that are being talked about in both of the programs out a number of years, again, I would ask the direct providers of these services themselves, we may be able to run PACE for 5 percent, 7 percent lower than what the same client would cost Medicare and Medicaid under current law. I do not think we could run them for 30 percent lower, which is where the Balanced Budget Act would take us in 2001–2002.

Mr. MCDERMOTT. Is it fair to say, then, if we pass legislation extending these programs, it really is a hollow promise if the other changes were to pass in terms of Medicare and Medicaid, particularly the Medicaid proposal, that you are looking at a bill that says yes, you are eligible, but there is no money to give you the services. Is that a fair thing to say?

Mr. VLADECK. Well, I think in all fairness, it is not inappropriate to suggest that we had made it clear that at least during the life of this administration, there will not be cuts of that magnitude in Medicare and Medicaid.

Mr. MCDERMOTT. Thank you.

Chairman THOMAS. Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Just briefly, Mr. Chairman.

Dr. Vladeck, would you just briefly go over for me the qualifications for enrollment in PACE? What does a person have to have in terms of income, or what are the other characteristics to enroll in PACE?

Mr. VLADECK. By and large, the income characteristics per se are not that important. The major criterion in general, which takes different specific forms in every State, is that that person be eligible for nursing home care as defined by the State's Medicaid Program. Now, the reason I say as defined by the State's Medicaid Program is that for private users of nursing homes in most states, eligibility is a determination made by the individual family and the facility. So, the only sort of systematic criteria we have for eligibility for a nursing home level of care, for long-term care, are those adminis-

tered by the State Medicaid Program. And each state has a somewhat different combination of income and assets and medical or clinical need by which they define that threshold, and they are state specific in the PACE program.

Mr. MCCRERY. But basically, these folks entering the PACE program are low-income folks?

Mr. VLADECK. Well, they may not have been low-income previously, but generally——

Mr. MCCRERY. They are either low-income or low-asset?

Mr. VLADECK. They establish eligibility for long-term care. They are not particularly affluent folks, I believe because the more affluent potential users of long-term care service probably are purchasing some mix of other services privately before they get to that.

Mr. MCCRERY. But for a SHMO, anybody can step up and pay the premium and enroll.

Mr. VLADECK. That is correct. And the great, overwhelming majority of SHMO enrollees are not Medicaid-eligible.

Mr. MCCRERY. Thank you.

Chairman THOMAS. Just let me follow on that point to pick up the jab that the gentleman from Washington placed. I appreciate your unwillingness to respond in the way that he wanted you to respond, because I do think that it is an unfair statement.

My concern is that when you take the definitional differences between the PACE program, which will make sense if you have an identified population and you focus your needs on that identified population, my understanding is—and we will find out more from the PACE people—that the cost increases per year are significantly lower than the average Medicare increase. In fact, they are taking care of an identified at-need population, on average, at less of a cost than Medicare in general, which tells me they are doing something good with the program.

But the one that seems to be even more expandable would be the SHMO, because all it does is take an HMO and say if you allow us to ignore certain rules that others have to follow: The 50/50 mix; we get 100 percent rather than the 95 percent with an adjustment. We will add a long-term component to paid prescription and vision, which seems to be a key component structure, and that we will, therefore, offer our services in this area.

One of the things that our colleagues in the minority tried to do was pull out of the AAPCC even for the coordinated care programs, the GME costs. And what we have done, of course, is set up a separate trust fund to get out of trying to pull it out of Medicare, which I think is a far preferable way of dealing with the question of GME, so that you would preserve it at 100 percent of the AAPCC.

I guess my concerns are, are we not getting the message that maybe some of the rules that we have for ordinary Medicare Programs, HMOs and others, probably should be removed like the 50/50 mix and others rather than just providing them for these people who say they are going to take an integrated long-term care approach? Because if we do that, then I think you are going to see even more innovation in the kinds of programs that you offer, and that if you let the market have some influence on it, there will be some that gravitate toward the SHMO model. Others will have modified adjustments to it and then will get that real-world experi-

ence on differing offerings as to how much some folks want, and they could even move between an HMO or a SHMO, moving into more, then, of a PACE kind of a program, and it is that broad option structure that I think will give us the best test environment for what works and does not work, limited only by the dollar amount available for the overall program. Is that——

Mr. VLADECK. Well, I think, as I said earlier, Mr. Thomas, I think that is right. I think the future of SHMOs lies in changes to the underlying legislation affecting Medicare and managed care, and I think under the President's proposal, in fact, it would be possible for many HMOs and other new kinds of plans to offer essentially the SHMO benefit package as one of a number of separately priced supplemental benefit packages. I think the future is in that direction. And I do not think now is the time to talk about the comparisons between the structure of choice in the various proposals, but I think it is not at all inconsistent with what the administration has proposed, let alone what others have proposed as well.

Chairman THOMAS. And I started out by asking the question where do we get the savings if there are any? Is it integration, or is it the multidisciplinary approach? Fairly obviously, with an HMO, there tends to be by definition a multidisciplinary approach in the managed structure. What concerns me is that I think where the savings are going to tend to come from is an elimination of what I consider to be more and more needless bureaucratic hurdles in the utilization of the various services in the old-fashioned fee-for-service that you have eliminated by waiver in the SHMO program, that probably should be eliminated all together. I am looking forward to trying to find some evidence that perhaps the ability to utilize, even in fee-for-service, some removal of barriers for use in a timely fashion for intervention and then pulling out might not save money all across the board for the Medicare Program.

Mr. VLADECK. Well, let me just suggest that the evaluations suggest that even with full capitation, the amount of integration that actually occurs and the amount of multidisciplinary integration in particular across service integration that has occurred in the SHMOs, has been highly variable and not something that occurs automatically by virtue of the financing mechanism.

Chairman THOMAS. Nor do we have a good grasp, as Dr. Wiener and others have indicated, as to whether we are robbing the chronic to pay the acute, or robbing the acute to pay the chronic the way the mix is structured. But frankly, that is less important to me, and it is inside the black box if we can get an overall program that meets a dollar amount regardless of which side the money is going on. If you are getting a product coming out that people like, and they can use, and it is not costing us any more, I think from a quality point of view, you have got to say it is a better program

Thank you very much, Dr. Vladeck. One moment. The gentlewoman from Connecticut has some more questions.

Mrs. JOHNSON. I didn't quite understand your answer to an earlier question. What assumptions did you use in estimating the 3-, 4-, 5-, 6-year money available for Medicare/Medicaid eligible patients under a block grant? You said there would not be sufficient money. What were your growth rate estimate assumptions?

Mr. VLADECK. I am trying to reconstruct this. Those are using CBO baseline estimates on growth in medical costs and growth in Medicaid enrollees.

Mrs. JOHNSON. And those are without reform, correct?

Mr. VLADECK. Well, those are the baseline.

Mrs. JOHNSON. Right; so current CBO estimates are based on the current growth rate in Medicare, which is 10 percent; the current growth rate in Medicaid, which is 12 percent. And without reform, those rates of growth are likely to continue, and the money would run out. With reform, bringing rates of growth down to 7 percent or so in both of those programs would, of course, extend the adequacy of the money. Is that not so?

Mr. VLADECK. Mrs. Johnson, I believe—and I may stand corrected—but I believe on a per capita basis, the current Medicaid baseline both from CBO and from OMB is below 7 percent over the next 6 or 7 years on a per capita basis.

Mrs. JOHNSON. I would be interested in some documentation on that.

Mr. VLADECK. We will provide that.

[The information was not available at the time of printing.]

Mrs. JOHNSON. Thank you.

Chairman THOMAS. Thank you very much, Dr. Vladeck.

Mr. VLADECK. Thank you.

Chairman THOMAS. I look forward to working with you on legislation.

Mr. VLADECK. It will be an interesting change of pace.

Chairman THOMAS. Next panel, please: Jennie Chin Hansen, executive director of On Lok, Inc., San Francisco; Dr. Robert M. McCann, medical director, geriatrics and Independent Living for Seniors, Rochester General Hospital; Sam L. Ervin, president and chief executive officer of SCAN Health Plan/Long Beach; and Rosalie DiPietro, who is a subscriber to Elderplan in Brooklyn, New York.

Having read the testimony, I think it will make more sense for the witnesses to present their testimony in the order that I will call you rather than the order that you are sitting. So Ms. Hansen, if you will address us, any written testimony you may have will be made a part of the record, and you have 5 minutes or so to inform us what you think we need to know about your program. And I would caution to all of you that these microphones are very unidirectional, so you need to have it right in front of you.

Thank you very much.

STATEMENT OF JENNIE CHIN HANSEN, EXECUTIVE DIRECTOR, ON LOK, INC., SAN FRANCISCO, CALIFORNIA

Ms. HANSEN. Thank you, Mr. Chairman as well as Members of the Subcommittee. I am accompanied by Judy Baskins, who is the president of the National PACE Association right behind me, who is also the project director of Palmetto Senior Care, which is the PACE project in Columbia, South Carolina. I am also accompanied by Dr. Chris VanReenen, who sits behind me, and is the executive director of the National PACE Association. And beside me, of course, you will be hearing from Dr. Bob McCann, who is the medi-

cal director of our Rochester, New York project, Independent Living for Seniors.

I would really appreciate the opportunity to comment on a program that has drawn so much response. Having been at On Lok now for my 16th year, it is very satisfying to see the evolution of this unique program much more mainstream. I represent not only On Lok but frankly, the other 10 projects that Dr. Vladeck mentioned which are also operating under full risk and the waivers that span from California to Colorado, Massachusetts, New York, Oregon, South Carolina and Texas as well as Wisconsin. And finally, as you have heard, there are other programs that are greatly interested in this approach that are in the states of Florida, Georgia, Illinois, Maryland, Virginia and Washington. The attachment that you have indicates that besides the 10 projects that are under full waivers, there are actually 59 projects spanning close to 30 states that are interested in this model.

Since 1973, On Lok had started with what was known to be a day program but really has evolved to a whole system of care that integrates acute and long-term care services for adults. And it was in 1986 that Congress authorized a demonstration to continue to test this pilot to see whether or not it could be replicated in other states around the country. And as you have heard, that, in fact, has occurred. There are probably five key elements of the model that I would like to address, some of which were asked in the questions here.

First and foremost, this is unabashedly a targeted program for who are frail elderly people. People qualify for this program as a result of the respective states' approach to certifying them for nursing home care. One question was whether or not this was strictly for the Medicaid population, and the answer is no. Nursing homes oftentimes a U.S. Senator from the State of tend to service low-income, Medicaid individuals, but we all have private-pay individuals in our programs.

Second, the programs provide a comprehensive set of benefits that are both acute and long-term care. This covers medical services as well as comprehensive long-term care services, and this is without limits in terms of dollars or duration of service. Third, PACE programs fully integrate the delivery system of acute and long-term care, and one thing that marks this program is not the financing but frankly, the way the services are actually administered by an interdisciplinary team that is familiar with the frailty and multiple problems in a very intimate way and can respond, frankly, on a dime. The ability to really quickly respond to emergencies, even on a Sunday, 7 days a week, these are the ways that you save money.

Fourth, PACE programs are reimbursed on a capitated basis. And what that means is rates are set for Medicare, for Medicaid in a way that addresses savings for the respective parties. Fifth, the programs assume total financial risk, and thereby, there is no incentive to really bump the cost to somebody else. The fact is we provide the services fully ourselves.

Dr. McCann will really give a clearer example of what a typical enrollee is like, but I brought some pictures to give you a sense of some of the people who are enrolled in the On Lok program, which

is not atypical whatsoever to many of the PACE enrollees. I would like to focus on the outcomes that have been key. One of the questions is where does the money savings really come from? In fact, it is really the hospital utilization, the Medicare funding that has really been able to help finance some of the long-term care services. What is significant is the fact that the hospital utilization for this very frail population whose average age is in the eighties with nine medical problems actually is less than the all 65-and-over, enabling tremendous savings.

The rate setting done by Medicare as well as the states also assure a cost savings, and then, that does not speak to the humane and community aspects of helping support families to continue on. Finally, the quality of care issue is always one that needs to be raised and must be raised. We are under the jurisdiction of HCFA and all of our respective state requirements, and in 1993, we were reviewed as a group by the Community Health Accreditation Program and received excellent survey results in terms of quality of care as well as coordination of services. We are most fortunate at this point to be able to get the grant from the Robert Wood Johnson Foundation that will allow us to develop performance standards as well as an accreditation process in this program.

We have been able to receive a great deal of bipartisan support over the years, mainly, I think, because it achieves the agenda of both parties in one sense, one for access and the other one for cost savings. And the 1995 PACE Provider Act introduced by Senators Dole and Inouye will actually allow us to increase the number of PACE providers as well as allow those providers who have performed well to become permanent providers for the future. Otherwise, they will be in demonstration for perpetuity.

It is urgent to expand the program not only because of the need and because of the quick movement of Medicaid and Medicare managed care, but it is important to see that this really does focus on quality of care. And finally, I would just like to say that this whole plan is not at all inconsistent with what the states are asking for—the flexibility. This program is not being legislated or asked to be legislated in a manner that would require states to do. It is strictly voluntary, and that it be one of the options for states. So, I hope that you would find the merit in supporting provisions of Senate bill 990.

Thank you.

[The prepared statement and attachments follow:]

Statement of Jennie Chin Hansen, M.S. R.N.
Executive Director, On Lok, Inc.

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.

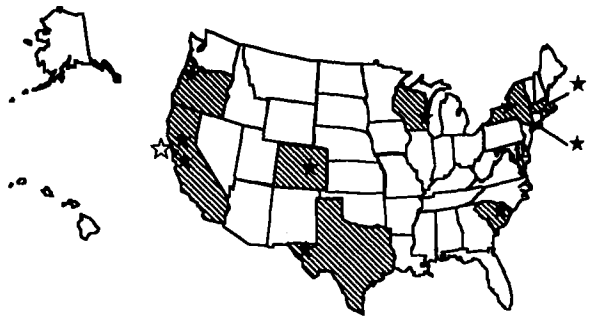
The urgency to expand PACE is generated not just by widespread unmet needs but also by the managed care focus of Medicare and Medicaid reform legislation. Today, PACE is the only managed care program providing services exclusively to enrollees whose health status qualifies them for long-term institutional 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
- Maluhia
  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

Chairman THOMAS. Thank you very much, Ms. Hansen.
Dr. McCann.

STATEMENT OF ROBERT MCCANN, M.D., MEDICAL DIRECTOR, INDEPENDENT LIVING FOR SENIORS, ROCHESTER GENERAL HOSPITAL, ROCHESTER, NEW YORK

Dr. MCCANN. Mr. Chairman and Members of the Committee, it is an honor for me to speak with you today. As Jennie said, I am the medical director of the PACE site in Rochester, New York, Independent Living for Seniors, and we currently serve just under 300 older persons in our community who are very frail.

Jennie has mentioned some of the principles of PACE, and what I would like to do is talk about one of our participants in our program to bring some of these principles to life for you. I have some enlarged photographs of the person, whom we shall call "Mr. B," that you can pass around.

Mr. B was 93 years old when he was admitted to the hospital. He had fallen several times, which led to bleeding inside of his head. After the surgery, he never quite regained his previous cognitive function. He became bedbound and noncommunicative, and he was awaiting placement in a nursing home. I was consulted after he had been in the hospital for 3 months. At that time, the area nursing homes were filled nearly to capacity, and he was a very low priority for admission, as his Medicaid had not been approved, so none of the nursing homes were rolling out the red carpet for him.

At this point, our ILS team set to work with Mr. B to enroll him in our PACE program. Our social worker met with his wife, who also had health problems, and a very supported but exhausted daughter. They were both extremely upset about his present state, but they felt considerable anxiety about bringing him home and handling him at home. So, we met many times with them, brought them to our day center. Our social worker dealt with a lot of different issues and made them comfortable with the team that would be caring for their dad.

Our physical therapists went to their house, did a few environmental things like put a bed downstairs, because their bedroom was upstairs; a commode by the bedside, some very simple things, but some things that could make the difference between staying home and going to a nursing home. It is the simple things often that make the biggest difference, and they are some of the hardest things to do sometimes.

He was discharged from the hospital to his home with a plan that included an aide to get him ready to come to the center, and you can see her getting him ready there in his home. She might go there for one-half hour to 45 minutes a day. Now, if you tried to get an aide in the traditional system to go to someone's house, the agencies in town would say 2 hours, 3 hours, or nothing. So again, we have an incredible incentive to use the people who work for our program most efficiently to give a person what they need but not to make them more functionally dependent.

Our nurses and physical therapists worked with him at the day center to help him learn to walk again, and you can see him walking there independently with his walker. This was a man who, only

a month or so before, was totally bedbound. I started him on an antidepressant, which led to an improvement in his appetite and a little bit of improvement in his cognitive function. Over the next few weeks, he really blossomed. He became one of our most social members in our day center. He continued to be incontinent of urine, but this was managed somewhat by just having him get toileted regularly, again, something that sounds simple but is very hard in reality to carry out sometimes, and to train people to do, particularly in the community.

As an enrollee, he did well for about 3 years, becoming again someone that everyone just fell in love with, and he engaged in a lot of activities, including playing checkers at our center, and he usually lost, but his checkers partner was extremely happy about that. And during these days, he did experience one episode of pneumonia. I remember going in to see him on a Saturday at our day center. For this condition, people would almost certainly go to the hospital. We gave him intravenous antibiotics at the center. I made sure that he kept walking. I made sure that he got proper nutrition and he did not get deconditioned and end up sort of in the same spot he had been a few months or years before.

Eventually, he developed abdominal pain and had a bowel obstruction due to a colon cancer. We brought him to the hospital to have this obstruction relieved and after a few days, brought him back out to his home with extensive home care. His wife and daughter were not comfortable with him dying at home, however, so after about 2 weeks, we brought him to a transitional housing apartment that we rent and staff around the clock with aides and with nurses who can visit and with physicians who will visit to make sure that he is comfortable, and that he dies with dignity and without a lot of pain. And he died very comfortably, with his wife and daughter present.

Now, had he not come into our program, he would have certainly ended up in a nursing home. And besides the excellent care that he got, Medicaid's costs were substantially reduced. Today, the nursing home that we will send people to, the Medicaid daily rate is about $122 per day, and this translates to about $3,700 a month, and our payment is about $2,900 per month. And again, when we look at Medicare costs, we look at the first 350 people who came into our program, and they utilized about 21 hospital days per person per year before coming into the program. And now, they spend about 4 to 4.5 days per year in the hospital. So, this is a substantial savings for Medicare.

And how does this work? How does it end up saving money? Well, the incentives are so different. A lot of times, you will have a patient in the hospital, and maybe the lift did not show up at home to be able to transfer them. Well, people will say, OK, we will send them tomorrow. Well, we say no, get them out of the hospital today; get that lift at home today. Because for me, every day in the hospital is a hearing aid, or every day in the hospital is an upper denture. And again, we have got so many incentives to use the money wisely in a capitated system and we know that the money will be used to go back into the system to provide further care that I think this is the reason why we really save money.

You can think capitated, but being capitated, I believe, really provides incentives to give a person what they need when they need it. We have a very low turnover of staff, including our personal care aides. Now, aides in our community generally turn over in nursing homes; 20 percent to 40 percent will turn over in a year. We have a turnover that is somewhere around 10 to 15 percent. This is because our aides participate in this multidisciplinary team. And again, it makes so much sense but is never done. The people who deliver the most hands-on care are frequently the last people who are normally asked how to improve care. We found out that by integrating them into our teams, not only do we bring them to the highest level of their function, but they work well, and they stay with us.

Thank you.

[The prepared statement follows:]

STATEMENT OF
ROBERT MCCANN, M.D., MEDICAL DIRECTOR,
INDEPENDENT LIVING FOR SENIORS, ROCHESTER, NY

Mr. Chairman and Members of the Committee:

It's an honor for me to speak with you today. I am the medical director of the PACE (Program of All-inclusive Care for the Elderly) site in Rochester, New York called Independent Living for Seniors (ILS). We started our program in 1990 and presently serve 300 frail elderly persons in our community. Jennie Chin Hansen has outlined the principles of PACE, and I would like to spend a few minutes talking about how these principles translate into compassionate, appropriate and cost-effective care for our participants and how a truly multidisciplinary approach to care creates a satisfying experience for families and for our employees.

The best way to bring the PACE philosophy to life for you is to discuss a participant whom we have cared for in our program -- Mr. B was 93 years old when he was admitted to the hospital. He had fallen several times, leading to cerebral bleeding that was surgically drained. After the surgery he never quite regained his previous cognitive function, became bed-bound, non-communicative and was awaiting placement in a nursing home. I was consulted after he had been in the hospital for three months. At that time the area nursing homes were filled nearly to capacity; and he was a low priority, as his Medicaid eligibility had not been approved at the time. At this point our ILS team set to work and Mr. B enrolled in our PACE.

Our social worker met with Mr. B's wife (who also has health problems) and a very supportive but exhausted daughter. Both were extremely upset about his present condition but felt considerable anxiety about being able to handle him at home. Our social worker had them visit ILS' Center and meet with some of ILS' team members so that they felt more comfortable pursuing a plan to discharge Mr. B from the hospital. Our physical therapist assessed the patient and his home, making several environmental recommendations. We arranged to have a hospital bed and commode placed on the main floor of his home, as the bedrooms were up one flight of stairs. Mr. B was discharged from the hospital to his home with a plan that included an aide to get him ready to come to ILS' Center seven days per week and an aide to help him into bed each evening. Our nurses and physical therapists worked with him daily at the Center to help him to learn to walk again and to recondition his muscles that had become very weak from extended bedrest. I started him on an antidepressant which led to an improvement in his appetite and some improvement in his cognitive function.

Over the next few weeks he steadily improved to the point of walking independently with his walker. We also supplied him with a hearing aid, which improved his ability to talk with others. He continued to be incontinent of urine which was managed with a regular schedule of toileting.

As an ILS enrollee, Mr. B did very well for about three years, becoming one of our most sociable participants. His wife was extremely happy to have him at home again. He engaged in many activities at the ILS Center and played checkers (usually losing but making his checker-partner very happy!).

During these three years he experienced an episode of pneumonia that was treated with intravenous antibiotics at the ILS Center along with enhanced help walking to prevent deconditioning, and he did very well. A few months later he developed a bowel obstruction from colon cancer, causing considerable pain. We admitted him for surgery to have the obstruction relieved and discharged him from the hospital to home for comfort care. After two weeks he was moved into our transitional housing apartment for around-the-clock care, as his wife was not comfortable with him dying at home. He died comfortably with his wife and daughter present.

If Mr. B had not had the option of enrolling in the ILS program, he would have eventually been discharged from the hospital three years ago to a nursing home with very little or no prospect of ever returning home. Beyond ILS' ability to enhance Mr. B's quality of life, by preventing nursing home placement, Medicaid's costs were reduced substantially. Today, the Medicaid nursing home rate in Rochester is $122 per day. On a monthly basis, this translates to almost $3,700 in contrast to Medicaid's monthly payment to PACE of $2,900 -- a savings of 20 percent.

This case, which is very typical of ILS' enrollees, illustrates the benefits of comprehensive care aimed towards improving psychological and physical function that maximize a person's independence. Many aspects of this care would have been difficult to provide in the traditional fee-for-service system, particularly the coordination of care within our interdisciplinary team. The continuous process of assessment and care planning that occurs at PACE sites contrasts dramatically with the comparatively intermittent approach to case management in the traditional long-term care system. Our unique financing breaks down the barriers between acute and chronic care and allows us to give participants what they need, when they need it.

Prior to my working in geriatrics I worked in a busy hospital emergency department. Emergency departments provide a unique opportunity to see many of the lesions in our health care system for older persons. The fragmentation of care, overuse of medications and testing, and lack of discussion about end of life decisions can lead to interventions that do not improve, and often adversely affect, a person's quality of life. Working in the PACE program has allowed me to work in a stimulating environment that addresses many of the problems in our current medical system for this population and aligns the incentives towards what people really need and not just what can be billed for.

Our participants and their families have been very happy with their care. A three year study of our program was conducted by the Center for Governmental Research (funded by the John Hartford Foundation, Feb. 1994). This study assessed patient and family satisfaction to be very high.

We have a very low turnover of staff including our personal care aides, which speaks to the satisfaction that our workers experience in working as equal team members with a real ability to be heard and influence the plan of care. This satisfaction can only lead to more efficient and compassionate care that we would want our own family members to experience.

Chairman THOMAS. Thank you very much, Dr. McCann.
Mr. Ervin.

STATEMENT OF SAM ERVIN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, SCAN HEALTH PLAN, LONG BEACH, CALIFORNIA

Mr. ERVIN. Good morning, Mr. Chairman and distinguished Members of the Subcommittee. I am Sam Ervin, president and chief executive officer of SCAN Health Plan, Long Beach, California. We are one of the original Social HMO sites selected by HCFA for the Social HMO demonstration. Directly behind me are representatives of the other two sites: Lucy Nonnenkamp, site director for Kaiser Permanente in Portland, Oregon; Eli Feldman, president of Elderplan, Brooklyn, New York.

I appreciate this opportunity to testify today on behalf of all of the Social HMO sites and to share with you our perspectives on the value of this important demonstration. This is an issue that should touch the heart of everyone in this room, everyone who has a mother and father, grandparents, ourselves as we age: How do we cost effectively enable older people to remain as independent and living in dignity as long as possible?

In the 11 years of operation of the Social HMO, we have served more than 50,000 seniors with this unique marriage of acute and community-based long term care. The program currently serves about 19,000 seniors, 12 percent of whom are classified as nursing home certifiable. This means that almost 2,300 of these members are eligible, based on state Medicaid guidelines, to be placed long term in custodial care.

Mr. Chairman, we are proud to report that we have been successful in meeting our program's goals. This vision of care integration, which was put in place in 1984, has succeeded in keeping over 90 percent of our nursing home-certifiable population in their own homes. That means that over the last 12 years, millions of dollars in state and Federal Medicaid funds were not spent on custodial care. It means that hundreds of seniors without the traditional support of nuclear families have been able to remain financially and physically independent. It also means that hundreds of families have been spared the pain of watching their loved ones placed in institutions for the remainder of their days.

This has been accomplished through the cost-effective application of services such as adult day care, respite care, emergency response, homemaker services, and personal care assistants, all of this coordinated by trained geriatric social workers. And importantly, it has reduced health care costs and improved quality and appropriateness of care.

I would like to share one brief case study, which happens to involve one of SCAN's members. A 73-year-old man became the prime care giver for a wife who developed Alzheimer's disease and for his mother, who was left half-paralyzed by a stroke. On the verge of emotional and physical burnout and severe financial distress in helping to pay for all of this care, they all enrolled in SCAN. SCAN pays $625 a month toward 24-hour, 7-day a week care for his mother and also provided for medical equipment and

railings for her bed. Thus, she was able to stay out of an institution.

SCAN also provided for a large portion of adult day care services for his wife, where she received care from 8 to 5 on weekdays in a specialized program for Alzheimer patients. In addition, SCAN's no-premium program supplies the Van Winkles with an unlimited pharmacy benefit, among other non-Medicare covered benefits and services. There are hundreds of similar stories from Elderplan in Brooklyn, New York; Kaiser Permanente's program in Portland, Oregon. Mr. Chairman, this is a program well worth continuing.

As we work to expand our services, in SCAN's case throughout southern California, we face expiration of the program 20 months from now. We respectfully ask that you consider Congressional action which will ensure continuation of the program. Please consider directing the Secretary of Health and Human Services to develop regulations which grant permanent waiver authority for existing sites and which provide a mechanism for other entities to apply for Federal qualification as a Social HMO. Upon promulgation of the regulations, existing sites would be granted permanent waiver authority if they met the requirements set forth in the legislation. If the Secretary does not promulgate regulations by December 31, 1998, the existing sites would automatically be granted permanent status.

Having submitted more substantive written testimony, I will stop now. I would be happy to take any questions from the Subcommittee.

[The prepared statement follows:]

[The SCAN Health Plan: Analysis of Cost-Saving Potential for the California Medi-Cal Program is being held in the Committee's files.]

TESTIMONY OF SAM ERVIN
PRESIDENT AND CEO, SCAN HEALTH PLAN
before the
HOUSE WAYS & MEANS SUBCOMMITTEE ON HEALTH

April 18, 1996

I. INTRODUCTION

Mr. Chairman and distinguished Members of this Subcommittee, I am Sam Ervin, President & CEO of SCAN Health Plan, one of the original Social Health Maintenance Organization (Social HMO) demonstration sites. I appreciate the opportunity to testify today on behalf of all Social HMO sites and to share with you our perspectives on the value of this important demonstration program.

Mr. Chairman, I am here today not only to provide evidence of the Social HMO's value, but also to urge your serious consideration of making permanent the current waiver authority for the existing sites and to provide a mechanism enabling other organizations to develop similar innovative approaches to integrated care. It seems to me entirely appropriate that the Health Subcommittee is reexamining the Social HMO and PACE demonstrations at a time when health care systems consolidation and integration are at their zenith and when there is so much interest in the concept of Medical Savings Accounts. Medicare and Medicaid restructuring and the development of managed care options for the elderly in many ways have their very origins in the Social HMO demonstration. The Social HMO is among the most successful demonstration programs and has provided approximately 50,000 seniors the opportunity to enroll in a program that covers the provision of home and community-based long-term care services. Upwards of ten years of experience demonstrates that the Social HMOs have proven effective in improving quality and consumer satisfaction while reducing costs and has provided literally thousands of Medicare beneficiaries an alternative to nursing home placement.

I would like to focus my testimony today on four areas of support for the Social HMO program. These include (1) the future of the program; (2) the tremendous benefits these programs offer to senior citizens and their caregivers, and by implication, other chronically-ill populations; (3) the benefits to both consumers and the health system that can be derived from the establishment of integrated systems of care that coordinate the provision of and pool financing for primary, acute and long-term care services; and (4) the cost-savings potential of this model.

II. BACKGROUND

The Social HMO demonstration was authorized under the Deficit Reduction Act of 1984. This purpose of this demonstration was to develop innovative financing and delivery models for integrating acute and long-term care services, and in the process, reduce health care costs and improve quality and appropriateness of care. Since the program's inception, more than 50,000 seniors have been served. The program currently serves approximately 19,500 seniors through three of the four original Social HMO sites.

Four sites initially were selected by the Health Care Financing Administration (HCFA) to participate in this demonstration: Elderplan, Inc. in Brooklyn, New York; Kaiser Permanente Center for Health Research in Portland, Oregon; SCAN Health Plan of Long Beach, California; and HealthPartners (Seniors Plus) of Minneapolis, Minnesota. The original (1984) legislation provided for a three and a half year demonstration which subsequently was extended three times (1987, 1990, and 1993). Current waiver authority is due to expire December 31, 1997. Three of the four sites continue to operate. In addition, the Social HMO I sites were instrumental in gaining the approval of six additional "second generation" sites ("Social HMO II") which are scheduled to become operational next year under authority granted by OBRA 1990. These projects will test variations on the Social HMO I demonstration.

The architects of the Social HMO intended to eliminate many of the problems which continue to plague the traditional fee-for-service system such as fragmentation of service delivery and

financing, duplication of administrative requirements across settings and programs, and conflicting policy directives. These problems are especially pernicious for providers serving the dually eligible population since duplication and fragmentation exists not only across health care settings but between the Medicare and Medicaid programs. Through the consolidation of acute and long-term care service structures and the integration of public and private sector funding streams, the Social HMO designers intended to achieve five key goals:

- producing Medicare and Medicaid cost-savings -- which could be used to increase service capacity in a budget neutral fashion -- through operational efficiencies, the provision of more appropriate levels of care and the downward substitution of lower-cost services;

- integrating the full range of acute and community-based long-term care services and providers to expand the continuum, more closely parallelling the needs of our aging Medicare population;

- consolidating services and professionals to enhance coordination of services and to generate norms of practice in caring for the frail elderly which would be applied uniformly across the spectrum of providers/settings;

- enrolling a cross-section of well and frail elderly to create an insurance risk pool for spreading the costs of care and reducing the burden on any one individual; and

- pooling funding sources for the dually eligible to eliminate barriers to effective clinical decision making -- such as the 3 day prior hospitalization requirement for Medicare SNF eligibility -- and allow providers to allocate resources based on individual enrollee needs.

The Social HMO sites have effectively implemented many of these goals to date. The remainder of my testimony will enumerate our successes in the areas of consumer satisfaction, cost-savings potential, and health systems benefits.

III. BENEFITS OF THE SOCIAL HMO

A. Consumer Benefits

Close to 60% of the 85 plus population are disabled and likely to need some type of support or assistance with activities of daily living. For those living in the community, nearly 90% receive assistance from relatives and friends. The majority of unpaid caregivers are women relatives, typically wives, daughters or daughters-in-law. Family support systems are often weak or non-existent, however, leaving those in need of assistance with daily living activities with no one to turn to for assistance. The frail elderly living alone, which account for almost 30% of the over 65 population, and higher for those 85 plus, are particularly vulnerable for institutionalization since often they don't have access to adequate informal support. Where family caregivers are available, they experience exhaustion from their enormous responsibilities and desperately need respite to be able to continue.

The burden of providing continuous care for an elderly relative can take a tremendous physical, emotional and financial toll on informal caregivers. Three significant problems faced by informal caregivers include the fragmentation of our current health and long-term care systems, the absence of financial support for long-term care services and the paucity of assistance available to negotiate the complex web of services frequently needed by a person with multiple disabling conditions. Further, despite older consumers' strongly stated preferences to remain in the community and receive care at home, and because our current reimbursement system is biased toward institutional services, older consumers frequently are forced to enter nursing homes in order to receive care. This payment bias needlessly increases overall health systems costs.

Demographic trends suggest that these and other challenges facing health care consumers, providers and policymakers will continue to escalate as we enter the 21st century. The

continued geometric growth of the over 65 population in general, and the over 85 population in particular, will severely tax public and private sector resources. The over 85 population, which account for the highest utilization rates for services associated with multiple chronic disabling conditions, will increase by 150% between 1990 and 2030. A number of demographic trends impede the ability of family members to provide adequate support for their aging parents such as the decrease in family size and the diminished supply of labor to provide support functions; the increase in the number of women entering the work force; adult children's conflicting loyalties between aging parents and their own children; and greater mobility of the working population.

The Social HMO has helped thousands of older persons and their families resolve these dilemmas by providing comprehensive coordination of all health and related services. We are particularly proud that this program has kept thousands of older persons out of nursing homes through community-based services designed to maximize their functional abilities and independence. Since the Social HMO's inception, we collectively have served approximately 50,000 individuals, roughly 12% of whom were classified as "nursing home certifiable." Between 90 to 95% of these members have avoided institutionalization at a cost savings of literally millions of dollars to the Federal and state governments. Below are a few "success" stories associated with the Social HMO program.

Case Study 1

Romilda is an Elderplan member who experienced difficulties in getting to the doctors' office for follow-up treatment after undergoing total knee replacement surgery. To accommodate her needs, Romilda's physician volunteered to make house calls and Elderplan's home health nurse and physical therapist worked with her in her home until she regained use of the new knee. Following rehabilitation, Elderplan continued to coordinate Romilda's transportation to medical appointments and provide in-home personal care services 12 hours per week. This combination of services prevented her from entering a nursing home and helped her to maintain her independence.

Case Study 2

Gladys lived an extremely active life until age 86 when she was diagnosed with cancer. Although she initially recovered from cancer treatment, she became increasingly frail and forgetful and eventually was unable to continue living alone. Her granddaughter Lynn was considering leaving her job to care for Gladys when she discovered Kaiser Permanente's Social HMO. Kaiser initially provided adult day care services for Gladys twice weekly, provided homemaker services and installed an electronic response system, paying for 90% of related costs. Eventually, expanded care services were changed to adult day care five days per week at a foster home near Lynn's house and respite care to relieve Lynn of caretaking responsibilities periodically. Gladys was able to remain independent with Kaiser's support until she passed away, never being forced to leave Lynn's home and Lynn was able to maintain her employment.

Case Study 3

At age 73, Floyd became the primary caregiver for a wife who developed Alzheimer's Disease and a mother who was left half paralyzed by a stoke. Floyd was on the verge of emotional and physical burn out and severe financial distress in helping to pay for his wife and mother's care when he discovered the Social HMO and SCAN. The plan paid $625 per month towards a 24 hour per day, seven day per week live-in assistant for his mother, and also provided for medial equipment such as a wheel chair and railings for her bed. SCAN also paid for a large portion of adult day care services for his wife where she received care from 8 Am to 5 PM on weekdays by professional caregivers trained in the care of Alzheimer's patients. The support provided by SCAN prevented Floyd from having to institutionalize both his wife and mother.

B. Cost Savings Potential

Social HMO services are financed on a prepaid capitated basis. Benefits may be paid for in three ways: (1) Medicare only; (2) Medicare and private premiums; or (3) Medicare and

Medicaid contributions. Differences in funding streams affect the relative size of the contribution to care. For example, SCAN contributes approximately $625 per month toward the cost of home and community-based services to the first two subscriber groups, but up to $1,000 per month for the dually eligible since SCAN also receives a capitation payment from Medicaid for this population. The enhanced package of services received by enrollees are provided in a budget neutral fashion. Social HMOs are paid, on average, 100% of the average adjusted per capita cost (AAPCC) of serving beneficiaries in their counties. Actual payment amounts are adjusted to account for the functional status of individual beneficiaries, as discussed under our recommendations in Section IV of my testimony.

Neither the Social HMO nor HCFA has conducted a comprehensive study of the cost-savings potential of this model. There are a number of built-in mechanisms to reduce or minimize health care expenditures, however, which we believe have substantially reduced system costs. Further, the Kaiser Permanente Center for Health Research conducted a study focusing on nursing home use between 1986 and 1988 which revealed substantial savings under this model. Data collected by the Social HMO Consortium reveal that the average spending for long-term care services plus the service coordination function averaged $38 per member per month across all four sites in 1990. This amount was equivalent to about 11% of Medicare's per capita payment to plans that year. There are several ways in which the Social HMOs have been able to hold down costs. Part of the cost-savings are achieved through the structure of the benefit. The Social HMO benefit package does not include unlimited long-term care services, but caps annual expenditures at between $7,500 and $12,000, depending on the site. In addition, the model includes a 14 to 30 day limit on non-Medicare nursing home care per spell of illness, consistent with the nature of the nursing home benefit which is used as a supplement to the community-based service benefit to pay for short-term respite stays, convalescence after Medicare nursing home coverage expires, or to cover the first portion of a permanent admission.

Data reveal that this per spell of illness limit has not placed a severe burden on enrollees. Of all Social HMO members using the long-term care benefit during a four year study period, less than 25% were authorized for care that exceeded 85% of the cap. Further, authorization for care does not automatically translate into the use of services. We attribute the efficient use of the long-term care benefit to our highly effective care management system which continuously monitors the health status of those at risk for nursing home placement, coordinates informal support services with those of paid services and maximizes the use of the Medicare skilled benefit which is otherwise available to Social HMO members.

Data produced by the Kaiser Permanente study reveal the cost savings potential of this model. This study compared the experiences of members enrolled in Kaiser Permanente's standard Medicare HMO and the Social HMO. During the study period, the Social HMO offered 100 days of ICF or SNF coverage per benefit period as well as up to $1,000 per month in services delivered in their home or community-based settings. Member copays were 10% for institutional and home care services. The benefits were managed by a service coordination unit that worked closely with hospital discharge planners, nursing home staff and home health care nurses to ensure appropriate and coordinated use of services. A major goal of members, their families and service coordinators was to avoid unnecessary institutionalization and to maximize independent functioning of members. Regular HMO members (i.e., those not enrolled in the Social HMO) received only Medicare-covered nursing home and home health care benefit.

The Kaiser Permenante study revealed many positive effects from the Social HMO benefit structure and service system. For example:

- short-term nursing home benefits reduced barriers to nursing home use for recuperative, respite and rehabilitative stays;
- home care benefits reduced nursing home lengths of stay by supporting more effective transitions back to the community;
- Medicaid expenditures resulting from "spend-down" were reduced by over 50% and these savings offset the higher AAPCC rate paid to Social HMOs by almost half;

- members received access to a coordinated package of chronic care services and a supplemental long-term care benefit which significantly reduced the out-of-pocket costs they otherwise would have incurred without access to the long-term care benefit.

The Kaiser Permanente study showed that, compared to the regular HMO programs, Social HMO members were more likely to enter a nursing home but less likely to stay as many days. Social HMO members had 25% higher admission rates but they spent 29% fewer days in ICFs and 24% fewer days in nursing homes overall. These patterns suggest that the Social HMO long-term care management and benefit systems reduce barriers to nursing home entry for short-term and recuperative stays and helped members return home more often and sooner.

The study also revealed that Social HMO reduced Medicaid spending on nursing home care. Since less than 1% of these members were categorically eligible for Medicaid, almost all of the savings were due to delaying or avoiding Medicaid spend-down. Medicaid spending for ICF and SNF care for regular HMO members was about $212 per member per month compared to about $80 per month for Social HMO members. Over the 24 month study period, the Social HMO saved Medicaid an average of about $5.50 per member per month which is equal to about 2.2% of the average Medicare capitation rate during the study period. Accordingly, although Medicare pays Social HMOs an average of 5% more than standard HMOs (i.e., 100% of the AAPCC vs 95% of the AAPCC), almost half of this additional reimbursement is offset through Medicaid savings.

Social HMOs also have developed a number of innovative approaches to further extend the formal services financed through Medicare, Medicaid and private insurance. I'd like to highlight an example of one such approach undertaken by Elderplan called the "Member-to-Member" program which operates as a Service Credit Bank. This program was established to help extend the formal chronic care benefit offered by the Social HMO. In this program, member-volunteers provide informal supportive services to member-recipients. These services fall into the general categories of escort, shopping, transportation, respite, friendly visiting, telephone reassurance, hospital/nursing home visiting, minor home repairs and peer counseling.

Service Credit Banking is an exciting new approach to mutual aid. It is based upon volunteers earning and spending Service Credits. Service Credits are a local, tax-exempt, computerized currency that utilizes time as the medium of exchange. Service Credits enable an individual to convert personal time into additional purchasing power by providing service to others. With this model, it is possible to generate large amounts of service without payment in money and, therefore, to operate a social service barter system on a scale much larger than ever before. Since the program's inception in June 1987, the Member-to-Member program has provided over 56,500 hours of service to almost 3,000 service recipients through the voluntary efforts of 238 volunteers. To provide some sense of the economic value of these services, in 1995 alone, this volunteer program delivered $161,701 worth of preventive and supportive services at a cost of about $74,000.

C. Health System Benefits

Chronic care represents the fastest-growing and highest cost segment of the health care sector. Our system is quickly moving from a predominance of short-term, cure-oriented conditions to a predominance of conditions that require ongoing, multidimensional and coordinated care. Eighty percent of all deaths and 90 percent of all morbidity are due to chronic conditions. Health care costs for the chronically ill only can continue to grow as the over 85 age group increases and the incidence of heart disease, strokes, respiratory disease, dementia and other chronic conditions expand as well.

To effectively meet the needs of this population, and reign in health systems costs, our health care system must recognize the critical importance of the linkage between acute and long-term care services. National studies as well as data collected by the Social HMOs reveal that almost all long-term care needs originate from acute care illness. Accordingly, efforts to

reduce the explosion of costs to the Federal and state governments and consumers for long-term care services must begin with the establishment of strong linkages between the acute and long-term care service sectors.

Social HMOs, which operate under TEFRA risk contracts, offer Medicare beneficiaries a voluntary choice. Those selecting the Social HMO option receive an enhanced package of Medicare services. In addition to all Medicare Part A and B services, coverage includes pharmacy benefits, hearing aides, eyeglasses, and up to $1,000 per month and home and community-based long-term care services. This enhanced package of services received by enrollees are provided in a budget neutral fashion. The home and community-based services benefits are critical to helping subscribers avoid institutionalization and maximizing their independent functioning. Among the services offered are the following:

Case Management: Geriatric resource managers review each senior's medical needs and determine the long-term benefit package best suited to the individual. Progress is monitored on a regular, ongoing basis. Individuals who become "nursing home certifiable" (NHC) and, therefore, eligible for the community-based long-term care benefit, receive quarterly assessments to determine their ongoing need for long-term care services.

Personal Care Assistance: Personal care aides attend to many basic health needs related to activities of daily living (ADLs) such as bathing, toileting and dressing, to help seniors remain in the community and as independent as possible. These services are made available around-the-clock, if necessary.

Homemaker Services: These services include coverage of home chores such as laundry, cleaning, cooking and shopping, to further enhance an individual's ability to remain independent and in their own homes.

Respite care: This benefit is intended to help relieve the burden of caregivers -- generally spouses and family members --who provide an average of 92 hours a week of their time for their fragile loved ones. Respite care may involve adult day care, overnight or weekend stays at hospitals or nursing homes or other relief.

Transportation for Medical Visits: Wheel chair, van and taxi services are provided to seniors to help assure access to health care services, such as physician office visits.

Adult Day Care: This service provides for a professionally staffed facility where seniors can remain safe and participate in social and medical activities during business hours, evenings or weekends.

Nursing Home Care: The Social HMO benefit provides for short-term nursing home stays of 14-30 days per spell of illness for additional rehabilitation or respite care which supports a home care plan.

Personal Emergency Response Systems: The Social HMO provides members a wireless electronic monitor which is worn around the neck and can be activated in the case of an emergency such as a fall. Members and their families gain a sense of security provided by this around-the-clock medical and emergency assistance benefit.

The Social HMO demonstrations have revealed a number of important linkages between these two systems and opportunities for cost-savings potential. One of the most important linkages relates to the identification of potentially disabling conditions and the development of treatment regimens to prevent or delay disabilities. Data from the Social HMO reveal that 60 to 70 percent of referrals to community-based LTC services come from the acute care system, including hospital discharge planners, utilization review staff, physician offices, etc. In many cases, individuals being referred only need short-term or mid-term rehabilitation service, not long-term custodial care. It is critical that acute and long-term care providers work together to identify patients' needs and develop appropriate treatment protocols and monitoring systems.

Social HMO data reveal that less than half of their enrollees assessed as nursing home certifiable (NHC) at any time remain consistently in this category for more than one year and

many become fully independent following rehabilitation. Further, the Social HMOs have identified several factors which predict whether a patient is likely to remain nursing home certifiable and eligible for long-term care services over the long-run, or to regain functional ability and discontinue long-term care service utilization. For example, predictors of moving from the NHC category include recent hospitalization, female gender, heart conditions and recent fracture or injury. Predictors of remaining NHC include higher age, becoming NHC soon after enrollment, having higher numbers of ADL impairments and higher income. The Social HMOs continuously monitor the health status of those who are at risk of becoming NHC or who are assessed as NHC to assure appropriate interventions. For those who are at risk, preventive measures are implemented to reduce the likelihood of progressive disability. For those who are certified as NHC, quarterly reassessments are performed to evaluate the effectiveness of the treatment regimens. Once an individual has regained functional independence, the long-term care benefit is discontinued and these resources can be directed to individuals in the system in need of these services.

Social HMOs include the type of effective geriatric assessment system which enables providers to (1) identify those at risk for disability and costly long-term care services; (2) develop appropriate interventions before the disabilities progress beyond the point of rehabilitation; and (3) establish a monitoring system for reassessing individuals' ongoing needs for services. A study published last year in The New England Journal of Medicine revealed that such assessments can delay the development of disability and reduce permanent nursing home stays among elderly persons living at home. This study examined the impact of an annual in-home comprehensive geriatric assessments and follow-up for individuals 75 and older. After three years of intervention, 22 percent of the survivors in the control group required assistance in performing the basic activities of daily living while only 12% of the survivors in the intervention group required such assistance. In addition, there were only one-sixth as many nursing home days for the intervention group. About 10 percent of those in the control group were permanently admitted to a nursing home compared to 4% of the intervention group. The study suggests that the prevention of decline in functional status was at least partially responsible for the reduction in nursing home admissions.

Although The New England Journal study did not include an analysis of the cost-savings potential of the geriatric assessment intervention program, certain assumptions can be made from the data provided. For example, during the second and third years of the study, there were significantly more physician visits among the intervention group than the control group. The cost of intervention for each year of disability-free life gained was about $6,000. This is approximately one sixth of the average cost of a year in a nursing home.

IV. SHMO CONSORTIUM RECOMMENDATIONS

As I indicated at the outset of my testimony, the waiver authority under which the Social HMOs operate will expire at the end of next year if no further action is taken. On behalf of the existing sites and members, we urgently request your intervention in granting permanent waiver authority to existing sites and making this valuable program available to other sponsors and subscribers. While the waiver authority is not due to expire until 1997, immediate action is imperative to protect the almost 20,000 senior citizens currently receiving Social HMO benefits. If the authority is not granted this year, the existing sites will have no choice but to begin to plan phasing down of operations in order to provide for an orderly transition from the Social HMO to an alternate health plan.

Immediate action also is needed to protect the integrity of the Social HMO II sites whose waiver authority also is due to expire in December of 1997. As you know, six additional sites are scheduled to begin operations this year under authority granted by OBRA 1990. Both HCFA and the sites have invested considerable time and resources in developing the framework for the next generation of this model. Without the extension, these sites would be fully operational for one year at most. I think you would agree that a one year demonstration would not provide HCFA a reliable basis for evaluation sites' abilities to achieve the second generation demonstration goals. We believe the organizational and financial commitment required warrants a minimum demonstration period of three to five years.

To accommodate both current and future subscribers and sponsors, we respectfully request that:

- Congress direct the Secretary of Health and Human Services to develop regulations which grant permanent waiver authority for existing sites and which provide a mechanism for other entities to apply for Federal qualification as a Social HMO;

- Congress provide legislative authority to continue the Social HMO I and II programs until such time as the Secretary of HHS has promulgated such regulations;

- Upon promulgation of regulations, existing sites shall be granted permanent waiver authority if they meet the standards set forth in the legislation (and described below). If the Secretary does not promulgate regulations by December 31, 1998, the existing sites shall automatically be granted permanent status.

We also request that Congress direct the Secretary to immediately make several modifications to the current waiver authority, as enumerated below, to allow current sites to operate more consistently with all TEFRA HMOs. Below is a description of our proposed modifications as well as recommendations regarding the standards organizations would be required to meet for qualification as a Social HMO.

Modifications to Current Waiver Authority

The Social HMO waivers currently provide for the following:

- payment at 100% of the AAPCC;

- the option to queue applicants according to disability;

- waiver of the 50/50 requirement that limits enrollment of the Medicare and Medicaid populations to 50% and requires that 50% of the membership be composed of commercially insured beneficiaries;

- waiver of the 3-day prior hospitalization requirement for SNF coverage.

We recommend and request several immediate changes to our waiver authority to allow the current demonstrations to operate in a manner more consistent with all TEFRA HMOs and to permit Social HMOs to be more competitive with TEFRA plans:

- eliminate any enrollment ceiling;

- eliminate the existing prohibition against enrolling nursing home residents;

- make regulations regarding marketing and evidence of coverage consistent with other plans.

Medicare Standards for Social HMOs

Social HMOs currently provide an enhanced package of primary, acute and home and community-based long-term care services to Medicare beneficiaries. We recommend that plans applying for Federal certification as a Social HMO under an expanded Medicare managed care program comply with several standards distinct from standard Medicare HMO risk contracts to ensure consistency with the current program. These standards pertain to benefits, case management functions and payment rules.

Benefit Standards

In addition to the Medicare benefits required under MedicarePlus, Social HMOs would offer the following benefits:

- Coverage of prescription drugs, eyeglasses and hearing aides.

- Home and community-based service benefits of at least $7,500 per member per year (exclusive of member copayments). Services would include personal care, homemakers, respite, medical transportation and adult day health care. Eligibility for services would be defined by the Secretary and include those who meet nursing facility admission standards and others at high risk for adverse long-term care outcomes.

- A minimum of 14 days per spell of illness $7,500 per lifetime of nursing facility care for stays that do not meet Medicare skilled criteria. (New spells of illness are defined as those beginning after 60 days of continuous community residence.

Case Management Standards

As indicated earlier in my testimony, the case management function has been critical to the success of the Social HMOs, from a cost-savings, quality and consumer satisfaction perspective. We recommend, therefore, that to qualify as a Social HMO, sites be required to provide comprehensive post-acute and long-term care case management services, including the following:

- initial and periodic screening of the enrolled population through a self-report health status form designed to identify members who meet nursing home admission standards, or who are otherwise at risk due to medical or functional difficulties;

- referral mechanisms that identify newly disabled and at risk members in acute care settings and through self-referral;

- comprehensive functional and social assessments;

- care planning, service authorization, and monitoring systems that ensure attention to member and family preferences and participation in decisions;

- linkages with acute care providers in hospitals, nursing homes, home health, physicians' offices and other settings to ensure timely sharing of appropriate clinical information, assignment of responsibility and coordination of care plans and covered benefits;

- a quality assurance system that integrates quality assurance activities for acute and long-term care services.

Payment Standards

We recommend that Social HMOs continue to receive reimbursement according to the current payment methodology. There are two important differences in the way Social HMOs and TEFRA HMOs are reimbursed. First, Social HMOs receive 100% of the AAPCC instead of 95% to account for the additional chronic care benefits provided. Second, while the only risk-adjustor used by the TEFRA plans to reflect health status is an institutional rate cell for those placed in nursing homes, the 1984 waiver language for Social HMOs specified payment at a higher rate for community-based residents who are "at risk of institutionalization."

Between 1985 and 1994, the AAPCC institutional cells were applied to both nursing home residents and "at risk" community residents. In 1995, a new formula was implemented based on updated research. This formula pays somewhat higher rates for those at risk of institutionalization than nursing home residents. Both the old and new formulas adjust the payment cells for members not meeting high risk criteria to keep the whole formula budget neutral. Accordingly, while Social HMOs are paid 100% of the AAPCC, on average, their actual reimbursement depends on the mix of well and frail or high-risk enrollees.

Mr. Chairman, I have tried to impart to you and Members of the Subcommittee the compelling nature of this HCFA program success which has proved to be a tremendous win/win for seniors and government, both federal and state. It is hard to paint a compelling picture in words about a faceless senior citizen whose dignity and dwindling independence has been buoyed by the application of the Social HMO program. But the essential morals and messages of the story are easy to tell:

- The Social HMO is a program that really works by allocating monies in the most cost efficient and beneficiary effective manner possible;
- The cost savings to the Medicare and Medicaid programs are just beginning to be quantified and understood;
- It is the type of government sponsored program which offers seniors significant choice in controlling their lives, offers health program planners the most cost effective approach to date in dealing with the fast growing frail population, and offers support and encouragement to families as they carry out their care giver roles; and
- Provides a care paradigm applicable to other costly home-bound and medically needy populations.

Mr. Chairman, this program is one that warrants you attention and support. We sincerely hope that you will consider the SHMO Consortium recommendations outline in Section IV of this testimony and help to make this cost effective care program available to thousands more seniors in the years to come.

Chairman THOMAS. Thank you, Mr. Ervin.

We have saved the best until last. Although we have heard some second-hand examples of case studies, we now have Ms. Rosalie DiPietro, who is a subscriber to Elderplan, and she is going to give us a firsthand statement about the program.

Ms. DiPietro.

STATEMENT OF ROSALIE DIPIETRO, SUBSCRIBER, MEMBER SERVICES, ELDERPLAN, INC., BROOKLYN, NEW YORK

Ms. DIPIETRO. Good morning. Thank you for inviting me to participate in today's hearing. I appreciate that you want to hear directly from a consumer about what this Social HMO means for Medicare beneficiaries. I am very concerned at the possibility that I could lose my health insurance coverage through Elderplan and have to find a whole new plan. This is why I agreed to come to Washington today.

From my personal experience, I think the Social HMO is excellent. I have had very good health care when I needed it and no paperwork. Most important, I have peace of mind about my doctors, hospital care and being able to manage my expenses, because I know that I will not be faced with deductibles or large copayments.

I have lived in Brooklyn, New York, all of my life. I own my own home, which I share with my daughter and her husband. I have six grandchildren and two great-grandchildren. I have been a widow for 43 years. I went to work after my husband died because I wanted to give my three young children a better living, what my husband would have wanted for them. I was employed at the bank for 30 years, and I held a second job in the evening for 20 years because I wanted to be sure that my grandchildren would have the best.

After working hard for many years, I retired at the age of 62. At the time, I had health insurance from my employer. I used it for several years, but I was not satisfied. There were many copayments, and I never knew how much I would have to spend if I became ill. How could I manage my expenses this way?

I decided to enroll in Elderplan in 1988. That was 8 years ago, and I have been very satisfied. I know what my health care will cost me, and I do not have to worry about anything. I keep up my Medicare part A and B, and I do not mind small copayments I pay for some services. For example, today, I am using glasses that I got from Elderplan. They are not fancy. They do the job, and for me, this is what I want.

For most of the time that I have belonged to Elderplan, I was very healthy. I went to the doctor once a year for a checkup, had my annual mammogram, and that was about it. And this fall, I really needed Elderplan. And if I had not received the right medical care and help while I was recuperating, I might not have been able to come here today to be part of this Congressional hearing.

My problems began 1 day last September when I was carrying a basket of laundry downstairs to the basement to do the wash. I fell and hurt my foot. At first, I just thought it was bruised. When the swelling did not go down, I called my doctor. He sent me for x rays and showed me a break. I was taken to the orthopedist immediately. I went home with my foot in a cast for 6 weeks. When

the time came, the cast was removed. Then, I used a special shoe and stocking until everything was healed. I did not have to spend a penny.

That was just the beginning. Just a few weeks after the cast came off, I broke my hip. One afternoon, I was walking along the sidewalk to see my neighbor, and a young dog came running out of his house and knocked me down. I knew something was wrong, because I could not walk. I really needed my health insurance this time. Elderplan was terrific. I received all of the health care and services that I needed. The doctors and hospital staff were excellent. They could not have taken better care of me if I had paid hundreds of dollars in premiums every month.

When I went home, an aide came to help me during the day for about 2 weeks. Later, when I was ready, I got a walker and then a cane. A physical therapist came to my house to show me how to move in the right way. All of this was arranged and paid for by Elderplan. Elderplan has meant a lot to my family, too. My children feel that I was well taken care of. If it had not been for the help I received at home when I broke my hip, my daughter would have had to take off from work. There would not have been any choices for us. I have peace of mind and a financial safety net because Elderplan took care of everything.

Elderplan has been very good to my brother-in-law and sister-in-law, who have been members for years. I see how other people are taken care of when they have heart surgery and other problems, so I know how much a good health plan like Elderplan can do. Now that I am pretty much back to my full activities, I like spending time with my family, and I scour my kitchen every Friday no matter what. Many of the things that keep me busy are connected to Elderplan. Elderplan sponsors quite a few programs about staying healthy. For example, I am in the walking club organized by Elderplan. Twelve of us walk together for about an hour once a week. Also, I am part of the Elderplan volunteer program called Member-to-Member. I usually spend 1 day a week in the office, unless I am taking care of my great-grandchildren. I go to health education programs that Elderplan has for members and the community at no cost to us. I have taken part in meetings, fitness and one on improving your memory, and for the past 2 years, I have been a subscriber representative to the Elderplan Board of Directors, which meets four times a year.

I can tell you that it gave me a great feeling at the meeting 2 weeks ago that we approved adding more benefits to Elderplan so Medicare beneficiaries like me will have many more choices and more control over their health care. Members suggested making changes, and Elderplan listened. One of the biggest changes will be having a budget of $100 a year for every member to use for trips to the doctor or other care. Right now, members who have a medical need can get free transportation from Elderplan. There will be more choices when it comes to selecting eyeglasses, hearing aids and dentures, and women who belong to Elderplan will be able to see their gynecologist and have their annual mammograms without getting referrals in advance from their primary care physicians. These improvements will be terrific.

Now, I never like to tell people what to do. I can only say what I like. I am very happy with Elderplan and very satisfied with the way I have been treated. I definitely believe that Elderplan should continue, because a lot of people will be in trouble without Elderplan and other Social HMOs.

Chairman THOMAS. Thank you very much, Ms. DiPietro.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. I thank the panel for your testimony. It was very interesting.

Ms. DiPietro, what premium do you pay——

Ms. DIPIETRO. Nothing.

Mrs. JOHNSON [continuing]. Per month?

Ms. DIPIETRO. Nothing; Medicare—they take my A and B, and that is it.

Mrs. JOHNSON. I see.

And can anyone else on the panel, maybe Dr. McCann, can you tell me what someone not eligible for Medicaid would pay in premium for the Elderplan program?

Ms. DIPIETRO. It is zero premium.

Ms. RAPHAEL. Yes, it is a zero premium health plan.

Mrs. JOHNSON. Pardon?

Ms. RAPHAEL. It is a zero premium health plan. Members need to maintain Medicare A and B. They do not pay an additional Elderplan premium.

Mrs. JOHNSON. It is a zero premium health plan, and you get a capitated reimbursement from Medicare of 100 percent of the Medicare capitated amount?

Ms. HANSEN. Our capitated amount from Medicare, targeting the frail elderly population that is already certified to be in a nursing home. I think Dr. Vladeck mentioned 2.39 of 95 percent of the AAPCC. That is the Medicare side.

On the Medicaid side, if someone is Medicaid-eligible, the state would pay anywhere from 5 percent to 15 percent, generally, lower than its Medicaid rate for a traditional fee-for-service system expenditures for this same population. From a standpoint of the consumer, if he or she is covered by both Medicare and Medicaid, there is no premium. If a person is middle income, they would pay whatever the same share the Medicaid person would have paid. And there are beginning experiments with long-term care insurers who are willing to start looking at paying some of that premium for someone who will be middle income.

Mr. ERVIN. For the Social HMOs, by the way, the premium at Kaiser is $156 a member month, and at the other two, Elderplan and SCAN, it is zero.

Mrs. JOHNSON. If the Elderplan's cost is zero, are you saying it is zero for those who also do not meet the Medicaid qualifications?

Mr. ERVIN. That is right.

Mrs. JOHNSON. And the reimbursement is 100 percent of the Medicare HMO rate?

Mr. ERVIN. Yes, each Social HMO receives 100 percent of the AAPCC.

Mrs. JOHNSON. That is very interesting. If the law should expire, what would prevent you from continuing in the form of an HMO, offering your services to Medicare recipients for a zero premium?

Mr. ERVIN. There are several waivers that the Social HMOs have which enabled us to exist. We were a small, community-based nonprofit organization which clearly could not meet the 50/50 rule; did not meet the Federal qualification rule and several other provisions. So we would not, for example, be able to continue. We have recently at SCAN, for example, started a commercial plan, which we hoped to build up to be large enough that we can apply to be a regular risk contractor side-by-side with the Social HMO. It would provide a certain level of insurance should the Social HMO ever come to an end. We hope that does not happen because of the incredible benefits that we are able to offer. And Elderplan is in a similar position, where they could not meet the requirements of a risk contractor currently.

Mrs. JOHNSON. Could they organize themselves simply as a Medigap insurance policy, offering all of the things that Medicare does not offer that you offer, the lower copayments and so on? What prevents that?

Mr. ERVIN. The thing that makes these benefits possible——

Chairman THOMAS. Mr. Ervin, would you talk directly into the mike?

Mr. ERVIN. Yes; I am sorry.

The thing that makes the benefits possible is the managed care system, putting all of the benefits into one managed system of care in an integrated fashion. In an indemnity model, it would cost far more to provide the same benefits.

Mrs. JOHNSON. Mr. Ervin, it is possible under current law to organize yourself as a managed care system and then offer yourself through the Medigap policy process. This is outside of the HMO risk contract. This is a completely different avenue. And if your law expires, what would be the impediments to organizing yourself as a managed care plan and offering a Medigap insurance policy for a zero premium? Is it that you could not have access to the capitated payment?

Mr. ERVIN. Yes, that would definitely be a major obstacle. It is the capitated payment that allows us to organize all of the strata of care that are required for the whole population that we serve, and in a managed care setting, you can accomplish that, and the capitation really is the financing mechanism that makes it possible.

Mrs. JOHNSON. Why have you found it difficult to compete with the TEFRA plans in your area?

Mr. ERVIN. I am sorry, Congresswoman, I missed the question.

Mrs. JOHNSON. Why have you found it difficult to compete with the TEFRA plans in southern California?

Mr. ERVIN. Well, in southern California, you probably know that it is certainly one of the two most competitive markets in the country. There are about 30 Medicare HMOs there. They are far larger than we are, almost all of them, and they have far greater money to spend on marketing, and it is a costly and labor-intensive effort as well, because we enroll generally one person at a time. We talk to them; we educate them. And it takes an educational process for them to understand the value of these added benefits, especially having them available if they do not need them right now. So this is not an easy thing to develop, plus, we have started very small, and we had an enrollment limit of 7,500 members until 1993, when

that was lifted, and then, it was raised to a possible limit of 12,000, which has not been imposed in our case.

Mrs. JOHNSON. The government put the limit on?

Mr. ERVIN. I am sorry?

Mrs. JOHNSON. The government established the limit?

Mr. ERVIN. The 1993 legislation gave the Secretary the right to impose a limit of no less than 12,000. Previous to that time, it had been 7,500.

Mrs. JOHNSON. Are you still operating under a limit?

Mr. ERVIN. At this time, two of the sites have been told that they are under a limit, as far as I know, of 12,000. We have not received such.

Mrs. JOHNSON. Does the limit in and of itself make it difficult to compete?

Mr. ERVIN. Yes, it does. It certainly limits your ambition in developing a network and in geographic expansion, and, therefore, in what your business plan for growth and expansion is.

Mrs. JOHNSON. Do you have any comment to HCFA's evaluation that the SHMOs have tended to serve the healthier clients?

Mr. ERVIN. Twelve percent of our population are nursing home certifiable. That has obviously changed over the years. There was a queuing mechanism in place for the Social HMOs to help prevent too great an adverse selection, which could have made it a very risky proposition and possibly driven us out of business early on. At this point, with 12 percent nursing home certifiable, definitely, we do not have a favorable selection compared to other risk contract HMOs.

Mrs. JOHNSON. Ms. Hansen, what about your population?

Ms. HANSEN. Our population probably is distinguished from the SHMOs. Our population is 100 percent targeted toward the 12 percent that he just mentioned, whereas the SHMO programs are really the blend of the well and a smaller proportion of the frail. And so that is the reason for the different types of programs that are here. When I mentioned the rates earlier, they are rate adjusted for that core population that is 100 state-certified to be eligible to be in a nursing home.

Chairman THOMAS. Before I turn it over to my colleague from California, Mr. Ervin, if, in fact, you were a regular HMO, and this program went permanent, and you could increase your amount from 95 percent of AAPCC to 100 percent, and you could remove the 50/50 rule and some of the other provisions, would not this be relatively attractive to a number of HMOs?

Mr. ERVIN. We believe it would.

Chairman THOMAS. Yes, I think it would, too. It would, significantly change the marketplace. Thank you.

The gentleman from California?

Mr. STARK. Thank you, Mr. Chairman.

I want to welcome Ms. Hansen here and welcome her to the East Bay of the San Francisco Bay area. I hope you do well.

You mentioned that you have both Medicaid and Medicare, and you do not charge premiums above that. What percentage of your budget comes from Medicaid—Medical, as we call it in California?

Ms. HANSEN. As is true for most of the sites, it is approximately 70 percent of the budget.

Mr. STARK. How about you, Dr. McCann? What percentage of your budget?

Dr. MCCANN. Very similar.

Mr. STARK. About 70 percent?

Dr. MCCANN. Yes.

Mr. STARK. I am not sure as much what will happen in New York as I worry about California, but if there was a 30-percent reduction in Medicaid, 20 or 30 percent, somewhere in that area, on a block grant basis, and assuming that that were spread evenly, which is not necessarily a fair assumption, but what would you guys do with your two programs?

Ms. Hansen?

Ms. HANSEN. For California, our rate is adjusted already at 15 percent below Medicaid average cost for that population. So already, there has been a 15-percent reduction. I think that all of us operating in the delivery systems are very keenly aware of that, and frankly, we continue to look for ways to have efficient delivery without compromising care. It still is one of those things that we realize is going to be a cut point where obviously, it will adversely affect.

Mr. STARK. I guess what I am asking, though, is if you had a 30-percent reduction in 70 percent of your volume, that means you have got about a 20-percent overall budget cut.

Ms. HANSEN. Right.

Mr. STARK. Can you operate with that?

Ms. HANSEN. I think that would severely curtail, certainly, our ability to provide services. And many of us are looking at how we can encourage a better mix of populations to service more of the private-pay population also to be a part of this.

Mr. STARK. Doctor?

Dr. MCCANN. Our rate in New York is set at 90 percent of the average Medicaid nursing home rate, and we also have not had a rate increase for 3 years. So another 30 percent cut would really be a problem for us.

Mr. STARK. Ms. Hansen, the idea of bringing in private pay is what we used to call cost-shifting. In other words, what you would like to do then is if you could get higher paying patients, they would, in theory subsidize the lower income patients, which is fine. That is, in effect, what you are hoping to do to offset any proposed cut in Medical; is that right?

Ms. HANSEN. Well, historically, what we have done is charge the private pay the same as the Medicaid. But I think also increasing the number of enrollees, frankly, the size——

Mr. STARK. If Medicaid went down, and private pay stayed the same, then if you increased the number of private pay, you could conceivably cover some of that reduction. Is what you are saying?

Ms. HANSEN. There would be, I think, possibly some ability to do that, but there would still be the issue of compromised ability to provide services if the cuts ended up being extremely severe, no matter what.

Mr. STARK. Mr. Ervin, one of the criticisms—I gather it is generic and not of your particular plan—is that physicians are not given greater time per patient in a SHMO when it is arguable that those patients need more time because of their condition. Did you adjust

the amount of time you are willing to pay a physician for various procedures, or is that an unjust or unfair criticism?

Mr. ERVIN. Congressman, I was not aware of that criticism. Perhaps I missed it someplace. We contract with—each of the Social HMOs is different. Kaiser has its group model; Elderplan contracts with medical groups, and so does SCAN Health Plan. We contract at the current time with about 15 different medical groups, and we work with them to understand our benefits. They set the policies and procedures by which their physicians operate, and we monitor them.

Mr. STARK. So if they do not like what you are paying, they could not bid on the job; is that in effect what——

Mr. ERVIN. That is correct. There is always a negotiation. And that always takes into account the kinds of patients that we will be sending them. And we work with them with our nursing staff, our quality assurance staff. We actually end up advocating considerably on behalf of our patients with medical groups as well as with hospitals if we find that they are not spending the kind of time and giving the care that is needed.

Mr. STARK. Fair enough.

Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Dr. McCann, earlier this week, we had a hearing on the GME, Graduate Medical Education System, and I wanted to hear if you had any ideas on how to restructure GME on geriatric care and geriatric medicine.

Dr. MCCANN. I can tell you that in our particular site, we do a lot of education. I am also on the faculty at the University of Rochester as an assistant professor of medicine, and we have medical students coming through our program; we have medical residents who do block rotations through our program, and we also have geriatric fellows who do a longitudinal experience through our program. So, we believe it is extremely important to introduce people to this type of care, to the most managed care that you can really have and a totally capitated system and let them know that you can practice great medicine in a system like this, just the kind that you thought you were going to practice when you went into medical school. I think it is extremely important, too, and certainly one of my high priorities in terms of medical education in our particular program.

Mr. CHRISTENSEN. One of the problems, though, that came out in the testimony from Governor Lamm was that under the Graduate Medical Education, we do not need the number of foreign medical graduates who are currently coming into the system. Is there a high concentration of foreign medical graduates in the geriatric care area, or would you agree with Governor Lamm that we have way too many in the system today?

Dr. MCCANN. I think that as far as people interested in working in geriatrics, there is a paucity of people. And as far as internal medicine graduates or people who go on to do a fellowship in geriatrics, we are not even close to meeting the need as far as the amount of geriatricians in our country. And it has not been a real

sexy area for people to want to go into when the other choices were ophthalmology and orthopedic surgery. But certainly, the people that we do attract tend to be very like-thinking and really find a program like this very conducive to the way they like to practice medicine.

Mr. CHRISTENSEN. Thanks, Doctor.

Dr. MCCANN. You are welcome.

Chairman THOMAS. We may find out that necessity is the mother of sensibility in terms of the kind of occupation that will be before us.

I want to thank the panel very much. The Committee will stand in recess until we get this vote in, probably about 10 to 15 minutes, and we will be back for the second panel. Thank you very much once again.

[Recess.]

Chairman THOMAS. The Subcommittee will reconvene, and we have a panel consisting of Dr. Leutz, associate research professor, Heller School, Brandeis University; Dr. Wiener, senior fellow at the Brookings; and Richard Bringewatt, president and chief executive officer for the National Chronic Care Consortium in Bloomington, Minnesota, with a slightly different profile than the other who has been presented.

Dr. Leutz, if you will proceed and inform the Subcommittee in any way you see fit. Any written testimony that you have will be made a part of the record.

STATEMENT OF WALTER LEUTZ, PH.D., ASSOCIATE RESEARCH PROFESSOR, INSTITUTE FOR HEALTH POLICY, FLORENCE HELLER GRADUATE SCHOOL, BRANDEIS UNIVERSITY, WALTHAM, MASSACHUSETTS

Mr. LEUTZ. Thank you, Mr. Chairman and Members of the Committee for this chance to talk today about the Social HMO. I have worked with this project for 15 years, so I have a real interest and a close knowledge of it. I am currently the chair of the Social HMO Consortium, which is an association of the sites and Brandeis University to do public policy and research about the project, but I speak today for myself from a research and policy perspective.

I could summarize my written testimony around two points. First a policy that the Social HMO is the only health care model that links Medicare with a privately financed long-term care benefit; I will elaborate on that. The second is a research point. A great deal has been learned from this project about how to integrate acute and long-term care. But there are still plenty of opportunities for learning.

On the financing point, there is a private risk-pooling mechanism that has not really been emphasized in the testimony. Most Medicare beneficiaries are neither rich nor poor. The poor have some access to long-term care benefits through Medicaid and programs like the PACE program, and people who are wealthy can either self-insure for long-term care or buy an expensive long-term care insurance policy. But the vast majority of Medicare beneficiaries really do not have those two options, and this program is an option for them to buy some protection against the costs of long-term care.

The other point that is unique about the Social HMO is that it is a program that serves all Medicare beneficiaries. It is not just a program focused on those with chronic disabilities and long-term disabilities. We have found that that is an important point, because many of the people who become disabled, like the member of Elderplan who spoke this morning, are disabled for a short term. What the Social HMO can do is pick up those people with short-term disabilities and help them to recover. And those individuals are not appropriately served in a PACE model, which separates people with permanent disabilities and focuses on their care.

The point about research is that we have learned a great deal about integrating acute and long-term care, and I think the work that we have done really confirms the importance of tying long-term care benefits to a Medicare set of benefits in a managed care model. The case management units in the SHMO programs, for example, receive two-thirds of their referrals of people who are newly disabled from the acute care system—from hospital discharge planners, from physicians' offices, home health agencies, nursing homes. We have found that one-third of the members who are discharged from hospitals are found to be frail within 2 months of their discharge, and again, they are picked up through the internal referral system.

We have found, when looking at the utilization of Medicare skilled benefits, the home health and nursing home benefits, and the Social HMO long-term care benefits that are available on the basis of disability, that there is a one-third overlap in eligibility for and use of those two benefits. That is, people are receiving those two types of benefits at the same time, and what the Social HMO does is make decisions on which benefits are used and how those services are coordinated into internal management decisions.

Another thing we have learned is that there are some savings in this model. There was a study done at Kaiser Permanente that compared the Medicaid costs for regular HMO members and Social HMO members who were not on Medicaid at the start of the study and found that they were significantly lower, $132 per member over the course of the study, for the Social HMO members. They used fewer nursing home days and had later Medicaid spend-downs and fewer Medicaid spend-downs.

There is still much more to learn in this project. More could be learned about the current sites through additional research about the long-term patterns of disability and relationships between service utilization and disability. The new Social HMO sites are testing a geriatric model and a chronic disease management model. Not mentioned yet today is that under this authority, there are end-stage renal disease managed care organizations being tested. An RFP went out last month for them, and this is an opportunity to learn how to bring managed care to this population.

So, I would make two recommendations. I agree with many of the others who have testified here that there is ample cause and good mechanisms to make this a part of the Medicare Program, but absent are the waivers for the current sites, and the new sites should be extended to complete the test of the model.

[The prepared statement follows:]

LEARNING FROM THE SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION: 1985-1996

Testimony to the Health Subcommittee
Ways and Means Committee

April 18, 1996

by Walter Leutz, PhD
Associate Research Professor
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Introduction

My name is Walter Leutz. I am an Associate Research Professor at the Institute for Health Policy at Brandeis University's Florence Heller Graduate School. I am also the Director of the Social HMO Consortium, which is an informal partnership of Brandeis and the Social HMO demonstration sites. Although I have long been associated with the Social HMO sites, I speak here today for myself and not the Consortium.

The purpose of the Social HMO Consortium is to perform research and improve policies concerning integrated acute and long-term health care systems. Although my colleagues and I have been an advocates of the Social HMO concept, in our work together we have tried to be objective, to be concerned about public and beneficiary interests, and to share our experience in the public domain. Over the years we have published more than 25 journal articles, 12 public reports, and one book on the Social HMO. A recent bibliography is attached.

Overview of the Social HMO Model

From a research and policy perspective, there are four distinctive things about the three Social HMOs that are now in their 11th year of operations under Congressional authority:

1. Social HMOs add community long-term care (LTC) to a Medicare HMO. By community LTC, I mean care beyond where Medicare definitions of skilled care leave off. The current sites' benefits cover up to $1,000 per month for personal and social care in the home and in adult day health centers. Short-term nursing facility stays are also included. Over the first ten years of the project, about 8,000 of the 40,000 Medicare beneficiaries who have been members have used the Social HMO's LTC benefits (Altman, et al., 1993; Consortium, 1996).

2. Social HMOs finance expanded benefits by enrolling a cross-section of Medicare beneficiaries. In contrast to PACE, which concentrates on Medicaid eligibles who meet nursing home eligibility criteria, the great majority of Social HMO members are private-pay and not disabled. The representative membership and private premiums create a private risk pool for financing long-term care and other supplemental benefits. Over the first ten years of operations, more than $60 million worth of community LTC benefits and case management have been provided - an average of more than $5,500 per year for members who have used these benefits (Consortium, 1996).

3. Social HMOs integrate the delivery of acute care and LTC. Social HMOs send their new members a health status screening form to identify individuals with disabilities and other risk factors. The forms are screened by nurse and social worker case managers. They connect members who have medical risks to physicians, and they go on to develop and oversee care plans for members needing community LTC. The case managers work closely with hospital discharge planners, nursing home staff, home health nurses, physicians' offices, and families to identify members who are newly disabled, who are transitioning across settings, and who need ongoing care (Abrahams, Capitman, Leutz, & Macko, 1989; Abrahams, Greenberg, Gruenberg, & Lamb, 1988; Leutz, Abrahams, Greenlick, Kane, & Prottas, 1988; Yordi, 1991a).

Although health status screening is an important way to find members who need LTC, integration with medical care is even more important. Two-thirds of the referrals to case managers come from the acute care system (Altman, et al., 1993). Nearly one-third of the members leaving the hospital are frail enough to meet community LTC eligibility criteria within 60 days of discharge (Leutz, Greenlick, & Capitman, 1994). More than one-third of members who are eligible for Medicare home health are also eligible for and receiving community LTC at the same time (Karon, Capitman, & Leutz, 1990).

These data show the close relationships of acute care and LTC. These relationships provide opportunities to reduce Medicare spending by substituting more appropriate and affordable community LTC. The integrated delivery system also raises providers' consciousness about addressing chronic illness and disability (Abrahams, Macko, & Grais, 1992). Finally, in contrast to PACE, which connects with community referral sources to find frail members, the Social HMO has internal referral systems. This allows Social HMOs to help with short-term disabilities and transitions across settings of care for a much broader group of beneficiaries.

4. Medicare pays Social HMOs 100% of estimated fee-for-service (FFS) expenditures. Paying 100% of the adjusted average per capita costs (AAPCC) gives sponsors the incentive to offer community LTC (as well as prescription drugs, eyeglasses, and hearing aids) and makes it more affordable for beneficiaries to choose this high-option plan (Leutz, & Hallfors, 1993; Leutz, et al., 1985). The Social HMO payment formula has special rate cells that pay higher for members with disabilities who reside in the community and correspondingly less for other community residents (Gruenberg, Silva, & Leutz, 1993). This protects sponsors against the extra costs of enrolling more than fair their share of beneficiaries with disabilities, and it protects Medicare against favorable selection.

Paying 100% of AAPCC may look like a cost compared to the 95% paid to TEFRA risk plans, but it is not a cost compared to FFS. If the underlying growth rate in Medicare expenditures are controlled, so are Social HMO expenditures. It does not make sense to require every Medicare program option to save money if there are other good reasons to support that program. TEFRA HMOs have not offered LTC benefits like those found in Social HMOs, and they are not likely to without the protections of disability-based payment formulas and relatively higher payment rates.

HCFA evaluation studies

The Health Care Financing Administration (HCFA) supported an outside evaluation of the Social HMO Demonstration over the period 1985-1989. Regretably, due to methodological problems with the basic approach to the final evaluation studies, there are no definitive conclusions on Social HMO impacts on Medicare costs and member health outcomes compared to FFS (Leutz, & Greenlick, 1995). Major findings from earlier studies included:

1. No selection bias: Social HMO sites enrolled memberships similar to Medicare beneficiaries in their communities in terms of disability and health status, in part due to a case mix quota system (HCFA, 1988; Newcomer, Harrington, & Friedlob, 1990b).

2. Choice: Beneficiaries joined the Social HMO because of its richer benefits for drugs, community long-term care, dental care, and eyeglasses (Newcomer, Harrington, & Friedlob, 1990a).

3. Satisfaction: Social HMO members were generally just as satisfied as beneficiaries in FFS or other HMOs (Newcomer, Preston, & Harrington, 1991).

4. Informal support: The Social HMO strengthened the informal support system of Social HMO members compared to beneficiaries in FFS (Yordi, 1991b).

Other research

Several other research findings based on studies by the sites and Brandeis are worth noting.

1. Medicaid savings: Kaiser Permanente Social HMO members had significantly fewer days of nursing home care, later Medicaid spend-downs, and lower Medicaid costs than Kaiser TEFRA members, after controlling for age and gender (Boose, 1993).

2. End of life savings: Kaiser Permanente Social HMO members in their last year of life had fewer days of nursing home care and were more likely to die at home than Kaiser TEFRA members, after controlling for age and gender (Brody,).

3. Low-cost and manageable community LTC benefits: Numerous community care demonstrations and national health reform proposals have examined how to deliver an affordable benefit to cover community LTC (Leutz, Capitman, MacAdam, & Abrahams, 1992). The Social HMO sites have shown definitively that community LTC is an insurable, affordable, and manageable risk in the context of a Medicare HMO supplement (Altman, et al., 1993; Greenlick, Nonnenkamp, Gruenberg, Leutz, & Lamb, 1988; Leutz, et al., 1994; Leutz, Greenlick, Ervin, Feldman, & Malone, 1991). The Social HMO thus shows a way for managed care organizations to fill a gaping hole in the private insurance coverage available to Medicare beneficiaries.

4. Private LTC benefits for the middle class: Citing reimbursement shortfalls, Health Partners closed the Twin Cities Social HMO site in 1994. Out of concern for its vulnerable members, Health Partners has studied experiences their experiences in the year after the closing. Preliminary results show that LTC services were reduced and stress was increased for these members, particularly for those who did not qualify for public LTC benefits (Fischer, 1996). This shows that the Social HMO was providing benefits that were difficult to replace in the private market.

Policy issues

Taking a step backward, the experience to date with Social HMOs, PACE, and other integrated health care approaches raise several questions for future policy at the federal, state, and provider level. On each of these issues, the Social HMO is testing unique, powerful, and potentially valuable approaches to service delivery and financing.

1. Geriatric care or community LTC? A second generation of Social HMO sites will soon test a model of care that expands geriatric evaluation and management services for Social HMO members with chronic illnesses (Harrington, Lynch, Newcomer, & Miller, 1993). This will require more far-reaching changes in sites' acute care systems than did the first generation model of integrating community LTC with existing acute care systems. It remains to be seen whether expanding benefits to geriatric services (the second-generatin Social HMO model) will produce better outcomes than expanded community LTC (the first-generation model), but both models are certainly worth testing (Leutz, Greenlick, Ervin, Feldman, & Ripley, 1995).

2. Integrated Medicare and Medicaid financing or expanded private LTC financing? The PACE initiative, as well as a number of state initiatives, seek to achieve savings and improve outcomes by integrating Medicare and Medicaid financing and services (Kane, Illston, & Miller, 1992; Wiener, & Skaggs, 1995). The Social HMO is the only major initiative that integrates Medicare with expanded private financing of LTC. Because it reaches the private market, the Social HMO is the only current managed care approach that has the potential to provide an affordable choice for millions of Medicare beneficiaries to insure for prescription drugs and community LTC.

3. Integrated acute and LTC through generic or specialty programs? Several Medicare demonstrations (e.g., PACE, Medicare Alzheimers, EverCare, Community Nursing Organization) (Vladeck, Miller, & Clauser, 1993), as well as a number of state Medicaid and provider initiatives (Kane, et al., 1996; Saucier, & Mitchell, 1995) all seek to integrate acute and

LTC for either a subset of the population or a subset of services. Such specialty programs have the advantage of concentrating on populations and services that they know well. However, they operate with eligibility and service network barriers that limit the number of beneficiaries they can serve and how they can serve them. The Social HMO is the only model that stands ready to enroll all Medicare beneficiaries and provide the full range of acute and LTC services. It thus has the potential to serve beneficiaries with all types of chronic illnesses, all levels and durations of disability, and in all settings. As the Kaiser Permanente Interregional Committee on Aging has affirmed, the model of care can and should be extended beyond the Medicare and Medicaid populations to citizens of all ages (Nonnenkamp, 1996).

Recommendations

The Social HMO sites are now in their 11th year of operations, and their Medicare waivers are set to expire on December 31, 1997. This schedule will require current sites to begin closing down and disenrolling members at the end of 1996. Pursuant to Congress's 1990 expansion of Social HMO authority, seven new sites are scheduled to begin operations this summer. Additionally, as directed by Congress in its 1993 waiver extension, in February 1996 HCFA issued an RFP for sponsors to demonstrate a capitated managed care program for End Stage Renal Disease (ESRD) beneficiaries. The ESRD site(s) may be ready to begin operations next year.

Both the current Social HMO sites and these new demonstration efforts deserve the continuing support of Congress. Two actions make sense: (1) making the Social HMO a Medicare option and (2) extending the waivers to allow further research on the model.

1. Develop a program to allow any qualifying managed care organization to become a Social HMO. Such Social HMOs would be paid at a slightly higher rate than regular HMOs using a disability-based payment formula providing they met minimum standards concerning benefits (LTC, prescription drugs, and other supplements), case management, and enrollment. There has been ample testing of the essential Social HMO operational protocols to feel confident of success, and time can be built in to refine other mechanisms. The Social HMO Consortium developed a proposal (but did not submit anything to the House yet) that would accomplish these ends by making the Social HMO one of several managed care options available to Medicare beneficiaries.

2. Extend the waivers for four years to support futher research. The 1997 waiver end date will not allow a test of the second-generation Social HMO and ESRD initiatives, and it will not allow time for the first-round sites to transition to new operational authority. More research should be conducted on both the new sites and the existing sites, which have not been studied in the last six years. A four-year extension through December 31, 2001 would cover all needs. HCFA has the authority to extend these waivers, but extension can be assured and greatly expedited with a Congressional mandate. This continuation of waivers needs to happen soon and should be enacted independently of making developing the Social HMO program within Medicare.

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Chairman THOMAS. Thank you, Dr. Leutz.
Dr. Wiener.

STATEMENT OF JOSHUA M. WIENER, PH.D., SENIOR FELLOW, ECONOMIC STUDIES PROGRAM, BROOKINGS INSTITUTION

Mr. WIENER. Thank you, Mr. Chairman.

Over the last few years, there has been a new interest in the integration of acute and long-term care services and financing. This derives from the observation that persons with disabilities do not come with just a need for acute care or just a need for long-term care, but they come with a need for both sets of services. Yet, we have a situation where the financing system is fragmented; where the delivery system is fragmented; and where the system as a whole is more costly than it likely needs to be.

There has been a hope that by integrating acute and long-term care services we will be able to provide both better quality care and to save some money as well. While there are a variety of models for the integration of acute and long-term care services, most of them depend on the application of managed care principles, including capitation.

We have a wide variety of models of integration, some of which have been discussed here today. Medicare HMOs, while not serving long-term care generally, do provide skilled nursing facility care and home health. We have Social HMOs and the On Lok/PACE program. A program not mentioned so far today is the Arizona Long-Term Care System, and a variety of other state demonstrations are underway as well.

As Congress considers what to do with the integration of acute and long-term care services, there are a variety of policy considerations that need to be taken into account. The first is do managed care organizations understand low-income elderly populations? Do they understand long-term care? To date, managed care organizations have little experience with the elderly and virtually no experience with the low-income elderly, the younger disabled population or with long-term care. Clearly, this is an area where they could learn, but they are not there yet.

Second, is managed care good for long-term care? Advocates for long-term care are not unanimous in their belief that this is the direction that we ought to go. In a capitated system dominated by doctors, some people worry that the acute care sector will end up with the lion's share of the resources, and that they will, in fact, end up stealing from the long-term care budget in order to finance acute care. There is also a worry that in a system dominated by doctors that the care will be medicalized; you will have a medical rather than a social model. There is also a worry that the current movement for consumer-directed care will be subverted by the move toward managed care. After all, many would argue that the essence of managed care is to shift power away from the individual client and their chosen provider to other third parties: The HMO, the insurance company, or some other like source.

Another question is what model of integration should be promoted. We have a wide variety of models in terms of the delivery system. Under most of the Social HMOs, we have a "hand-off" model that tries to ease the transitions across the acute and long-

term care sectors. The On Lok/PACE model tends to be more of a geriatric model that builds on team providers, geriatricians, and aides who really try to change the way in which both the long-term care providers and the acute care providers do business.

Another question is how will quality and access be assured? It is well-known that the fee-for-service system tends to produce overutilization, but under capitated systems, there is always the danger of underutilization. The question is when does efficiency fade into underservice, and how will either the managed care organization, the state Medicaid agency, or the Health Care Financing Administration know? The reality is that no one has the personnel, the data systems or the technology to monitor those questions very well.

Another question is how should these managed care organizations be paid? We have had a considerable amount of discussion about the problems with the AAPCC not adequately adjusting for risk. Between 1980 and 1984, I worked for the Health Care Financing Administration, and one of the first meetings I attended in 1980 was on how to improve the AAPCC. Sixteen years later, the AAPCC is exactly the same.

Who gets the savings? A lot of the expanded benefits that are provided by both the PACE program and the SHMO are funded by savings from the acute care sector paid by the Medicare reimbursement. Eventually, Medicare will claim those savings as part of budget deficit reduction. So the question is, will there be money left over for these expanded benefits?

How much freedom of action will states have? Currently, states have a significant amount of flexibility in managed care but not that much. Certainly, in terms of the dual-eligible population, states do not have the flexibility in dealing with the Medicare Program.

So, in conclusion, one of the great triumphs of the 20th century has been the great conquest of acute illnesses. We now have the rise of chronic illnesses, which is very important. And the question before us is, how to extend managed care and how to deal with those chronic illnesses so that we can adequately serve them.

Thank you.

[The prepared statement follows:]

STATEMENT OF JOSHUA M. WIENER, PH.D.,
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MANAGED CARE AND LONG-TERM CARE:
THE INTEGRATION OF FINANCING AND SERVICES

Persons with disabilities currently receive care in a splintered and uncoordinated financing and delivery system (Evashwick, 1987, National Chronic Care Consortium, 1991). Financing for acute care is largely the province of Medicare and the federal government, while long-term care is dominated by Medicaid and state governments. Because of the bifurcation of financial responsibilities, there is a strong incentive for the federal government to shift costs to the states and vice versa. At the very least, there is indifference about initiatives that would save money for the other level of government.

In terms of service delivery, fragmentation exists both within and between the acute and long-term care systems. A major consequence of this fragmentation may be that total costs are higher than they would be in an integrated system (Finch et al., 1992). For example, some elderly patients may remain unnecessarily in acute care hospitals because appropriate nursing home or home care services are not immediately available, appropriate follow-up physician care cannot be arranged, or financing is not available.

Because of the growing awareness of the inadequacies of the current system, there is increasing policy interest in finding ways to bring the acute and long-term care sectors together into a single integrated system. Almost all of these initiatives depend on managed care. Under these models, capitated organizations have financial incentives to avoid both the functional decline that can result from unmet needs and the unnecessary costs associated with providing services in needlessly expensive settings. At least in theory, this coordinated approach would produce acute care savings because lower-cost outpatient and home-based services could be substituted for more costly inpatient services when appropriate (Rivlin and Wiener, with Hanley and Spence, 1988; National Chronic Care Consortium, 1991; Leutz, Greenlick, and Capitman, 1994). These acute care savings, in turn, could be used to fund more comprehensive long-term care benefits or could be captured by third-parties as savings.

DEMONSTRATIONS AND OTHER INITIATIVES

A substantial number of demonstration projects are underway to test various approaches to integrating acute and long-term care services. The best known of these demonstrations are the Social Health Maintenance Organizations (Social HMOs), On Lok and its Program of All-inclusive Care for the Elderly (PACE) replications, and the Arizona Long-Term Care System (ALTCS) program. Several other initiatives are under way which either seek to enroll Medicaid eligibles with disabilities in health maintenance organizations for their acute care services or for both their acute and long-term care services (Wiener and Skaggs, 1995). Although not directly involved in long-term care, conventional HMOs participating in the Medicare program are required to provide the full range of benefits, including home health and skilled nursing facility services.

Medicare Health Maintenance Organizations (HMOs)

Under rules established by the Tax Equity and Fiscal Responsibility Act of 1982, Medicare beneficiaries may enroll in HMOs (McMillan, 1993). Congress is currently debating various changes to these rules. Medicare beneficiaries who enroll in HMOs give up their free choice of providers and agree to use the providers approved by the HMO. These organizations provide or arrange for Medicare-covered services in exchange for a capitated payment which based on 95 percent of the estimated costs of serving an enrollee in the fee-for-service system.

Social Health Maintenance Organizations (Social HMOs or S/HMOs)

Social HMOs extend the traditional HMO concept by adding a modest amount of long-term care benefits (Leutz, Greenlick, and Capitman, 1994; Harrington and Newcomer, 199; Greenberg et al., 1988; Rivlin and Wiener, 1988; and, Leutz, Greenberg, and Abrahams, 1985). A coordinated case management system authorizes long-term care benefits for those who meet the established eligibility criteria. Social HMOs are intended to serve a cross-section of the elderly population, including both functionally impaired and unimpaired

persons. In fact, the overwhelming majority of enrollees are not disabled. While all enrollees are Medicare eligible, relatively few Medicaid beneficiaries are enrolled. Enrollees pay premiums to cover the extra benefits. Originally a four-site initiative, Congress has authorized a "second generation" of demonstrations.

On Lok/Program of All-inclusive Care for the Elderly (PACE)

In 1983 On Lok Senior Health Services obtained federal waivers allowing it to receive monthly capitation payments from Medicare, Medicaid, and (in a few cases) individuals to provide a comprehensive range of acute and long-term care services (Ansak, 1990; Zawadski and Eng, 1988). PACE is a an effort to replicate the On Lok model in 10 sites throughout the country (Kane, Illston, and Miller, 1992; Irvin et al., 1993). Enrollment is limited to persons who are so disabled that they meet nursing home admission criteria. Because expenditures per person are so high, very few persons can afford to pay an actuarially fair insurance premium. As a result, almost all enrollees are Medicaid eligible. PACE sites operate as geriatrics-oriented, staff model HMOs, with primary care physicians as employees of the organization. Finally, the approach makes heavy use of adult day health care, which is integrated with primary care.

Arizona Long-Term Care System (ALTCS)

The Arizona Health Care Cost Containment system (AHCCCS) is a statewide demonstration project which finances medical services for the Medicaid-eligible population through prepaid contracts with providers. Beginning in 1989, the ALTCS program incorporated Medicaid long-term care services into the AHCCCS program (Northrup, 1994; McCall, Korb and Bauer, 1994; McCall et al., 1993; and, Irvin et al., 1993). Participation in the program is limited to individuals who are certified to be at risk of institutionalization. ALTCS covers acute care services, as well as care in nursing facilities, intermediate care facilities for the mentally retarded, and home and community-based services. Under the ALTCS model, the state contracts with one entity in each county to assume responsibility for covered services to elderly and physically disabled eligibles. In the overwhelming majority of cases, the contractor for elderly people and persons with physical disabilities is the county government.

WHAT HAVE WE LEARNED?

Research on Medicare HMOs, Social HMOs, On Lok/PACE, and ALTCS provide evidence regarding enrollment, satisfaction, quality of care, and utilization and costs. With the exception of the ALTCS program, these demonstration projects generally depend on voluntary enrollment, which provides both a market test of different plans and a check on quality of care. In most areas of the country, these capitated approaches, which require enrollees to give up freedom-of-choice of providers, have had a difficult time enrolling the elderly and disabled populations (McMillan, 1993; Harrington and Newcomer, 1991; Finch et al., 1992; Leutz et al., 1993; Kane, Illston, and Miller, 1992; Branch, Coulam, and Zimmerman, 1995). As more older persons become familiar with managed care, this resistance appears to be diminishing, at least for the Medicare HMO program.

Evidence from conventional HMOs and the Social HMOs suggests that Medicare enrollees tend to be healthier and less disabled than persons remaining in the fee-for-service system (Brown et al., 1993; Riley, Rabey, and Kasper, 1989; Newcomer et al, 1995; and, Manton et al., 1994). Some researchers and administrators associated with the Social HMOs strongly challenge these findings as methodologically flawed (Leutz, Greenlick, and Capitman, 1994). Although the On Lok/PACE enrollees are clearly very disabled, they appear to be less disabled in the activities of daily living than nursing home patients and may have other characteristics that distinguish them from persons who are institutionalized (On Lok, 1993). Medicare HMOs and Social HMOs tend to have fairly high disenrollment, but Medicare makes it extremely easy to disenroll (Brown et al., 1993; and, Harrington, Newcomer, and Preston, 1993).

An argument in favor of integrated systems is that quality of care and consumer satisfaction will be improved because artificial barriers between care providers will be eliminated. Overall, evidence concerning Medicare and Social HMOs suggests generally high levels of consumer satisfaction among enrollees (U.S. Department of Health and Human Services, Office of the Inspector General, 1995; Brown et al., 1993; Newcomer; Weinstock, and Harrington, 1989). Consumers were most satisfied with covered benefits and the out-of-pocket costs. However, compared to persons receiving fee-for-service care, consumers were generally less happy with the care provided. A notable exception to this generalization is the "impaired" group within the Social HMO, who were more satisfied than the comparison group on almost all dimensions of care.

Formal studies of quality of care have shown mixed results. Although evaluations of Medicare HMOs generally show that they produce outcomes roughly comparable to the fee-for-service sector, enrollees receive less care (Brown et al., 1993; Greenwald and Henke, 1992; Carlisle et al., 1992; and, Yelin, Shearn, and Epstein, 1988). Of concern is that some studies find outcomes for persons with disabilities and persons with chronic illness to be worse in HMOs than in the fee-for-service sector (Shaughnessy, 1994). Within the Social HMOs, at least some disabled groups had higher mortality rates than persons receiving fee-for-service care (Manton et al., 1993), although, again, these results have been challenged by the Social HMOs on methodological grounds (Leutz, Greenlick, and Capitman, 1994). In a evaluation of nursing home care, quality of care was lower in Arizona under the ALTCS program compared to New Mexico, but it is difficult to know the cause of the differences (Balaban, McCall, and Paringer, 1994).

To policymakers, one of the major attractions of the integration of acute and long-term care services is the potential for cost savings in acute care that could be used to finance long-term care services or to reduce overall expenditures. In evaluating this issue, it is difficult to separate the effects of capitation from the effects of integrating acute and long-term care services. Evidence concerning Medicare HMOs, Social HMOs and On Lok/PACE show that acute care utilization can be reduced in capitated care settings, but it is less clear that integrating acute and long-term care services generates additional savings (Brown et al., 1993; Finch et al., 1992; Harrington and Newcomer, 1991; On Lok, Inc., 1995; On Lok, Inc., 1993). Social HMOs did not appear to do substantially better than conventional HMOs in reducing acute care expenditures. The early evidence from On Lok/PACE is more encouraging, but the data are very preliminary, do not adjust for casemix, and involve a relatively small sample. Complicating the evaluation of cost savings are the inadequacies of the Medicare and Medicaid payment methodologies which do not adjust adequately for risk (National Chronic Care Consortium, 1993; Kane, Illston, and Miller, 1992; Leutz, et al., 1993; and, Brown et al., 1993). As a result, for conventional HMOs the evidence suggests that Medicare is overpaying the plans, and thus losing money (Brown, 1993).

The ALTCS program appears to save money, largely because of how it provides services to the population with mental retardation and developmental disabilities (McCall et al., 1993). For older people and persons with physical disabilities, savings are smaller and derived largely from providing services to fewer people than would have received them in a traditional Medicaid program. It is unclear whether the savings come from acute or long-term care services. In an early assessment of the home and community-based services provided under ALTCS, the program appeared to successfully target persons at high risk of institutionalization and was cost-effective in its provision of noninstitutional long-term care services (Weissert, 1992).

POLICY CONSIDERATIONS

As states and the federal government explore ways to reform its system of financing and paying for acute and long-term care services for persons with disabilities, at least seven issues should figure in the calculus:

Do Managed Care Organizations Understand Low-Income Elderly and Long-Term Care?

To date, managed care organizations have mostly focused on providing acute care to the nonelderly population. Nationally, only about 10 percent of the elderly Medicare beneficiaries are enrolled in HMOs (HCFA, 1995). In addition, the vast majority of states have focused their Medicaid managed care programs on children and nondisabled adults; few states have actively attempted to enroll the elderly or persons with disabilities in managed care programs (Rowland et al., 1995). Only a scattered number of health maintenance organizations provide long-term care services. As a result, few managed care organizations have any experience with low-income elderly and virtually none have any experience with long-term care. Thus, it may take time before a substantial number of providers become knowledgeable about caring for this population.

Will Managed Care be Good for Long-Term Care?

A persistent concern of long-term care advocates is that the integration of acute and long-term care services will have negative consequences for the provision of long-term care services (Wiener and Illston, 1994; Schlesinger and Mechanic, 1993; and, Batavia, 1993). One concern is that fiscal pressures within integrated systems will end up shortchanging long-term care. Within the Social HMOs, there is some evidence that chronic care benefits were reduced because of rising acute care costs and market resistance to higher premiums (Harrington and Newcomer, 1991). Another concern is that long-term care will become overmedicalized in integrated settings and that services will become less consumer-directed. After all, many would argue that the essence of managed care is that the balance of power shifts from the individual client and his chosen provider to HMOs, insurance companies, or other administrative entities. On this issue, there are virtually no data in the published literature, although managed care supporters deny that this has been a problem in the demonstrations (Leutz, Greenlick, and Capitman, 1994).

What Model of Integration of Acute and Long-Term Care Services Should be Promoted?

Proposals to "integrate" acute and long-term care services are receiving increasing attention as a way to save money and provide better care. Conceptually, financial integration is relatively straightforward, referring to the pooling of funds from Medicare, Medicaid, insurance, and consumers.

On the other hand, there is little consensus about what constitutes "integration" in the delivery system. One view conceives of integration as improving the transitions and referrals back and forth between the acute and long-term care services (Leutz et al., 1995). The alternate view conceives of integration as dramatically changing how acute and long-term care providers provide services and puts multidisciplinary teams trained in geriatrics at the center of the care process (Harrington, Lynch, and Newcomer, 1993). The shape of the delivery system will depend on which model is promoted, if any.

How Will Quality of Care and Access to Services be Assured?

A major issue with all managed care initiatives is how to make sure that the drive to reduce utilization does not result in underservice to beneficiaries. This is a particular concern when managed care organizations enroll disabled individuals, who are likely to have high needs for both acute and long-term care services. Unfortunately, at this time, the states and the federal government lack the technology, personnel, and data systems to monitor the quality of care in managed care organizations. As limited as their general capability to monitor quality of acute care, there is no experience in assessing quality of long-term care in managed care settings.

How Should Managed Care Organizations be Paid?

With the exception of the ALTCS, almost all managed care providers of integrated acute and long-term care are paid a rate based on a percentage (usually 90 to 100 percent) of

what it is estimated the enrollee would have cost if he had remained in the fee-for-service system. The model for this reimbursement methodology--Medicare's Adjusted Average Per Capita Cost (AAPCC)--does a poor job predicting an individual's use of services (U.S. General Accounting Office, 1994; National Chronic Care Consortium, 1993; Kane, Illston, and Miller, 1992; Leutz et al., 1993; and Brown et al., 1993). The payment rate varies with the individual's geographic location, age, gender, reason for entitlement (age or disability), institutional status (residing in a nursing home or not), and whether they are Medicaid eligible. In spite of these adjustments, Medicare spends approximately 5.7 percent more for persons who enroll in HMOs than it would have spent on fee-for-service care (Brown et al., 1993). Thus, Medicare is currently losing money on its HMO program. The increase in costs to HCFA is due primarily to favorable selection in the Medicare HMOs, which leads to a healthier than average enrollment within each payment category. Because of lack of confidence in the reimbursement methodology, providers fear that they will not be adequately reimbursed, while policymakers worry that the government is spending more than is necessary.

In addition, capitated Medicaid rates, which generally follow the Medicare model of a percentage of the costs that would have been incurred in the fee-for-service system, are difficult to calculate because they must be relative to some comparison group. States are uncertain whether the appropriate comparison group for rate calculation is with nursing home residents, nursing home eligible or certifiable clients, community-care clients or some blend of these. The fact that some beneficiaries become Medicaid-eligible only after they have been admitted to a nursing home and impoverished themselves further complicates the computation of Medicaid payment rates for integrated systems.

Who Gets the Savings?

In general, integrating acute and long-term care services has a goal of reducing hospital and physician utilization by increasing the use of home and community-based services and sometimes nursing home care. Thus, cost savings usually accrue to the acute, rather than long-term care side of service delivery. As a result, Medicare rather than Medicaid may claim the savings. In addition, if the proposals to control Medicare expenditures are enacted, then Congress will extract the savings that managed care organizations may be able to obtain. In addition, as noted above, limited research raises questions as to whether the addition of long-term care services produces additional acute care savings.

How Much Freedom of Action Will States Have?

Under current law, most projects that integrate acute and long-term care financing require waivers of Medicare and Medicaid regulations. For example, to operate a Social HMO, administrators must obtain waivers of regulations regarding open enrollment, covered services, payment methodologies and levels, and the limitation on the percentage of HMO enrollment that can be Medicare or Medicaid beneficiaries. But these waivers are only available for research purposes and the process for receiving waivers is cumbersome, time consuming, and approval is not guaranteed. Moreover, because these waivers are for research demonstration purposes, the waivers are time-limited and tied to specific populations.

Under changes being considered by Congress, States will have much greater freedom of action to fashion their Medicaid managed care programs, but they will not have any control over the Medicare program. Since Medicare reimburses most of the acute care expenditures of elderly Medicaid beneficiaries, Medicaid agencies will either have to obtain Medicare waivers or work around the Medicare program. Because Medicaid pays only the deductibles, coinsurance, and uncovered services (mostly prescription drugs), the State may not have a great deal of leverage over the HMO's provision of acute care services. In addition, given the relatively small role of Medicaid in acute care for the elderly, it may be difficult to mandate that the elderly enroll in HMOs.

RECOMMENDATIONS

Although integrating acute and long-term care carries risks, such as overmedicalizing long-term care and loss of funds transferred to acute care from long-term care, the overlap of long-term care and acute care needs of persons with disabilities makes the integration of the financing and delivery of these two disparate systems a worthwhile goal. However, integration faces numerous technical, political, and attitudinal barriers. To a large extent, policymakers and providers are just beginning to learn how to create a seamless financing and delivery system for persons with disabilities. Indeed, the ideal model may not yet exist.

While comprehensive health care reform, including greatly expanded funding for long-term care, would help the cause of integration, such initiatives are unlikely for the foreseeable future. Despite these limitations, there are at least three broad initiatives that would further the integration of acute and long-term care financing and delivery:

Expand Research and Demonstrations on Integration

Although progress has been made over the last decade, not much is known about how to integrate the financing and delivery of long-term care. Thus, a major priority for the Health Care Financing Administration, foundations and philanthropic organizations should be to fund research and demonstrations (including their evaluation) of new ways of integrating acute and long-term care services.

Research and demonstrations should focus on three issues. First, high priority should be given to analyzing ways of improving the Medicare reimbursement rate formula--the Adjusted Average Per Capita Cost (AAPCC)--to better account for the costs of caring for the disabled elderly population. Since efforts to revise the AAPCC have been ongoing for the last 15 years without a great deal of success, accomplishing this task will not be easy.

Second, HCFA, foundations and philanthropic organizations should encourage innovative projects that foster the integration of acute and long-term care. In evaluating these initiatives (and they must be systematically evaluated to be useful), key questions should include: What do acute care providers do differently in integrated systems than they do in unintegrated systems? What do long-term care providers do differently in integrated systems that they do not do in unintegrated systems? Do integrated systems cost less than unintegrated systems? Is quality of care better or worse in integrated than unintegrated systems? Are outcomes better in integrated systems than unintegrated systems?

Finally, research should continue on ways of "bundling" post-acute Medicare skilled nursing facility and home health payments with hospital DRG and other payments. With the rest of the health care system moving rapidly toward managed care, it seems unlikely that the elderly population will be able to resist capitation forever. However, for the near term, older people have been reluctant to enroll in HMOs, forcing proponents of integration to look at what might be done in the fee-for-service sector.

Support Geriatric Education

Most doctors as well as other health professionals know little about the health care needs of the chronically disabled population and almost nothing about long-term care. While there is dispute about the necessity of depending on board-certified geriatricians, there is widespread consensus among those concerned with the elderly population that more geriatricians and geriatric education would likely increase the sensitivity of health professionals to the special needs of the chronically disabled. Although drawing large numbers of persons into the field will require a major restructuring of the medical profession, additional federal financial support for training programs would help.

Make Social HMOs and On Lok/PACE a Regular Part of Medicare and Medicaid

Finally, the Medicare and Medicaid programs should be altered to allow states and providers that want to experiment with the integration of acute and long-term care services to do so without having to obtain research waivers. Under current law, organizations seeking to integrate acute and long-term care services generally require Medicare "222" and Medicaid "1115" waivers, the research and demonstration waiver authorities under the two programs. Waivers are restricted to time-limited periods and to specific projects.

This is a controversial recommendation because Social HMOs were not without their problems and the On/Lok PACE demonstrations have yet to be evaluated. While these shortcomings are undeniable, the basic principles of these two demonstrations--providing comprehensive care to older people in a capitated environment--are basically sound. This recommendation is not made with the intent of propagating the "one true model," but rather in the spirit of "letting a hundred flowers bloom." The purpose of the recommendation is to move the integration of acute and long-term care beyond "greenhouse boutiques" and into the mainstream of care for the elderly population (Personal Communication from R. Bringewatt to J. Skaggs, 1994).

While there are several minor changes to Medicare and Medicaid statute and regulations that would be necessary (e.g., requirements for statewide implementation and uniformity in terms of amount, duration and scope of services), there are two important changes that should be made to Medicare and Medicaid and one commonly proposed change that should be rejected at this time. First, organizations that wish to replicate Social HMOs or On Lok/PACE or that want to try new methods to integrate acute and long-term care services need an adjustment to the Medicare AAPCC in order to account for the costs of caring for severely disabled persons in the community. Without this adjustment, there would be a perverse incentive for organizations to admit persons to nursing homes in order to obtain the higher Medicare reimbursement rate that is available for the institutionalized population.

Another change that should be enacted is the elimination of the Medicare requirement that Medicare and Medicaid beneficiaries comprise no more than half of the membership in any participating HMO; a similar Medicaid requirement limits the proportion to 75 percent. This requirement was initially enacted to guard against poor quality HMOs that would only enroll Medicare and Medicaid beneficiaries. Since the financial incentives under capitated arrangements are to undersupply services, quality of care in HMOs remains an issue. However, organizations that do not specialize in the elderly populations are less likely to change their delivery systems to accommodate persons with disabilities.

Finally, in response to the original Social HMO concerns about adverse selection due to enriched benefits, HCFA permitted waivers of the requirement for open enrollment without regard to medical status. In the demonstration, the sites were permitted to close enrollment to the impaired population if enrollment exceeded estimates of the proportion of the elderly populations residing in the community who were functionally impaired. Although allowing queuing would make life easier for new organizations, it should not be permitted. Closing enrollment based on health status is inconsistent with the fundamental tenet of equity, which requires open enrollment for all individuals regardless of health status. Moreover, if the technology becomes available to make improvements in the reimbursement methodology, plans would be more likely to receive adequate payment if they enrolled a disproportionate number of disabled individuals, thus tempering concerns about adverse selection..

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Chairman THOMAS. Mr. Bringewatt.

STATEMENT OF RICHARD J. BRINGEWATT, PRESIDENT, NATIONAL CHRONIC CARE CONSORTIUM, BLOOMINGTON, MINNESOTA

Mr. BRINGEWATT. Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to testify today on behalf of the National Chronic Care Consortium. The National Chronic Care Consortium represents 27 of the nation's leading health networks and functions as an operational laboratory for integrating primary, acute and long-term care for people with serious and disabling chronic conditions such as heart disease and Alzheimer's. These people represent the highest cost and fastest growing care segment of health care spending.

Today, I would like to make three points. First, Medicare problems only can be fixed by a better understanding of the problems faced by chronically ill people. Let me give you an example related to the care of Mrs. Jones, an 88-year-old woman with Alzheimer's. Mrs. Jones was living alone in her apartment when she developed Alzheimer's. Her children were concerned that their mother was falling, but the present Medicare and Medicaid system does not generalize a process for identifying risk. Further, existing payment strategies are designed to react to events, not to prevent them.

So, Mrs. Jones eventually fell and broke her hip. Then, the entire continuum of care became available to her, until Mrs. Jones was transferred to a nursing home for rehabilitation. Then, Medicare stopped paying part A benefits, because she was not making progress with her rehabilitation. Her coverage was shifted to Medicaid, enabling her to continue to receive nursing home care. But after several weeks, she developed a urinary tract infection because she was eating poorly and became dehydrated.

The payment system favored transferring her back to the hospital for IV fluids, antibiotics and feeding tube placement. After 3 days in the hospital, she returned to the nursing home for a feeding tube and continued to collect Medicare part A coverage for the full 100-day benefit as long as she kept the feeding tube. To continue receiving payment, the nursing home did not resume regular feeding until day 101. Does this sound like humane or cost-effective care?

Second, Medicare long-term demonstrations have provided us very valuable information about meeting the needs of the chronically ill. Just three quick examples. These demonstrations first tell us that containment of Medicare costs requires long-term care to become more integral to integrated health networks. People in need of long-term care also have extensive medical needs. Keeping long-term care out of integrated health networks does a disservice to the payer and to clients as well.

Second, the current wave to consolidate assets and authority for hospitals and physician groups may increase efficiency, but it will never improve health care for the chronically ill or save money unless these mergers also integrate the ongoing management of care across the spectrum of services used by disabled people.

My final point is to reduce spending and contain long-term costs, we must develop policies that reduce the accumulation of costs

across settings and over time and recognize the interdependence between Medicare and Medicaid. Policies governing acute care and long-term care must be made more consistent. Spending Medicare funds to prevent, delay or minimize disability can significantly reduce the accumulation of long-term care costs under Medicaid. Spending Medicaid funds to reduce adverse medical conditions can reduce acute care expenditures under Medicare.

Third, we must move beyond demonstrations. We can ill afford to conduct endless demonstrations and wait 5 to 10 years for evaluation results. How can we ask an organization to fundamentally change standard operating procedures for a subset of patients representing less than 5 percent of the system's overall costs? How can we convince sponsors to make a substantial investment if they cannot apply demonstration learnings to their ongoing business?

In conclusion, I simply want to make three recommendations. First, the NCCC urges the Subcommittee to grant permanent waiver authority to the Social HMO I and II sites and establish PACE as a permanent Medicare Program. Second, we recommend enabling other mainstream provider networks to establish variations on integration and managed care financing for chronically impaired people under permanent waiver of identified requlations that impede effective integration. And third, we recommend that authority and financial responsibility for Medicare and Medicaid be invested either with the Federal or state government. In the interim, all unnecessary inconsistencies in the administration of Medicare and Medicaid must be eliminated.

Mr. Chair, we are in a major crisis, as you well know. Medicare and Medicaid costs are out of control. We have to move demonstration out of the greenhouse and into the real world. We must take the learning we have accrued and get on with the business of containing costs through better care. This requires a fundamental reengineering of how we finance, administer and deliver care for the chronically impaired elderly.

Thank you, Mr. Chair and Members of the Committee.

[The prepared statement follows:]

STATEMENT OF RICHARD J. BRINGEWATT
PRESIDENT, NATIONAL CHRONIC CARE CONSORTIUM
before
WAYS & MEANS SUBCOMMITTEE ON HEALTH

APRIL 18, 1996

I. INTRODUCTION

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to testify today on behalf of the National Chronic Care Consortium (NCCC) regarding long-term care and managed care options for Medicare beneficiaries. NCCC is a national nonprofit organization representing 27 of the nation's leading health networks, all of whom serve the Medicare and Medicaid populations. Our mission is to establish new methods of integrating care for persons with serious and disabling chronic conditions, such as heart disease, Alzheimer's and stroke. We appreciate the Subcommittee's interest in the Social HMO and PACE programs as examples of how Medicare could be restructured to expand managed care options for our nation's seniors. Several Consortium members operate PACE and Social HMO programs within their systems and over half have Medicare risk contracts. In addition, NCCC members are participating in other long-term care managed care programs such as the Alzheimer's Medicare Demonstration Program and the Community Nursing Organization Demonstration and several have submitted proposals to be demonstration sites for the Minnesota Long-Term Care Options Program (LTCOP). The Consortium itself has a contract with the state of Minnesota to develop a Technical Assistance and Education Program for LTCOP. This extensive experience with managed long-term care programs affords the NCCC an inside view of the advantages and constraints inherent in these models.

I would like to focus my testimony on three critical issues related to long-term care options including: (1) the rationale for developing integrated financing and delivery models providing primary, acute and long-term care services for the elderly and chronically-ill populations; (2) the lessons we have learned from existing demonstration programs such as the Social HMO, PACE and LTCOP; and (3) the rationale for moving beyond the demonstration mode for Medicare and Medicaid demonstration programs and into mainstream delivery systems. I will conclude my testimony with NCCC's recommendations for moving beyond the status quo.

NCCC strongly supports Congressional efforts to expand Medicare options for integrating primary, acute and long-term care services through managed care and integrated delivery system approaches. We believe that sufficient evidence from private sector initiatives and public demonstrations exists regarding the cost-containing potential of integrated delivery and managed care approaches to warrant deployment of these models and other variations into mainstream programs. NCCC strongly urges the Subcommittee to make permanent the waiver authority for the existing Social HMO sites and to establish a new managed care option under the Medicare program which provides for the expansion of Social HMO and PACE programs and includes enough flexibility for sponsoring entities to continue evolving these models. The Consortium strongly urges Members of Congress to enact legislation which establishes mainstream provider initiatives compatible with principles for serving the chronically-ill. We recommend that such legislation (1) consolidate administrative and oversight requirements for integrated provider networks that serve a common high-risk population; (2) establish incentives for risk-based capitated financing for provider-based networks building upon risk-based payment methodologies which adjust for health status; and (3) direct the Secretary of HHS to conduct research to determine the aggregate costs targeted, high-cost chronic conditions and to establish outcome indicators for chronic conditions that measure quality over time, place and profession.

II. A CASE FOR HEALTH SYSTEMS INTEGRATION

The prevailing view in the United States is that our nation no longer can afford its current health care system. The government, business and the general public increasingly are burdened by unmanageable expenditures and by concerns that high priced care is not resulting in desired health care outcomes. The past few years have witnessed tremendous consolidation in the health care marketplace among providers and payors in the form of joint ventures, mergers and other affiliation models. In most cases, integration efforts have focused on the merger of assets and the consolidation of governance among hospitals, physicians, and managed care plans. Participating provider organizations have sought to achieve a competitive advantage in obtaining contracts with third party payors and expanding and stabilizing their share of the health care market. They hope to achieve new levels of efficiency through reduction in hospital capacity, decreased expenditures for subspecialties and medical technology and greater use of primary care. While nursing homes and other long-term care services have, for the most part, been exempt from network integration, newly aligned networks are beginning to establish exclusive vendor relationships with targeted long-term care providers and to use managed care financing methods. A number of states such as Arizona, California and Minnesota also have begun to move toward application of managed care principles in the purchase of long-term care. These efforts have resulted in long-term care providers exploring network affiliations of their own that mirror developments in the acute care sector.

These integration efforts *have* significantly changed the nature of authority and the distribution of health care dollars among existing health care institutions. They *have not* significantly changed the nature of the relationship among purchasers, payors and providers serving people with serious chronic conditions. We continue to treat problems in response to acute events and to manage care within the walls of provider institutions and the confines of established health care professions. The effectiveness of cost containment initiatives and care for millions of

Americans afflicted with chronic disease and disability will require that we extend the concepts of integration beyond the consolidation of assets and authority to the integration of care, information and systems. Chronic conditions such as heart disease, stroke, arthritis, and Alzheimer's Disease represent the highest-cost and fastest growing expenditure categories in the health care system. Approximately 80% of all deaths and 90% of all morbidity is related to chronic disease. The proportion of health care dollars devoted to chronic illness will continue to escalate into the next century with the aging of the population since chronic diseases disproportionately affect the elderly.

Cost containment and quality of life for persons with serious and persistent chronic conditions are both significantly dependent upon the full array of primary, acute, transitional and long-term care providers working together to prevent, delay or minimize disability progression and its associated costs. Hospitals, nursing homes, physicians and community-based long-term care providers are becoming increasing interdependent in serving a common chronically-impaired population. Effective management of chronic illness requires an interdisciplinary approach which recognizes the multidimensional and progressive nature of chronic disease and disability. It requires that we move beyond containing costs within isolated health care sectors such as hospitals and nursing homes and establish administrative, clinical and financial incentives for managing aggregate costs across time and settings. It requires that we empower the individual and their family caregivers to more fully and effectively optimize their own health and well being.

While the managed care approach is intended to reduce costs by carefully directing patients to the most appropriate and lowest cost targets, current regulations substantially impede providers' ability to do so. Care for the same person frequently is provided by multiple organizations with little or no incentive to work together to meet common goals regarding patient outcomes and cost-containment. Impediments to integration are rooted in statutes and regulations which require duplication across health care settings and often contain conflicting financial incentives as patients move across health care settings and/or payment sources (i.e., Medicare and Medicaid). Fully integrated service networks manage care across all settings in the service of a common care plan which seeks to optimize patient outcomes through collective action. Administrative, financial and information systems must be integrated to support a common approach to care for people with chronic conditions. For integration to occur under managed care plans, all providers serving the same patients must share in the financial risks and rewards associated with providing care, with all providers working toward common cost and quality goals across the network. Incentives among providers within a given network must be aligned for a network to be integrated. When new capacities exist for serving this population, new approaches to deregulation can be applied.

III. BARRIERS TO INTEGRATION

The challenge of constraining Medicare and Medicaid costs requires more than tinkering at the margins. It requires that we recognize the critical interdependence between the Medicare and Medicaid programs, with respect to serving both the dually eligible population and individual Medicare or Medicaid beneficiaries. Excess Medicare and Medicaid costs currently are incurred in two ways. First, aggregate program costs can be increased by reimbursement policies that focus on producing short-term savings for each health care segment (e.g., hospitals, nursing homes) instead of long-term savings across the system. While significant attention has been devoted to controlling short-term costs within individual provider settings, such as hospitals and nursing homes, scant attention has been paid to reducing aggregate costs for chronic condition across time, place and profession.

Second, we must consolidate and restructure administrative systems to produce health care services more efficiently. Policies governing acute and long-term care programs must be made more consistent through strategies such as standardized goals, objectives, service definitions, standards and reporting requirements for programs serving the chronically-ill. Since most providers serve both the Medicare and Medicaid populations, the establishment of compatible regulatory requirements would substantially increase the efficiency of provider operations.

A. Administrative Policies

Health care administrative policies and procedures are based primarily on the acute care model with its episodic orientation. Separate policy authorities exist for major segments of chronic care financing and separate administrative authorities exist for each Federal program. Regulations governing eligibility criteria, coverage rules, payment policies and evaluation methods differ across program categories such as Medicare and Medicaid. Requirements regarding patient assessments, care planning, data collection and record keeping are separately defined by clinics, hospitals, nursing homes and community-based service settings resulting in high costs and care fragmentation.

The administration of health care financing also must be standardized across providers and payors. Administration should be shifted from cost accounting systems focused on different payors and providers to a system which integrates financing administration for the network of providers offering services to common patients. All network providers serving a common population should be given incentives to collect a standard set of core data on client characteristics, health status, service use, costs and quality outcomes. While different providers and payors require information that is unique to their own settings, it is critical that integrated delivery systems define information the same way among providers where information is common to all. For example, assessment protocols for measuring

functional and cognitive status should be the same whether collected by a nurse or social worker in a nursing home or home care setting. In addition, financial management systems must begin linking cost data with outcomes data across providers and payors for purposes of assessing the cost-effectiveness of various treatment protocols and establishing outcome measures for evaluating performance.

B. Financing Policies

Our current health care financing system is replete with disincentives to cost-effective service delivery. Most cost-containment strategies, including those involving capitated, managed care financing, focus on short-term cost savings within existing provider structures with separate contracts and risk arrangements. There is little or no incentive for providers to collaborate in cost-savings across the continuum of care. Even managed care organizations, such as HMOs, engage in a certain amount of cost-shifting within the system. For example, many HMOs limit their financial risk by passing it on to the providers with whom they contract on a fee-for-service or discounted cost contract basis. In contracts, under managed care plans, all too often individual providers work under separate contracts and work within their own settings to maximize billing opportunities.

Instead of identifying strategies to *suppress* annual costs for specific health care sectors (e.g., hospitals, nursing homes, etc.) through artificial means such as spending caps and routine cost limits, we should develop solutions that *eliminate* expenditures by preventing, delaying or minimizing the progression of chronic illness. Cost avoidance will generate far greater savings over the long-run than cost reductions.

For example, Medicaid policies prohibiting reimbursement of physician visits to nursing homes more than once every 30 days result in cost-shifting to the Medicare program and actually may increase Medicaid costs over the long-run. When nursing home patients need to be transferred to hospitals to receive medical care, both programs incur administrative costs related to discharges and admission/re-admission in addition to the costs of medical care delivered in the hospital. Likewise, it may be more cost-effective in the long-run to increase Medicare acute care spending for certain services that could prevent, delay or minimize chronic disease and disabilities as a strategy for avoiding or reducing Medicaid long-term care expenditures in the long-run.

Health care financing policies must be modified to be less prescriptive of process and more focused on outcomes. Financial incentives should be established to encourage providers to collectively contain costs, prevent disability progression and emphasize consumer satisfaction across time, place and profession. Provider based systems should be established where provider networks are paid under shared risk arrangements for achieving common cost and outcome targets. Authority, responsibility, and accountability for the ongoing management of care should be delegated to provider-based networks of care rather than micro-managed by health plans functioning as third party payors.

C. Barriers to Serving the Dually Eligible

Efforts to control costs for elderly beneficiaries receiving benefits under both Medicare and Medicaid long have been confounded by the duplicative and conflicting regulations governing each of these programs. Differences in program requirements not only require providers and payors to maintain parallel administrative systems at an exorbitant cost, but the differences in clinical and financial rules actually create conflicting incentives which make it all but impossible to establish an efficient financing system. Below is a summary of the key differences between Medicare and Medicaid rules and examples of the conflicts that often arise and administrative inefficiencies inherent in developing service programs for the dually eligible population.

Membership Requirements

One of the most significant barriers to integration consistently cited by providers, purchasers and payors alike are membership requirements that Medicare and Medicaid risk contracts include both commercial and publicly financed residents. Medicare restricts enrollment of public beneficiaries to no more than 50% of the plan total and Medicaid restricts this number to no more than 75%. The remainder of beneficiaries must be enrolled from the commercially insured population. This requirement for commercial enrollees originally was implemented to assure quality of care for Medicare and Medicaid beneficiaries. Public officials believed that the commercial sector would demand high standards which, in turn, would protect those financed under public programs.

This requirement raises several important issues for consumers, providers, payors and state agencies. First, NCCC believes that the 50/50 rule is an inappropriate mechanism for assuring that Medicare and Medicaid beneficiaries receive appropriate care. This strategy shifts the burden for quality assurance from the Federal and state governments to the commercially insured who are expected to advocate on behalf of the elderly and poor. Clearly, the Medicare and Medicaid programs have sufficient quality controls to provide HCFA the necessary tools for monitoring. Moreover, in many cases, there is now sufficient managed care penetration in the commercial population to lift the 50/50 burden from providers with special interest in serving the low-income and elderly populations.

Second, it forces providers to divert their primary attention from serving the elderly to serving the population at large. In addition to developing specialized programs of care and marketing programs for the elderly, providers must also develop clinical and marketing programs for the general population. From the state's perspective, it

diminishes the size of the pool of potential providers and contractors with whom the state can contract. Although states may have a wide network of contracts for serving the Medicaid population on a risk basis, these contractors can not provide Medicare services to the dually eligible unless at least 50% of their plans' enrollees are commercially insured -- even though Medicaid rules require that only 25% of enrollees come from the commercial pool. This forces states to develop multiple contracts for serving the same population, and prevents them from being able to adequately and efficiently coordinate the delivery of services to the dually eligible by using the same providers for a defined population.

Enrollment Options

Under 1115 waiver programs, states are permitted to mandate the enrollment of the Medicaid population in managed care plans if they offer enrollees more than one choice of plans. In large states with heavy managed care populations, this "freedom of choice" requirement generally is not a problem. In small states, however, this requirement can virtually doom a state's ability to mandate enrollment. Because HMOs do not perceive significant enrollment opportunities in rural regions, small states have experienced difficulty in attracting managed care organizations.

The Medicare prohibition against mandatory enrollment and "locking-in" for more than 30 days Medicare beneficiaries who voluntarily enroll also disadvantages states. Since states may not require the dually eligible to obtain their Medicare benefits through a managed care plan, opportunities to coordinate and manage the care of this population through a single network operating under joint risk contracts are severely diminished. States have argued that this prohibition reduces the incentive to produce Medicaid savings since these savings are passed on to Medicare. In effect, states pay double for services: once for the Medicaid capitation payment, and a second time for Medicare premiums, deductibles and cost-sharing requirements. To maintain states' interest in the establishment of managed care programs for the dually eligible, states should be permitted to require subscribers to pay the difference between Medicare fee-for-service costs and the costs of providing the care through a capitated payment arrangement or provide opportunity for a lock-in for a limited period of time, e.g., one year.

Covered Benefits

Differences in Medicare and Medicaid requirements regarding covered services and benefit levels can complicate the provision of care to the dually eligible for both states and providers. States can dictate what Medicaid benefits a health plan must offer, but they have no control over Medicare benefits. Each individual health plan can determine which optional Medicare benefits to offer in addition to those required by Federal law. Further, health plans are required to offer supplemental benefits if Medicare payments in a given community exceed the plan's cost of providing the standard benefit package. This variation prohibits the establishment of uniform state-wide programs and diminishes opportunities for minimizing costs through administrative efficiencies.

The provision of care for the dually eligible also creates challenges for provider networks that offer services in multiple locations within a state or in more than one state. Networks must effectively develop multiple "products" or benefit packages to account for variations in benefit requirements across counties -- due to different Medicare payment levels -- and across states -- due to differences in Medicaid coverage requirements.

Differences in benefit requirements between Medicare and Medicaid programs further complicate care to the dually eligible due to conflicting financial incentives that lead to cost-shifting. For example, since Medicare is biased toward acute care, hospitals have the incentive to discharge patients as quickly as possible to LTC settings to maximize their DRG rate. Since Medicaid is biased towards long-term care, nursing home residents often must be transferred to an acute care setting to receive payments for services such as physician care.

Finally, differences in requirements for accessing certain benefits, such as Medicare's three-day-prior hospital requirement prevent providers and purchasers from providing the most efficient combination of services at the best time to meet patients needs. For example, under the Medicare fee-for-service program, home and community-based service eligibility is conditioned upon prior receipt of a higher level of care. Second, most HCBS waiver programs only allow Medicaid to pay for community-based services if the person is at risk of institutionalization. This prohibits providers from offering services early enough in the disability process to prevent further decline and ultimately leads to higher health care costs per capita and in the aggregate.

NCCC recommends that Congress address these problems by vesting authority for the Medicare and Medicaid programs for the over 65 with either the Federal or state governments in favor of the current structure of parallel authority between the two. Vesting authority with a single governing entity would pave the way for establishing uniform standards of care for the chronically ill and consolidating under a uniform system administrative structures, oversight requirements, reporting procedures and payment rules. It would substantially reduce duplication and eliminate conflicting incentives that frequently lead to cost-shifting from one program to the other. Further, delegation of authority for the Medicare and Medicaid programs for those over 65 to either the Federal or state

governments not only would diminish the challenges of caring for the dually eligible populations, but also, it would also create incentives for establishing a uniform policy for caring for the chronically ill in general.

Payment Methodology

States experience several problems based on differences in Medicare and Medicaid payment methodologies. Medicare payment rates are established by the Federal government based on a formula that takes into account utilization rates and prices in the fee-for-service sector. A payment rate is established for each county based on the "average adjusted per capita cost" of caring for the population and plans are paid 95% of this amount. States have no ability to negotiate rates with Medicare risk contract plans. Further, states are not permitted to receive direct payments from Medicare which would enable them to merge Medicare and Medicaid dollars into a single pool and establish a single, blended capitation payment for each plan enrollee. Under the Medicaid program, states have the ability to set capitation rates and providers can negotiate these rates with the state. States clearly would have greater flexibility in providing services under a pooled capitation rate. It also would enable them to address to some degree the county-by-county variance in Medicare AAPCC rates which makes it impossible to establish standardized benefit packages across the state.

IV. DEMONSTRATIONS FOR INTEGRATING PRIMARY, ACUTE & LTC SERVICES

Over the past 15 years, the public sector has undertaken a number of demonstration programs designed to eliminate legislative and regulatory barriers to the integration of primary, acute and long-term care services. These programs have been directed at improving access to services, enhancing quality of care, and reducing public expenditures for health care services. For purposes of this testimony, I will focus on three particular demonstration programs, including the Social HMO, PACE, and the Minnesota Long-Term Care Options Project (LTCOP). Each of these programs diverge from the Medicare HMO program established under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Federal government's first attempt at making managed care options available to Medicare beneficiaries. Each of these programs operate under TEFRA-like contracts, but extend TEFRA benefits to include some level of coverage for long-term care services. Each of these programs offer important lessons which will inform the ongoing development of managed care approaches and integrated delivery networks.

Social HMO and PACE Demonstrations

The Social HMO and PACE demonstrations have been operational the longest of the three demonstration programs. Upwards of 10 years experience with Social HMO and PACE programs provides extremely fertile grounds for better understanding how to predict and control chronic care risk and reduce costs through the integration of primary, acute and long-term care financing and delivery structures and aggressive care management techniques.

Both models represent prepaid, capitated health plans which provide elderly beneficiaries an enhanced package of primary and acute care services and varying amounts of long-term care benefits. For example, in addition to all Medicare Part A and B benefits, beneficiaries receive coverage for prescription drugs, eyeglasses, and hearing aides. Standard Medicare risk contracts cover all Part A and B services and Medicare copays and deductibles, but are only required to offer additional benefits if the cost of a health plan's benefit package costs less than 95% of the AAPCC based on the average community rate for the area. The Social HMO also includes up to $1,000 per month in home and community-based service benefits and PACE offers unlimited coverage of long-term care services. TEFRA contracts only cover short-term skilled nursing facility and home health care services for rehabilitation services related to acute care episodes. Providers also have more flexibility to allocate resources based on individual patient needs -- as opposed to restrictive payment guidelines -- under the demonstration programs than TEFRA contracts. For example, enrollees can be admitted directly to nursing homes without a prior three day hospital stay.

Social HMO and PACE Services are financed through pooled funding from Medicare, Medicaid and private premiums. Between two-thirds and three-quarters of PACE dollars are contributed by Medicaid and most of the remainder by Medicare. Only two sites (The Bronx and Rochester) have a relatively high percentage of Medicare only clients where subscribers pay a monthly premium equivalent to the Medicaid capitation payment. Alternatively, Social HMO funding is provided almost entirely by Medicare. Less than 5% of Social HMO patients are dually eligible and two of the three operational sites have eliminated private premium contributions.

Despite these similarities, the Social HMO and PACE models differ significantly in the populations they serve and the focus of their integration efforts. The Social HMO is an insurance model targeted toward a cross section of well and frail elderly. Although Social HMOs are permitted to queue to prevent adverse selection, only one site uses this technique. Currently, between 10% and 15% of Social HMO beneficiaries are disabled. The PACE program is a risk-management model directed exclusively at the frail elderly. Applicants to the PACE program

must be assessed "nursing home certifiable" to qualify for coverage. On average, members are disabled in between 1.8 to 3.4 out of 5 activities of daily living

The difference in the populations served has led each of these models to focus on a different aspect of integration and a different area of health service delivery. The Social HMO has expanded LTC insurance opportunities for the general population of Medicare beneficiaries. Because the Social HMO's long-term care risk is limited through an annual benefit cap, these demonstrations have placed greater emphasis on issues of rehabilitation prior to the time an individual qualifies for nursing home care. The capped chronic care benefit of up to $1,000 per month is intended to supplement the Medicare skilled benefit through coverage of convalescence after Medicare nursing home coverage expires, payment for short respite stays to provide relief for family caregivers and to pay for the initial portion of a permanent nursing home admission. Social HMOs would have stronger incentives to manage the interrelated costs of primary, acute and long-term care benefits if they were fully at risk for all of these benefits.

The PACE program targets a smaller niche of the Medicare market, those who are extremely frail as well as dully eligible for Medicare and Medicaid services. About 90% of PACE enrollees are dually eligible. Since PACE is fully at risk for all primary, acute and long-term care services for a frail population, this program has been forced to more extensively restructure and more fully integrate all patient care services, but only after the subscriber has become severely disabled. This is accomplished through an interdisciplinary team approach to care provided under an adult day care center model. PACE enrollees visit day care centers up to 6 days per week where they receive a wide range of primary care, rehabilitation and medical services on frequent basis.

Another important advantage of the Social HMO and PACE models over the TEFRA model relates to the payment structure for disabled enrollees. Both models include stronger financial incentives to care for the severely chronically ill, unlike traditional risk contracts. TEFRA risk contractors are only rewarded financially for subscribers who are sufficiently ill or impaired to warrant institutionalization. Payment for the institutionalized can be significantly higher than for community-dwelling subscribers. The Social HMO and PACE programs include a risk-adjustment for *community-dwelling* seniors who are frail as well. Plans receive almost 2.4 times the premium level for frail elderly, regardless of where they are living.

The Social HMO and PACE programs have demonstrated the importance of linkages between the acute and long-term care systems. Both have produced strong evidence, for example, of the critical importance of care management as a tool for preventing the onset or progression of disabilities and for controlling costs. PACE subscribers' plans of care are monitored continuously thorough day care staff to determine the need for a change in proposed treatment plans. The care coordination resulting from regular communication with subscribers helps to anticipate health problems, avoid flair-ups of chronic illness and prevent acute illness. While PACE has not been formally evaluated, sites report a 15% savings compared to the traditional fee-for-service sector.

The Social HMOs perform quarterly assessments of the nursing home certifiable population to determine ongoing need for services. This care management function is extremely important to helping control costs since Social HMO beneficiaries only remain eligible for long-term care services while they are nursing home certifiable. Less than half of those qualified as nursing home certifiable at any time remain in this category consistently for more than one year and many fully recover following rehabilitation. Thus, the long-term care benefit can be discontinued for those who regain functional ability and these dollars can be redirected to those in need, thus helping to maintain stable costs and premiums. Social HMOs also have identified several factors which predict the likelihood of someone remaining nursing home certifiable vs regaining functional ability. This information is used to monitor subscribers' health status and develop appropriate interventions.

Notwithstanding the initial progress towards integration and cost-containment made by these demonstration models, there are a number of constraints that will need to be addressed in further generations. One of the most significant barriers to effective management of chronic illness and the consequential cost-savings potential relates to each model's targeted population. The Social HMOs have a limited incentive to aggressively manage LTC benefits since they are not at financial risk for these services. PACE has the financial incentive to manage all services, but opportunities to reduce expenditures associated with chronic illness are limited by the nursing home certifiable eligibility requirement. This represents a significant limitation relative to overall system cost containment since the majority of long-term care episodes originate from acute illness.

The Social HMO and PACE models also could be significantly enhanced through consolidation of administrative and oversight requirements. While both models permit providers considerably greater flexibility in clinical decisions regarding service allocation by virtue of waiver authority, many of the administrative barriers to integration cited above continue to plague these programs. For example, providers must enter separate contracts with Medicare and Medicaid and are subject to parallel and often duplicative oversight requirements related to data collection and documentation. NCCC also believes that the PACE program could be enhanced through relaxation of prescriptive protocols governing service delivery. For example, barriers to entry include unwillingness of

prospective subscribers to attend the adult day care program the expected four to five times weekly, and the importance of family support to provide coverage outside of the day care setting. Greater exploration of housing options such as assisted living and supportive senior housing arrangements could help eliminate these barriers.

Finally, it is important to highlight a problem experienced by the Social HMOs with respect to a conflict between marketing and risk-management. Social HMOs have had to invest precious resources resolving marketing issues that could have been targeted more effectively on systems development. Social HMOs have found it difficult to compete with the TEFRA plans in their area due to the higher costs associated with the long-term care benefit. Since they can't be price-competitive, they must highlight the long-term care benefit as a justification for their higher costs and to demonstrate superiority over their TEFRA counterparts. Yet, by highlighting this benefit, Social HMOs risk substantial adverse selection since they will attract those who most need this benefit. If they minimize or "de-market" this benefit to prevent adverse selection, they undermine their own ability to compete with TEFRA risk contracts based on price. Almost all of the Social HMOs experienced difficulty meeting their enrollment targets early on which led to higher than projected administrative costs per capita and lower revenues.

The marketing/risk management conflict has affected Social HMO sponsors' ability to get the degree of "buy-in" across the entire system which is critical to developing a fully integrated system of care. Social HMOs do not have sufficient market share to leverage providers to change their practice patterns. For example, some programs have experienced resistance from physicians in requiring that a separate set of clinical protocols be employed for a subset of patients comprising less than 5% of the systems' total patient population (i.e., Social HMO subscribers).

These marketing challenges have diminished the Social HMO's ability to effectively integrate the provision of primary, acute and long-term care services to date. Two of the three existing sites have eliminated the private premium originally charged in order to be more competitive with TEFRA HMOs. The elimination of the Medicare premium may increase the Social HMOs' competitive position with seniors, particularly if it is clarified that these entities no longer are subject to an enrollment cap.

NCCC recommends that Congress enact legislation which makes permanent the waiver authority granted to existing Social HMO demonstrations and enables other provider networks to establish like programs. We also strongly recommend that legislative authority be established to provide for the establishment of additional Social HMO and PACE programs. However, it is critical that this authority be sufficiently broad to enable provider-based networks to continue evolving these important models as opposed to simply expanding the same models under existing protocols.

Minnesota Long Term Care Options Program

The Minnesota Long-Term Care Options Program (LTCOP) was developed to facilitate the integration of primary, acute and long-term care services for persons over age 65 who are dually eligible for Medicare and Medicaid benefits. After two years of intensive efforts, the state received a unique package of waivers which will enable them to combine the purchase of both Medicare and Medicaid services under a single contract and permit the state to contract with smaller entities which previously were prevented from contracting with Medicare on a risk basis.

A major goal of this demonstration is to eliminate the extensive duplication of effort and conflicting financial incentives which typically characterize programs for the dually eligible.
The LTCOP program will combine services and funding from several sources, including Medicare, the prepaid medicaid managed care program (PMAP) and the Elderly Waiver program. Minnesota already has been enrolling elderly medicaid beneficiaries in managed care programs for a number of years, but PMAP does not cover extended long-term care benefits. PMAP does cover hospitalization, physician visits, rehabilitation therapies, home care services, medical supplies and equipment, dental, prescription drugs and Medicare copayments and deductibles. Under the LTCOP program, enrollees also will be entitled to all Medicare Part A and B benefits, home and community-based services covered under the Elderly Waiver program, and the 180 days of nursing facility care for those who enroll while living in the community. Additional nursing home expenditures will be funded under the traditional nursing home benefit, outside of the managed health care capitation rate.

The LTCOP program differs from the Social HMO and PACE programs in several ways. First, it will initially be implemented in seven counties with a view toward state-wide expansion over time. Unlike the Social HMO and PACE, the number of participating sites is not restricted under law so the number of beneficiaries served could be substantially higher. Second, pursuant to Minnesota's 1993 health care reform legislation, services will be delivered primarily through integrated service networks (ISNs) and community integrated service networks (CISNs). These organizations will be responsible for providing the full range of primary, acute and long-term care services for a pre-determined, capitated premium. To qualify as a LTCOP contractor, providers will be required to meet a higher "standard" of integration such as developing integrated information systems which assure the flow of pertinent clinical and logistical information across points of service from hospitals to home health care agencies.

NCCC believes the use of the ISN and CISN models will result in much greater mainstreaming of this program even during the demonstration phase.

Third, although it is targeted toward the dually eligible program like PACE, enrollees do not have to be nursing home certifiable to qualify for LTCOP. Well-elderly also will be enrolled and, like the Social HMO providers, will have the opportunity to take precautions against chronic illness either before the onset of disabilities or earlier in the process. This has tremendous cost-savings potential. Fourth, the LTCOP program has further refined the risk-adjustment process used by the Social HMO and PACE programs by developing four different payment levels that account for different levels of disability. For example, for community-dwelling subscribers who are not nursing home certifiable, plans will be paid 95% of the non-institutional Medicare AAPCC, the non-institutional PMAP rate and a nursing facility add-on to account for up to 180 days of nursing home care. For individuals receiving nursing home care for at least six months who return to the community for at least one year, plans will receive Medicare payments based on the PACE risk adjustor (i.e., 2.39 times 95% of the AAPCC); the institutional PMAP rate; and twice the average monthly Elderly Waiver Payment. Unlike TEFRA HMOs which only reimburse higher amounts for the institutionalized, this payment methodology creates significant financial incentives to care for a severely chronically ill population.

The fourth difference between PACE and Social HMO programs and LTCOP may be among the most significant from the states' perspective because it significantly simplifies program administration, diminishes opportunities for cost-shifting between Medicare and Medicaid, and provides an opportunity for states to implement a fully coordinated state-wide long-term care strategy as distinct from the current county-by-county approach. The LTCOP is the first state-based managed care program for the dually eligible elderly which enables the state to consolidate the administration and oversight of both programs under a single umbrella. It includes several unique features. The state will negotiate a single contract with HMOs and CISNs for capitated risk-based Medicare and Medicaid services under an agreement with HCFA, instead of multiple contracts for various providers under each program. In addition, there will be a single, instead of dual, enrollment process for the dually eligible. The state will incorporate quality assurance functions for Medicare services into its existing PMAP (Medicaid) managed care quality assurance process instead of being required to establish a separate system. Finally, the overall continuing care of each enrollee will be coordinated by a case manager who will have access to all of a health plan's medical information and health resources.

The LTCOP program clearly has the potential to demonstrate the impact of a more fully coordinated system of care on cost and quality. To date, no formal mechanism has existed for documenting the costs of parallel administrative and oversight requirements for Medicare, Medicaid and state-based long-term care programs. Further, LTCOP will help assess the impact of more fully integrated systems on quality of care and health care outcomes. Improvements in these areas could have tremendous implications for consumer satisfaction and cost-containment. Like the other demonstrations, however, LTCOP has a few limitations worth noting. First, the waivers do not allow health plans to require subscribers to receive Medicare services from health plan providers within the capitation payment. Subscribers are free to continue receiving Medicare services outside the plan. This makes it difficult for the health plan to assure coordination between plan providers and Medicare providers which can lead to inefficiencies. Demonstration guidelines, however, would not require plans to cover the copayments and deductibles for Medicare services provided outside the plan since enrollees are locked-in for Medicaid services. This provides a strong incentive for enrollees to obtain their Medicare benefits within the managed care system.

A second limitation of the LTCOP program is that it only serves the dually eligible which prevents Medicare-only patients from accessing the many advantages offered by this coordinated system of care. Given that the dually eligible represent the greatest challenges, both in terms of regulatory barriers to integration and the high costs of care, NCCC believes that this population is an appropriate place to start. The lessons learned under this program will be more easily translatable to the Medicare population since services are funded primarily from one source.

V. THE CASE FOR MOVING BEYOND DEMONSTRATION STATUS

Demonstrations provide a valuable opportunity for testing concepts in a controlled environment prior to implementation on a wide-scale basis. NCCC believes, however, that sufficient experimentation with the integration of primary, acute and long-term care services has occurred to warrant moving beyond demonstration models and toward mainstream programs that could be implemented on a wide-spread basis within a clear regulatory framework to assure ongoing quality and cost controls. There are a number of limitations related to demonstration programs that impede the development of integrated programs for the elderly and chronically impaired. The rapid growth of the elderly population, the advancement of chronic conditions as the fastest-growing segment of the health care market, and the acceleration of costs associated with these two trends argue strongly for moving beyond a demonstration model. A number of serious limitations of the demonstration model aptly make this case.

First, demonstrations are implemented in an artificial environment, freezing in place certain research designs and prohibiting modifications to these protocols as learning occurs. The evolving dynamics in health care require a reengineering approach to change implemented in mainstream environments under flexible arrangements rather than a research and demonstration strategy. Second, size creates significant limitations on the demonstration approach. There are only 3 Social HMO sites currently operational with six more scheduled for implementation later this year. Over 10 years, only 50,000 seniors have been served. Demonstration authority for the PACE program is limited to 11 sites which serve between 170 and 350 members each.

Size creates several problems. It impedes rapid learning since so few sites are testing and refining concepts and minimizes the cost savings potential and efficiencies that only can be gained through economies of scale. It also creates internal challenges to organizations and discourages providers from fully embracing the goals of the program. It limits providers' ability to penetrate the market and test the competitive advantage of this model over others. Consider the difficulty of convincing physicians and other clinicians in a large health care system to use one set of protocols for regular HMO patients that comprise over 95% of the systems' patient load and a different set of protocols for a patient population that may in fact represent 5% or less of all subscribers. Consider convincing administrators to implement a separate management information system which aggregates clinical, cost and quality data for a patient population that represents a small percentage of the system's total revenue. Consider convincing the chief financial officer to enter a risk-sharing arrangement for a population that is at risk of consuming significantly higher than average resources when this risk will be spread across less than five percent of the entire patient population.

Third, demonstration status can discourage providers, payors and state governments from establishing programs. Demonstrations require considerable time and investment of resources, yet the "pay-off" and return on investment is uncertain unless sponsors receive some assurances that they will have the opportunity to mainstream the programs in which they are investing. PACE sites need to make a significant investment before even applying for Federal waivers since they must become operational under state-based Medicaid capitation systems first. Even after demonstrations are operational, demonstration status continues to absorb significant amounts of administrative, financial and clinical resources since sites must continuously return to the Congress and Administration for extensions of waiver authority to remain operational. Valuable time is taken away from day-to-day operations, research and patient care while sites are collecting data and building a case for their ongoing existence.

Demonstration status also has discouraged consumers from enrolling in programs due to the uncertainty of the health plan's future. HMOs already have difficulty attracting seniors unless the senior's physician already is part of the health plan. Seniors are more reticent to "leave" their physicians behind than the younger population. Adding a second significant barrier -- the prospect of having to change plans and providers in the future if the demonstration is not continued -- exacerbates the marketing problem. This can be especially problematic for senior citizens and chronically impaired persons whose "insurability" may be marginal to begin with due to the high risk of needing extensive health care services.

The NCCC does not intent to suggest that selected concepts should not be tested under controlled conditions. Yet, unless the Federal government breathes more flexibility into mainstream operations with incentives for developing new and innovative approaches, the health care industry will not successfully respond to emerging demands as we enter the 21st Century. For these and other reasons, NCCC strongly urges the Committee to establish a permanent provider category under Medicare and Medicaid which promotes the establishment of integrated provider networks.

VI. NCCC RECOMMENDATIONS

NCCC recommends that Congress take the following actions to help promote the integration of primary, acute and long-term care services as a strategy for increasing consumers' access to needed health care services, improving health care outcomes, and reducing health care expenditures.

A. Comprehensive Initiatives

EXPANSION OF PROVIDER-BASED NETWORKS: Establish authority for provider-based networks as a new managed care option available to Medicare and Medicaid beneficiaries. Networks would be subject to a uniform set of requirements governing administrative, payment and oversight policies. Networks would be required to demonstrate capacity related to integration and risk-based financing criteria would build on the experience of the Social HMO and PACE projects in areas such as establishing risk-adjustment payment methods.

ADMINISTRATIVE REFORM: Direct the Secretary to consolidate administrative requirements for organizations providing services to a defined population through an integrated health care network. All Medicare and Medicaid services provided by a federally qualified provider network would be subject to a uniform set of administrative reporting procedures, performance standards and payment methods.

PAYMENT REFORM: Direct the Secretary to develop incentives for risk-based, capitated financing for provider-based networks which provides for the pooling of Medicare, Medicaid and private coverage including Medicare supplemental policies, private LTC insurance policies or subscriber premiums. Payment reform should build upon the risk-based payment methodology designated for Social HMOs and PACE programs. Incentives might include health status adjustments, blended capitation/actuarial use rates, risk corridors, risk and outlier pool arrangements and withhold and bonus arrangements.

CHRONIC CARE RESEARCH: Direct the Secretary to conduct research related to the costs of chronic illness to: (1) determine the aggregate costs of services for the chronically ill by documenting Medicare, Medicaid and private expenditures across settings for specific conditions and (2) establish outcome indicators for chronic conditions that measures quality over time, not at the point of discharge from each individual setting.

B. Targeted Initiatives

- Direct the Secretary to develop regulations which grant permanent waiver authority for existing Social HMO I and II sites.

- Provide for the establishment of additional provider-based integrated delivery networks as an expanded Medicare managed care option. Criteria should be sufficiently broad to permit the expansion of Social HMO and PACE sites as well as alternative integration strategies that continue to evolve the Social HMO and PACE models under permanent waiver authority.

- Explore opportunities to further enhance integration capabilities through collaborative efforts between provider networks and the newly established Veterans Integrated Service Network initiative.

- Eliminate 50/50 rule requiring Medicare HMOs to enroll at least 50% of subscribers from the commercially insured population.

- Establish a state-based dually eligible demonstration program to develop models for integrating primary, acute and long-term care services for the dually eligible which would permit states to integrate quality assurance systems, enrollment procedures and other administrative, financing and oversight requirements for the Medicare and Medicaid programs under a single umbrella.

- Provide either the Federal or state government with the financial responsibility and program authority for the Medicare and Medicaid programs for the elderly and disabled as a strategy for consolidating program administration, increasing operation efficiencies, and aligning financial incentives between programs

Chairman THOMAS. Thank you very much.

Mr. Bringewatt, my goal when I first involved myself in this area was to try to get the payment system to reflect a continuum of care based upon patient need. You have given us a couple of good examples of how it simply does not do that. You deal with the patient care based upon the payment system, and I went through this personally with my father, which got me focused in the area. It made no sense in terms of some of the things I had to do based upon his needs, and the answer I always got was well, if we do not do it that way, we do not get paid for it.

And so, my goal has been to create a need-based continuum of care that you draw on. I agree with you totally on that, and then, you went to a solution, which is to create a permanent waiver for particular programs. And my concern is to find out what it is that we are waiving that makes these programs work and get rid of it, because I think it is a problem for the entire system, and that I do not want to go to a permanent waiver for particularly defined programs; I want to change the system so folks can get in and out of it in providing for the various needs.

In listening to the discussions, and even, Dr. Wiener, in yours, and I want to know if this is a fair criticism because I simply do not know; we are talking about making comparisons in the costs for these programs to the traditional Medicare and Medicaid, and I am wondering if we are looking at the universe of costs when we compare, say, a SHMO, integrating long-term care into the normal acute program. Is there any money outside of the Medicare/Medicaid model we use for comparative purposes on costs that we are not considering which should be part of the pot if we are creating a completely integrated program between acute and chronic?

Just let me give you an example: We passed a health care bill—it is over in the Senate; it is being debated right now—in which we are allowing long-term care insurance costs to be deducted as part of health care costs above 7.5 percent of AGI on your income tax, on Schedule D. And we accepted a memo which would allow actual long-term care costs to be deducted. It seems to me when we are dealing with several billions of dollars of deductions off of income tax, that is probably not part of the pot we have considered historically available to pay for these programs. And one of the things this Committee has wrestled with is long-term care. Everybody talks about it out there; it is something we need to deal with; it is on the horizon; when in fact, it is here, and we are not really facing it. And what I see is the possibility of setting up a program which takes the current arrangement, increases it 5 percent from 95 to 100 percent, gets rid of some arcane rules as far as I am concerned that may have had some historical use for us, 50/50 or others, and we essentially begin to deal with the long-term care problem. To say that it may not be cost-effective because it does not stay within 100 percent of the expenses of Medicare and Medicaid is not fair because it requires that model be based upon the potential costs that this Congress will place on the American taxpayer in another context to deal with long-term care. Do you understand my direction? Are we not counting all of the money that should be in the pot to deal with the unique continuum of care provided by the SHMOs and for a defined group, the PACE program?

Mr. WIENER. Well, certainly for the SHMOs, there are private payments as well.

Chairman THOMAS. I am looking primarily on the government side in terms of expenses that we would accept. I understand the private payments. Are you with me? Do you understand what I am talking about?

Mr. WIENER. I am not entirely sure.

Chairman THOMAS. Does anybody understand what I am talking about? Take a shot at it.

Mr. BRINGEWATT. Well, let me try here. Obviously, Medicare and Medicaid represent the lion's share of dollars relating to people who have chronic diseases and disabilities on the acute and the long-term care side. However, there are other public programs that also provide care to the same population. They include social service block grant programs under Title 20; they include the Older Americans Act programs; and they include the Veterans Administration, where there is a significant dollar amount relating to similar populations.

Chairman THOMAS. And, I might add, all the legislation we have not yet passed to deal with long term care, which will certainly cost significant amounts of money, and especially when you can begin talking about programs that focus on defined groups, as PACE has done with the frail elderly, but as programs will do with end-stage renal disease and others which will give us a packaged program that if we examine all of the costs that would otherwise have been expended rather than just the Medicare and Medicaid 100 percent dollar amount, then, in fact, we would find savings larger than we think and more importantly programs that meet specific needs of patients so that the quality aspect, which we cannot always quantify, is nevertheless one that we believe strongly in.

Mr. WIENER. Mr. Chairman, I would certainly hope that we would find those savings, but I do not think that you can guarantee it. For example, if you have a nursing home-level person who is out in the community and receiving SSI and food stamps, once they enter the nursing home, basically they lose all of those SSI payments and food stamps, and it all shows up in the Medicaid budget. If we succeed in keeping that person out in the community, then we have to pay SSI; we have to pay food stamps; and whatever their medical and long-term care costs are. So it may net out that we save money, but it may net out that we do not.

Chairman THOMAS. And all I am saying is that we need to look at the larger picture whenever we talk about the costs that are necessary.

You also indicated, Dr. Wiener, that there was some concern about who controls the programs that the doctors are involved in. Is not one of the key aspects of both the SHMOs and certainly of PACE the idea of this team component, which is more and more emphasizing a kind of interdisciplinary geriatrics approach to dealing with the issues, and, certainly, various models will have different folks in control. But would the marketplace not tend to take care of that if you made permanent the concept, and instead of making it a permanent waiver, simply allow HMOs a higher percentage of the costs or all of the costs if they would fold in these costs? With programs that better met the needs of seniors through

an integrated geriatric program instead of—and I do not mean this pejoratively—a narrow, doctor-controlled program that did not look at the larger picture—there would be winners and losers. And I would much rather have the marketplace try to determine winners and losers than government trying to identify structures that may or may not work.

Mr. WIENER. Well, we can certainly—if we can open things up, we could see what the effects of the market are. As you know, only about 9 percent or 10 percent of the elderly have chosen to join HMOs, and we have only a small handful of programs that integrate acute and long-term care services. In terms of integration, the Social HMOs have focused on smoothing the transitions between acute and long-term care. But certainly the PACE model has done that. But again, we just do not have a whole lot of data. It may be that PACE and the SHMOs are able to take into account the needs and the desires of the individual clients. But it may also be that, driven by the need to save money, in a larger setting, they may decide that there are certain things that people cannot have. And at least at this point, there are not a lot of options out there for people.

Chairman THOMAS. Well, and the other cost that I am looking at is the last 6 months argument and the quality of life versus quantity and the expense that this society currently spends on the question of death and near dying. And finally, and Dr. Leutz, if you want to get in, I will let you in, the whole question of data collection has been frustrating us across the health care spectrum in terms of outcomes research not just for this particular area. Frankly, we are way behind the curve in utilizing the current data gathered in a way and manipulated in a way with complete security for privacy that would provide us with a whole lot more information than we should have. And so, one of the thrusts, I think, which is currently bipartisan that we are trying to move forward on is outcomes research and data collection.

Mr. LEUTZ. Mr. Chairman, I just wanted to respond to your question about putting this out on the market. It is important, I think, if this does go on the market that there be some minimum standards set about what a Social HMO is and what you do for this extra 5 percent. The proposal that we made has set out minimum benefits in terms of dollar amounts. Prescription drugs has always been and I would maintain should continue to be a part of the benefit package, and also, you might include standards around geriatric care; you might include standards around service integration; about screening the membership; having case management; doing chronic disease management and so forth. And there should be a minimum set of things that you do in order to be able to call yourself a Social HMO on the market, it seems to me.

Chairman THOMAS. Well, my concern there would be to define a particular product which would not allow for continued innovation, which I think we probably need, although obviously, a positive definition of who you are to me is far better than a waiver structure with a restriction on the amount of folks you can bring into the program. That seems to me relatively self-defeating; in fact, it defines a demonstration program and guarantees that you will re-

main a demonstration program. And I think what we are talking about is trying to break out of that.

The limits on the breakout in terms of what you can and cannot do are obviously something we could discuss as we move forward. I want to thank the panel very much, and especially for your written testimony. You never get to present as much material as you have in your written testimony, but it is very helpful to us, because this is an area, I think, that the Subcommittee will continue to want to increase our knowledge curve on.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. I do not know whether you have the experience to answer this question or not, but managed care plans have had some experience in Medicare, particularly in those areas where Medicare Select was allowed. They currently have the legal right to offer Medigap policies. The terms of the Medigap policies are that you participate in the managed care system. It would have the effect of their receiving the Medicare premium for payment for participation in the Medicare managed care plan.

Now, under a Medigap policy offered by Medicare Select plans, in other words, if any managed care plan wants to offer a Medigap policy covering exactly the services you want, it would have the effect of a capitated payment, plus whatever additional costs they thought they had to charge for the Medigap policy, and they would not be covered by the 50/50 rule for, I think, any of the impediments that block your development.

Now, is that true or untrue?

Mr. LEUTZ. Well, one impediment that has not been mentioned in terms of the payment system that a Social HMO gets, and it is also fundamental to the PACE plan, is a disability-based AAPCC. The payment is based upon Medicare fee-for-service equivalent, but within that is a different underwriting factor that pays higher for community residents who meet nursing home eligibility criteria.

Mrs. JOHNSON. So, in other words, if we wanted that development to move forward in the private sector, we would have to offer not just the Medicare premium but the higher disability-based premium?

Mr. WIENER. I think the key point is that under current law or practice, if you have a very severely disabled person, and they go to a nursing home, that is great for the HMO, because they get a significantly higher payment. If they keep that very same person out in the community, they get a dramatically lower reimbursement rate. What you have for the SHMOs and for On Lok/PACE is an ability to get that higher reimbursement while that person is in the community.

Mrs. JOHNSON. But if, under a Medicaid block grant structure, there would be no impediment to a state setting a rate for Medicaid eligible disabled for a Medigap premium, for a plan that would offer a managed care Medigap premium plan that would offer everything you are offering and for that Medicaid eligible disabled a higher premium. That would leave the Medicare-eligible disabled at a disadvantage, correct?

Mr. WIENER. There would be no impediment except the one that Representative Stark alluded to—which is that the gross amount

of money available to the state might be substantially less. But you would still have the problem on the Medicare side.

Mrs. JOHNSON. Now, in terms of the Medicaid issue, my impression is that there has been a demonstration project that has demonstrated that you can reduce the rate of growth of long-term care costs by more effectively targeting your reimbursement rate just the way we have been talking about, I think it is in New Jersey, but I am not sure. One of the states was able to merge their Medicaid and Medicare moneys.

Mr. WIENER. Arizona.

Mrs. JOHNSON. Was it Arizona?

Mr. WIENER. Well, I think Arizona is a very interesting case. But if you look very carefully, you will see that they get most of their savings by serving fewer people than would be served under a traditional program. The per-member, per-month cost in Arizona compared to a traditional program is basically the same. So they do get significant savings, but they come from serving fewer people.

Mrs. JOHNSON. Mr. Bringewatt?

Mr. BRINGEWATT. Yes; if I could make a couple of points. One, first of all, just in looking at the Medicare Select program by itself, in terms of the moneys that are available for long-term care, I think it is important for us to keep in mind that the dollars there really relate to acute care benefits and not long-term care benefits. And so, it is helpful to free a system up to spend those moneys, but it does not necessarily mean that there will be long-term care that comes as a result of that.

Mrs. JOHNSON. You misunderstood me.

Mr. BRINGEWATT. OK.

Mrs. JOHNSON. My assumption is that the managed care plan would offer a Medigap insurance policy that would add on these benefits and would charge a premium for that. But their savings, the benefit for them, would be that the Medicare participant would then participate in their managed care plan, which would be a good deal for them on the acute care side, and they would use this to encourage people to be in their managed care plan. And what the person would get back for it is an integrated care system which is broader than anything that Medicare offers. So, I am not suggesting that they would not be offering the same benefits. In fact, what interests me is that they would have the power to offer those same benefits, and they would have to charge some additional premium.

For a Medicaid disabled person who was not Medicaid-eligible, this would provide them with access. And I get the idea that the premium probably would be modest.

Mr. BRINGEWATT. I think—and maybe Mr. Leutz can speak to this—but in some ways, what you are describing would be a variation on the Social HMO program. You could offer an additional long-term care benefits that could be developed through an additional premium.

Mrs. JOHNSON. Right. My question is—and you can also think about this and get back to me—is there any reason why the Social HMO model could not be offered through the private sector, through managed care plans offering a Medigap policy to add on all of the other benefits of the Social HMO?

Mr. LEUTZ. Well, the one reason we talked about before was this disability-based payment to protect them on the Medicare side. But on the Medicaid side, in fact——

Mrs. JOHNSON. Excuse me; on the Medicare side.

Mr. LEUTZ. Yes?

Mrs. JOHNSON. The disabled might simply have a higher premium for the Medigap insurance.

Mr. LEUTZ. Well, they would get a higher Medicare payment to protect against the——

Mrs. JOHNSON. Well that would help, because it would function like a capitated payment.

Mr. LEUTZ. Yes, it would be—oh, I see, so you are talking about an indemnity insurer at this point.

Mrs. JOHNSON. No, the way the government relates to a managed care plan, the premium goes to the managed care plan.

Chairman THOMAS. Let me try it.

Mrs. JOHNSON. Yes.

Chairman THOMAS. Instead of getting 100 percent of the AAPCC, what we actually did in the Republican plan was to give all of the managed care 100 percent as an inducement to increase the opportunities. Instead of taking that 100 percent and the waiver from the 50/50 rule and the other requirements for your average Medicaid patient and then putting the long-term care component within the dollar savings that you get because of managed care, including prescription and vision, she is suggesting that you take your managed care program and have a Medigap policy available to those who can pay it which would add a long-term care component to the HMO plan.

Mr. LEUTZ. That seems to me essentially what the Social HMO models that are out there do right now.

Mrs. JOHNSON. You have the right to do that under current law.

Chairman THOMAS. So, it would be a self-selecting SHMO by the individual in terms of the package that they pick up from the HMO. Not everyone in the HMO would be in a SHMO, only those who have picked up the Medigap aspect of the long-term care, making it a SHMO for them.

Mrs. JOHNSON. See, that is exactly what I am saying. Now, it means that the managed care plan could offer this, cultivate that, develop. But you would not have to be tied by the 50/50 rule; you would not be limited by the waiver; you would not be a demonstration. You would just simply be an insurance plan. But you would take the benefit of what we have learned in SHMOs and even PACE.

Now, with PACE, you would need the state to guarantee you the disability level payment. But this is one of the things I want you to think about is how do we replicate this in the private market, because the private market is way ahead of us, and no matter how fast we legislate, they are probably going to be doing this in 6 months or a year, and we ought to think about how they are going to do it and whether we like the way they are going to do it.

Mr. LEUTZ. Just if I could—as I read what the private market has been doing under Medicare anyway, the tendency has been to offer in most markets less benefits and not richer benefits, that the fear is that plans will attract the sicker people; in this case, if you

offer disability-based services, more disabled people who are more expensive. So the question is, why would they do that if they can offer a stripped-down Medicare plan with minimum benefits and get plenty of people's money that way?

Mrs. JOHNSON. They cannot offer a stripped down Medicare plan. They can only offer Medicare benefits. I mean, the Medicare HMOs, that is all that is in the market now. The right of managed care plans to be in the market is fairly recent, and so, those plans are only now qualifying themselves. But as they develop their position in the market, there is absolutely no reason why they cannot offer a Social HMO as one of the Medigap policy benefits.

Mr. LEUTZ. That is right; there is no reason why they cannot.

Mr. WIENER. I think that is right. I think what it boils down to is the question that Walter raises, which medical underwriting, because nobody is going to offer a long-term care benefit if they cannot do extensive medical underwriting. And at least in the HMO program, that has not been allowed so far. I think that is one of the key issues. But I think you are basically right that if plans want to offer these kinds of benefits, they can now. It may not be optimal in terms of the Medicare reimbursement, but they could probably do it if they wanted to.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. And just add the one other component to it, in which you could, then, from a government point of view create an incentive on the multiplier factor like we do with PACE for those people who perhaps cannot find a product. All you have to do is get a profile of those people, the disabled or others, and you create multiplier factors based upon those individual patients so that you get a mix of benefit to the HMO on the dollar amount. That would be a more sophisticated AAPCC model far beyond that so you can get people on the basis of what it costs to pick them up and put them in the program, and the government pays on a more specific basis of what the needs are. And then, I think you will find a home for everybody who is out there.

The difficulty is, of course, the risk factor formula, which has been eluding everybody for 15 years or more, and that is an area along with data collection that we need to work on to be able to have a sophisticated ability to say this is how much we need to help this person in this program.

The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman. I appreciate the discussion we have just had, and I think there are tremendous problems associated with trying to do what the gentlelady suggests if you are trying to have the government supply the wherewithal or private plans to operate in that manner. It seems to me the administrative burden of individually figuring thousands and thousands of conditions of individuals would be mindboggling.

But anyway, be that as it may, let me get back to some easier questions for you. Dr. Wiener, you talked about the possibility that in these comprehensive, continuum-of-care plans, the bias of the medical community may intervene to allocate more of the resources toward acute care and not to long-term care. Have you any evidence in any of the plans that are out there now that that is occurring, or is that just——

Mr. WIENER. Well, we do not have a whole lot of evidence. There is some evidence—Walter may wish to dispute it—that over time, that as the Social HMOs entered a more competitive acute care marketplace and as the costs on the acute care side rose, that the long-term care benefit, was pared back so that they could keep the total premium down to a competitive level. So, that is one illustrative example, but we do not have a lot of evidence on that. But it is a worry. If you have a Social HMO model, the vast bulk of the expenditures are for acute care, and the long-term care is relatively small, and it just becomes easier to chip away at that to feed the much larger, much more dominant acute care system. It does not necessarily have to happen; it is just one of the risks that is out there.

Mr. MCCRERY. Dr. Leutz, do you have any comments about that?

Mr. LEUTZ. Well, one place that I think Josh is right that the current sites did cut back on their coverage of long-term nursing home care. But most of them increased their coverage of home and community-based services, because this was where they thought they were having the most effectiveness and this was the preference of members.

The fear, though, that is expressed is a fear that I hold, too, and I have been an advocate of having minimum or clear standards for eligibility so that people understand what their benefit is in long-term care and also clear standards for what it buys in terms of a set of services up to some kind of well-understood amount, a dollar amount like the current sites have if there is going to be a limit.

Mr. MCCRERY. And finally, Dr. Leutz, do you have anything to add on this whole question of whether this form of providing medical services, this continuum of care concept, provides us any long-term savings in the system? Dr. Wiener, for example, pointed out that as you keep people in a community setting rather than a nursing home setting, you continue to give them SSI benefits, food stamps, have you considered that whole question of net costs to the system?

Dr. LEUTZ. Well, I guess it depends on how large you define the system. Medicare has been set up—at least under the demonstration so far—not to make any savings. Medicare pays its fee for service equivalents. So then, the question is if there are savings on that, where do they go? And I think that there have been savings on the Medicare package of services. If you look at the utilization levels for hospital care, for example, they are much lower than fee-for-service. And those savings have now gone to the members who joined the plan in the form of a richer package of benefits; prescription drug benefits and the long-term care benefits are the primary ones.

There has also been some evidence of savings for Medicaid, in terms of reduced utilization of nursing homes by private-pay members, which has slowed spend-down.

Mr. WIENER. I think it is an important thing to underline that these demonstrations have not been set up to produce large savings. There may be large reductions in utilization; there may not be. But whatever savings you get from that are being recycled back into the program for other kinds of benefits. So if your eye is on the, the Medicare Trust Fund, you are not getting any particular

savings, and you would not get large savings by expanding the program.

Mr. MCCRERY. Yes. I agree with you that the trust fund is not being particularly affected one way or another by these demonstrations, but looking no larger than that, it seems to me that you do have potentially some Medicaid savings. But it really gets down to the question of does this method of providing care for elderly and disabled folks, provide us any net savings, and I will go so far as to say the private system or the public system, because we have heard conflicting testimony about preventive care and managed care, and whether, in the end, it provides us any savings at all. It may provide for a better quality of life in the last few months or something like that, but if you are talking dollars and cents, it does not really provide us any savings.

Any thoughts on that?

Mr. LEUTZ. I think that for many Social HMO members, there are some real potential savings. If it allows a member who comes in under private pay, for example, to remain at home and not have to enter a nursing home, which they would have had to pay for out of pocket, then that is a savings to them. Now, I cannot quantify those savings, but that is one type of savings that could occur to beneficiaries.

Mr. WIENER. I think the demonstrations clearly show that capitation works here as well as elsewhere. Whether you get substantial additional savings by integrating acute and long-term care, I think the jury is still out on that. But capitation does produce savings, by creating a system that allows substitution and by really turning the financial incentives on their head.

Mr. BRINGEWATT. An important issue in addressing cost savings, I think, is asking "savings relative to what," because we tend to look at cost savings in relation to specific provider types or kind of care as opposed to looking at cost savings relative to addressing a particular problem over an extended period of time. And at this point, we really do not know what the cost of care is for a number of conditions, because we do not collect or monitor care or cost of care in relation to problems. We monitor and manage cost in relation to providers. And until we make that shift in looking at cost in relation to problems from looking at cost in relation to providers, we are not going to have the kind of cumulative cost savings we need. A critical step in getting there is mainstreaming this kind of private sector approach that enables different provider networks to move dollars into different provider arrangements that, from a cumulative perspective, demonstrates cost savings so that they are not locked into managing costs within narrow, unrelated provider silos.

Mr. MCCRERY. Thank you.

Chairman THOMAS. I want to thank the panel, and I think we need to constantly remind ourselves that the yardstick that we use for saving is the fee-for-service model, and there are a number of changes that are going to be occurring in that area, and if we could plow back "savings" into more benefits within a continual slowing of the growth of what has been a 10.5-percent increase area, then I think you do get on a comparative basis cost savings and, I think,

from everyone I have talked to to a very great extent a qualitative improvement, and there is some value in that as well.

I want to thank the panel very much. We may have you back. The Subcommittee stands adjourned.

[Whereupon, at 1:12 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

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COMMITTEES:
AGRICULTURE, NUTRITION, AND FORESTRY
FINANCE
RULES

United States Senate
WASHINGTON, DC 20510-1601

April 18, 1996

Mr. Chairman,

I appreciate the opportunity to testify before you today on a bill that I introduced in the Senate in June of last year, S. 990, the PACE Provider Act of 1995. PACE, the Program of All-inclusive Care for the Elderly, is a cost-effective managed care system pioneered by On Lok Senior Health Services in San Francisco.

PACE programs provide a comprehensive package of primary acute and long-term care services. All services, including primary and specialty medical care, adult day care, home care, nursing, social work services, physical and occupational therapies, prescription drugs, hospital and nursing home care are coordinated and administered by PACE program staff.

Mr. Chairman, PACE programs are cost effective in that they 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.

The PACE Provider Act does not expand the number of individuals eligible for benefits in any way. Rather, it makes available to individuals already eligible for nursing home care, because of their poor health status, a preferable, and less costly alternative.

Specifically, the act would increase the number of PACE programs authorized from 40 in 1996; to 50 in 1997; and to an unlimited number in 1998.

Mr. Chairman, today, 11 PACE programs provide services to 2,200 individuals in eight States--California, Colorado, Massachusetts, New York, Oregon, South Carolina, Texas, and Wisconsin. At least 45 other organizations are actively working to develop PACE in many other States.

By expanding the availability of community-based long-term care services, On Lok's success of providing high quality care with an emphasis on preventive and supportive services, can be replicated throughout the country. PACE programs have substantially reduced 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.

Mr. Chairman, analyses of costs for individuals enrolled in PACE show a 5-to 15-percent reduction in Medicare and Medicaid spending relative to a comparably frail population in the traditional Medicare and Medicaid systems.

States have voluntarily joined together with community organizations to develop PACE programs out of their commitment to developing viable alternatives to institutionalization. This is particularly relevant as the demand and responsibility for long-term care expands.

Mr. Chairman, as our population ages, we must continue to place a high priority on long-term care services. Giving our seniors alternatives to nursing home care and expanding the choices available, is not only cost effective, but will also improve the quality of life for older Americans.

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**STATEMENT OF DEBRA SYLVESTER,
COORDINATOR, SENIOR HEALTH SERVICES,
FALLON HEALTHCARE SYSTEM**

The Fallon Healthcare System is a vertically integrated system made up of a well-developed network of services and facilities offering different types and levels of health care. Within this network, Fallon can provide continuity of care and utilize alternatives to costly treatments.

The Fallon Healthcare System includes Fallon Community Health Plan (FCHP), a federally qualified HMO with over 178,000 members; the Saint Vincent Healthcare System with an acute hospital, a home health care provider, a nursing home system and a laboratory; and The Fallon Clinic, a large multi-specialty group model clinic. Fallon is a physician directed system in which primary care physicians coordinate care for their patients within a seamless delivery system. By bringing all of the elements of health care together, Fallon enables patients to move among the levels of care effectively and efficiently.

Fallon Community Health Plan, established in 1977, is recognized as a leader in providing high quality care at an affordable price. Approximately 1000 of the area's best doctors are affiliated with Fallon, with that number growing continually. FCHP continues to grow and expand into new areas with the most recent expansion into the Boston area adding even more physicians and hospitals from which to choose. In addition, Fallon introduced the Peace of Mind Program for HMO members enrolled through group plans. This program enables members to request specialty care at some of the most prestigious of Boston's hospitals.

Fallon continually works to ensure a network of the highest quality providers, following stringent credentialing procedures and closely monitoring the quality of care provided by all network providers. In 1994, FCHP received a full three year accreditation from the National Committee on Quality Assurance, one of only a small percentage of HMOs to do so. In addition to Fallon's achievements in the areas of quality and utilization management, Fallon is also proud of its 93% member satisfaction ratings for the commercial plan and 98.4% satisfaction ratings for our Senior Plan(s).

EXPERIENCE WITH THE MEDICARE POPULATION

Fallon has been a leader in managed care for the Medicare population since the Health Care Financing Administration (HCFA) initiated the Medicare risk contracting process. On April 1, 1980, FCHP became the first HMO nationally to enroll Medicare beneficiaries and accept reimbursement from HCFA on a prospective, per capita basis as a demonstration project. Since then, Fallon has maintained a risk contract with HCFA and has consistently offered a more comprehensive range of health care benefits than standard Medicare supplements, while maintaining competitive premiums.

Since 1980 Fallon has offered the Senior Plan, now called Senior Plan Preferred, which provides a full array of benefits including full prescription drug coverage. In 1994, Fallon introduced two new benefit plans from which Senior Plan members can choose in addition to the established plan. Senior Plan Saver's coverage is identical to Senior Plan Preferred's coverage but does not include drug coverage. Senior Plan 1000 also offers identical coverage except for a cap of $1000 on prescription drug coverage in each calendar year. Senior Plan Preferred and Senior Plan 1000 are offered to members enrolling through employer groups.

The Fallon Senior Plans are open to individuals who reside in the FCHP service area and are eligible for Medicare Parts A and B or Part B only. Individuals are entitled to join when they first become eligible or during a yearly open enrollment. There is no screening of applicants.

After fourteen years in Medicare risk contracting, the Fallon Senior Plans have grown to over 28,000 members. Fallon's experience as a leader and agent for innovation in senior health care makes it an ideal site for the SHMO II expansion. In particular, Fallon has made strides in member screening, use of Geriatric Nurse Practitioners and Social Workers, geriatric assessment, coordination of the care of nursing home patients, health maintenance programs for the well elderly, and participation in the Medicaid Managed Care Program. Since 1986,

Fallon has also been coordinating members' medical care with available community support services.

In 1994, Fallon became the only HMO to sponsor a PACE (Program of All Inclusive Care for the Elderly) replication. The Elder Service Plan is part of a statewide replication as one of six sites in Massachusetts serving the most frail and at risk seniors. Elder Service Plan at Fallon provides all-inclusive care for those age 55 and older who are eligible for nursing home care but prefer to remain in their own homes. All medical and long term care services needed are provided or arranged for by the ESP team of professionals. Services include but are not limited to primary care, in-home care, adult day health care, physical therapy, transportation podiatry, dentistry, and prescription drugs.

As the population ages, the need to supplement the basic Medicare benefit with additional supportive services and long-term care becomes increasingly urgent. Fallon believes that the SHMO model can address the needs of those seniors who are at risk but not yet nursing home eligible.

BACKGROUND OF SOCIAL HMO

The Social HMO demonstration was authorized under the Deficit Reduction Act of 1984. The purpose of the demonstration was to determine if investing in some long term care benefits for Medicare HMO enrollees could save money through coordination of care and the provision of services that might present more costly medical complications. Services provided include personal care aides, homemakers, medical transportation, adult day health care, respite care and case management in a community setting. In 1985 the first generation of Social HMO projects became operational at the following four sites: SCAN Health Plan in Long Beach, California; Group Health and Ebenezer Society established Seniors Plus in Minneapolis-St. Paul; Kaiser Permanente Northwest established Medicare Plus II in Portland, Oregon. In 1990, Congress authorized an extension of the demonstrations and established the second generation of social HMO projects, known as Social HMO II. These sites are Fallon Community Health Plan; CAC-United Healthcare Plans of Florida in Coral Gables, Florida; Contra Costa Health Plan, in Martinez California; Health Plans of Nevada, Inc. in Las Vegas, Nevada; Richland Memorial hospital in Columbia, South Carolina and Rocky Mountain HMO in Grand Junction, Colorado.

BENEFITS UNDER SOCIAL HMO's

The Social HMO program provides standard HMO benefits such as hospital, physician services, skilled nursing home, and home health services as well as extended long term care benefits not currently available or provided through traditional fee for service Medicare or Medicare risk contracts. Extended long term care benefits under Social HMO range from community-based care to nursing home care. Services include personal care aides, homemakers, medical transportation, adult day health services, respite care and case management in a community setting. The Social HMO II sites will continue to provide many of the expanded benefits offered in Social HMO I sites. It is expected that the Social HMO II sites will address the following areas. Expand chronic care case management with linkages to acute and long-term care; geriatric focused care delivery; redefine the long term care benefit package; refine the financing methodology to a risk-adjusted payment methodology; target special populations such as minorities and residents living in rural areas.

GERIATRIC FOCUSED CARE

The elderly population often have multiple interactive chronic conditions, which need to be addressed through specific approaches to geriatric care. Medicare risk contracting allows for more flexibility in care provision than is possible within the traditional Medicare program. However, risk contracting does have its limitations The reimbursement in risk contracting is based on costs incurred for acute care only. While innovation is possible, it simply cannot meet the long-term, multi-dimensional needs of the elderly. The dual themes of the SHMO II project - expanded benefits and more comprehensive geriatric care will enable a new level of effectiveness in caring for the elderly.

Because of the unique needs of this population, health care for the elderly requires integration of ambulatory, acute chronic, home care, prescription, and support services. Appropriate geriatric care also involves the following:

Care Management. Care management functions are critical in managing the complex health care needs of the elderly population. Under the SHMO program a case manager will screen assess, intervene and monitor the medical, psychological and social risk factors of members that are potentially at risk. The desired outcomes of case management would be decrease in hospital, and nursing home admissions, improved quality of life and disease specific outcomes.

Screening mechanisms that result in early detection. A high incidence of functional loss has been found among the aged and those with chronic disease (Jette and Branch, 1981). Research shows that functional decline in the elderly is reversible (Branch, 1984), and that improvement is more likely when loss is recent and not severe (Crimmins and Saito, 1993). Although functional dependency has been shown to predict increased care needs (Williams, et at, 1987), impairments often go undetected and untreated (Besdine, 1988, Lachs, 1990, Applegate, 1990). Routine screening can ensure that these and other geriatric care issues are addressed appropriately.

Intervention. Identification of functional loss and other geriatric problems is futile unless intervention is planned. For an elderly patient, the most appropriate intervention may, at times, be supportive services, or coordination of care by two or more providers. For those most at risk, ongoing involvement of the care provider is essential. Limitations in current coverage prevent routine availability of such services and coordination activities.

Integration. Service delivery to the elderly remains fragmented. Typically, each care delivery site is focused on volume and resource use under its own roof. An integrated system with total risk for the care of elderly enrollees will only succeed if it coordinates care across all delivery sites while taking the patients' future care requirements into account (Wolford, et al, 1993), which the SHMO will do.

Health Maintenance. Only by extending improved geriatric care approaches to all enrollees, including those without perceptible frailties, can this approach yield the greatest long-range results. Evidence suggest that the primary prevention can significantly reduce functional decline (Mor, 1989). Early identification and appropriate geriatric care will play a role in improving health status for the population enrolled, slowing decline, reducing the need to enter a hospital or use an emergency room, and improving outcomes.

The SHMO will provide for initial and routine patient screening and care coordination. Monitoring of the at-risk patient will be increased. Expanded benefits will allow for all-important follow-through when additional services are needed.

The structure and financing of the SHMO is the only model on the horizon today that make these care delivery goals attainable.

FINANCING

Under the TEFRA Risk agreement with HCFA Fallon accepts full responsibility for health care costs under both Medicare Part A (hospital) and Part B (physician). HCFA pays Fallon a capitated amount equal to 95% of the average area costs per Medicare beneficiary. Under the Social HMO model services are also financed on a prepaid capitated basis. However, the plans receive 100% of the average area cost per Medicare beneficiary. The additional 5% of the AAPCC is used for financing the additional expanded benefit package. Under the capitated payment system, managed care organizations have the flexibility under the Social HMO program to tailor benefits to the unique needs of each beneficiary.

CONSUMER BENEFITS OF SOCIAL-HMO's

Social HMO's, which operate under TEFRA risk contracts, such as in the case at Fallon can offer Medicare beneficiaries an enhanced package of Medicare services. In addition to all Medicare part A and B services, coverage includes pharmacy benefits, hearing aids, eyeglasses, and up to $1,000 per month in home and community long term care services. These benefits help members to avoid institutionalization and maximize independent functioning. Under the Social HMO model of care, early identification and interventions can prevent serious illness or disabilities.

Under Social HMO's consumers have comprehensive coordination of all health as well as related services. Consumer choice will be enhanced and consumers will be able to choose a richer package of long term care benefits currently not available under Medicare risk contracts.

RECOMMENDATIONS

The Social-HMO demonstration programs are effective mechanisms for integrating acute and long-term services, offering richer benefit packages not available under Medicare risk programs. Consumer choice is enhanced. There is potential with the second generation sites and continuation of the first generation demonstration to continue to explore cost savings measures in order to reduce health care expenditures as well as improved health outcomes. Authorization for both the first and second generation Social HMO's will expire on December 31, 1997. The Fallon Healthcare System, as well as the other Social HMO's sites, will not become operational until July 1996 or, in many cases, late 1996. Therefore, the Social HMO's II sites would not be operational for more than a year and then would have to begin a process of phasing down the program. An extension of the Social HMO demonstration will provide the necessary time to further determine the potential for providing higher quality integrated care and extended benefits, in the most cost effective manner.

We respectfully request that:

- Congress direct the Secretary of Health and Human Services to develop regulations which grant permanent waiver authority for existing sites and which provide a mechanism for other entities to apply for Federal qualifications as a social HMO;

- Congress provide legislative authority to continue the Social HMO I and II programs until the Secretary of Health and Human services promulgated such regulations;

We also recommend the following modifications to the current waiver authority

The Social HMO waivers currently provide for the following:

- Payment at 100% of the AAPCC;

- the option to queue applicants according to disability;

Oxford Health Plans

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Timothy B. Meyer
Director, Government Relations

(203) 851-1865
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April 30, 1996

Ms. Elise Gemeinhardt
Professional Staff
Subcommittee on Health
Committee on Ways and Means
1136 Longworth House Office Building
Washington, DC 20515

Dear Elise:

Enclosed is Oxford's written testimony for the record regarding the Long Term Care of April 18th, 1996. As you will note Oxford is supportive of the PACE program but we do believe we have additional experiences which we should have the opportunity of bringing to the program. Therefore, we oppose any restriction to participation whether it be prohibiting for profit companies or limiting participation to community based provider organizations.

I look forward to working with you on these issues. Please don't hesitate to contact me if we can be of any assistance.

Sincerely,

Timothy B. Meyer

cc: Kate Sullivan
Enclosure

Overview

Oxford's Medicare Advantage program began in 1992, and currently has over 80,000 members in New York, New Jersey and Connecticut. Oxford's Medicare program is one of the fastest growing in the country, with more than 5,000 new beneficiaries enrolling each month. Oxford has been enrolling Medicaid Members since 1992, and we currently have over 130,000 Members in New York, New Jersey, Connecticut and Pennsylvania.

Support for Capitated Long Term Care

Oxford is very encouraged that the Ways and Means Committee is addressing the continuing need for managed long term care, and is very supportive of S.990. In our experience, the fragmentation of funding for long term care and acute care services inhibits our ability to effectively manage the care of the frail elderly. Needless to say, care follows funding, so that fragmented funding results in fragmented care. The classic example of this is the incentive for emergency room admissions from nursing homes. Clearly, if one party were responsible for both the long term as well as the acute services, emergency room admissions would be less frequent and more appropriate, making everybody, most importantly, the member happier. We see great potential in being able to truly manage the entire continuum of care for a frail elderly Member.

We have been truly impressed with the achievements of the PACE sites around the country. We have followed their progress, and their success has solidified our belief in the value of comprehensive care.

Participation of For-Profit Medicare HMOs

While Oxford is very supportive of S.990, we are concerned about the language in Section 2 of the bill that states that waivers will be granted "to public or non-profit community-based organizations." Our understanding is that this language would preclude for-profit corporations such as Oxford from receiving waivers to provide comprehensive care through the PACE model.

We would assert that the tax-status of a company does not indicate the standard of care it provides. Like non-profits, for-profits have an incentive to provide quality care to maintain their Membership bases. Interestingly, a recent study found that for-profit HMOs generally spend more of each premium dollar on actual health care services than do non-profits. Oxford's efforts at providing excellent care have resulted in high ratings in customer service satisfaction surveys, and having recently been cited as having the country's lowest number of Member complaints upheld by HCFA per thousand members.

Track records for quality and member satisfaction can be used as a measurement of the standard that management uses to run its company. These representations of quality of care will much more accurate than whether an organization in for-profit or non-profit. Oxford's commitment to quality is evidenced in the extensive Quality Management programs it has in place. The goals of Oxford's Quality Management Program are to improve and/or maintain high quality patient services through ongoing monitoring and assessment of: provider compliance with the delivery of care in accordance with recommended clinical treatment guidelines; Member satisfaction with Oxford's services and health care services; provider satisfaction with Oxford's services; mechanisms to ensure that Oxford's cost containment programs do not adversely affect the quality of care provided to the Membership; educational needs for Oxford's providers and Members to facilitate their involvement in quality improvement activities.

Medicare HMOs have unique core competencies that will be very important to the success of broadened managed long term care efforts. Below are several other attributes that for-profit Medicare HMOs can bring to a demonstration of capitated long term care.

Education and Outreach

While we cannot speak for all for-profit Medicare risk contractors, many have demonstrated a real commitment to the care of older adults, which has even taken them beyond the realm of covered benefits.

Through our Outreach department for example, Oxford connects members with needed social services, such as transportation, meals on wheels, adult protective services, and custodial home care. In addition, Oxford implements a Health Promotion Series that provides a series of health education lectures and training programs on topics such as healthy eating, diabetes, arthritis, exercise, and prostate health. Oxford also publishes a bi-monthly health and wellness newsletter specifically for our Medicare Members. Other

initiatives include a pilot study to measure the impact of nutritional education on the health of our Members through the nationally recognized Nutrition Screening Initiative; and a comprehensive flu immunization program to educate our Members and physicians about the importance of receiving flu vaccinations.

Oxford has also received a matching grant from The Robert Wood Johnson Foundation to run a service credit banking program which also can provide community based seniors with needed services. This program encourages our active Members to volunteer their time to help frail Members perform custodial care activities, such as light housekeeping and cooking. In exchange, Members receive a guarantee which states that they will be eligible for those services if they ever need them.

Disease Specific Programs

Oxford is currently developing a number of disease specific, Member-help-Member programs. We will start with COPD "Leaders in Learning" this summer. The frail elderly could benefit immensely from "Learning to Live with Lung Disease," where they might be visited by a community senior who also has lung disease, and taught relaxation techniques customized for the frail elderly. These specific programs demonstrate our commitment to serving the elderly as well as the innovative community based approaches that we take which could be beneficial to these managed long term care programs.

Network

While HMOs are often not direct providers of medical services, they generally have broad based, well-established networks of providers that can meet all of their Members' needs. Oxford maintains a network of top-quality hospitals and physicians. Oxford requires each physician to have board certification in his or her specialty (as recognized by the American Board of Specialties) or become board certified within five years of becoming eligible. Our corporate medical director of data analysis employs an extensive software system to manage our 33,000 physicians, hospitals and ancillary providers. Through its network development and medical management, Oxford has consistently been able to reduce overall health costs in each region it covers while maintaining quality.

Marketing

One important aspect of any comprehensive care site is attracting a sufficient number of participants. The literature shows that current non-profit capitated long term care programs such as the PACE sites and Social Health Maintenance Organizations (SHMOs) have had

significant problems building census due to the difficulties involved in marketing to the frail population.

The lack of a clear marketing strategy and an inability to reach the home-bound elderly have been census-building barriers for PACE sites.[1] Oxford, in contrast, has a strong marketing and sales organization that has led to an increase in Medicare membership of over 5,000 per month. Oxford's Medicare sales approach involves a motivated and compassionate sales force that often provides one-on-one sales calls in the home. These "house calls" are particularly essential when marketing to a frail, home-bound elderly population.

Inadequate initial marketing budgets and inexperience in marketing to Medicare beneficiaries were also cited as reasons for enrollment problems. Oxford has a strong reputation in its service area and significant resources dedicated to acquisition of members. In addition, Oxford has a well developed marketing program with which to target potential members for a long term care program. Oxford has a large, experienced staff dedicated to acquisition marketing. We are skilled in developing communications appropriate for elderly consumers. This is important because we are able to demystify complicated concepts and make sure that potential members know what they are buying.

One of our most successful marketing programs is our Ambassador program for Medicare Advantage. Our Ambassadors are Members who voluntarily communicate the advantages of Oxford within their own communities. We have found that our audience is more receptive to our messages when they come from people they know and trust. When peers from their community believe in Oxford and the benefits of managed care, community Members feel more secure in having Oxford as their healthcare provider.

Tracking Systems

Another important attribute of for-profit Medicare HMOs is the ability to use sophisticated information systems to track encounters and outcomes. This ability is critical to evaluating the effectiveness of any demonstration effort.

Oxford has developed an information system specifically to meet the needs of the Medicare population and the providers who serve them. This system includes software for physician profiling and hospital profiling, allowing Oxford to evaluate practice patterns and analyze

[1] Robert Kane, MD, Laurel Hixon Illston, MPH, and Nancy A. Miller, PhD, "Qualitative Analysis of the Program of All-Inclusive Care for the Elderly," *The Gerontologist*, 1992, Volume 32, Number 6, page 778.

quality outcomes and cost effectiveness. The physician profiling software adjusts for differences in casemix, severity, and comorbidity, and recognizes that primary care providers have responsibility and accountability not just for the care they provide directly but the care provided by specialists to whom they refer cases. The resulting data helps determine expected costs and utilization, and enhances communication between Oxford and our providers. Oxford's systems are capable of providing utilization data based on particular services and the amounts of the claims for those services. This can be used to evaluate disease patterns and treatment patterns of enrollees.

Capital Investments

As a for-profit health plan, Oxford has the financial means to make significant capital investments in programs and services deemed necessary to implement an effective comprehensive long term care program.

Oxford has already illustrated its commitment to using its financial resources to provide services to its members by building two Health Centers in undeserved sections of New York City. Both centers will provide primary care and will service our Medicare and Medicaid Members. Each center will have gerontologist on site, in addition to podiatry, radiology, dentistry, and other services. The center in South Bronx is expected to open in May, and the center in East New York in Brooklyn is expected to open in July. The two centers will provide care for about 13,000 Oxford government programs Members, over 5,000 of whom are expected to be Medicare Advantage Members, who did not previously have access to quality health care.

The financial flexibility that Oxford has to make this kind of investment is something that non-profit organizations often lack. With this access to capital, Oxford could ensure that a comprehensive long term care program would be adequately funded to provide all necessary care needs.

Financial Reserves

For-profit HMOs usually have the financial wherewithal, expertise and experience to adequately reserve against the risk of essentially providing long term care insurance. In contrast, non-profit organizations often have difficulty weathering unexpected costs. According to a study of PACE programs in the *Gerontologist*, "the shaky financial base of these independent organizations makes them barely able to sustain any delays in start-up, much less to survive the costs of catastrophic cases early in their operation." (Kane, pg.

778) Oxford's reserve policy is very conservative; we currently have $301 million in reserves which translates to 72 days of operations. In addition, Oxford has reinsurance coverage to cover excessive medical expenses for our members.

Risk Management Experience

Many Medicare HMOs have already demonstrated though management of their current membership the ability to manage risk effectively. With capitated payments from HCFA for over 80,000 Medicare Members, Oxford has experience in successfully managing health care of the elderly in a capitated environment. Our satisfaction surveys show that this can be done while continuing to keep members satisfied.

Conclusion

We at Oxford truly believe in the concept of capitating acute and long-term care for the elderly and providing a comprehensive plan of care coordinated by a single entity. We also believe that as an for-profit HMO we bring attributes that can enhance a managed long term care program significantly.

It would be a disservice to the recipients of integrated long term care to preclude any interested party from participating solely based on its organizational structure. Instead, guidelines should be set for provision of care, and each organization should then be evaluated individually to determine whether it can provide acceptable care. Quality of care should not determined by the profit status of an organization, but by the outcomes it achieves in caring for its members.

WRITTEN COMMENT OF

THOMAS E. BROWN, JR.
ASSISTANT TO THE PRESIDENT
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FOR
HEARING ON LONG TERM CARE OPTIONS
APRIL 18, 1996

Introduction

My name is Tom Brown, and I am the Assistant to the President for Special Projects at Richland memorial Hospital in Columbia, South Carolina. One of the projects that I am involved with at Richland Memorial is the Social HMO II demonstration. Several years ago I was instrumental in development of the hospital's PACE site.

Richland Memorial Hospital is unique in that it is currently the only health care provider or health plan which participates in both the PACE and Social HMO II demonstrations. These two innovative programs will offer older South Carolina Medicare beneficiaries choices for receiving their health and long term care and provide opportunities for improving the method of organizing, financing and delivering their care.
Both of these demonstration programs require additional legislative authority to continue to provide these new models of health care financing and delivery which are important to the Medicare beneficiaries and federal and state policy makers.

Common Program Elements

The Social HMO II and PACE models integrate acute, medical and long term care service delivery. Richland Memorial's PACE program, Palmetto SeniorCare (PSC), is a staff model HMO and the program provides most services internally with limited external contract providers. PSC staff assure that program participants' care is delivered effectively across all settings, i.e. medical, acute and long term care. The Social HMO II demonstration program will utilize an IPA model delivery system, supplemented by protocols, guidelines and management information systems, to integrate the care and services across all settings.

An important policy issue for South Carolina policy makers is the applicability of the PACE and Social HMO II models to the Medicare/Medicaid older population. The State's Medicaid agency, working with Richland Memorial, has developed strategies for including the dually eligible population in these projects. This policy decision has enabled the programs to offer more choices to beneficiaries and to meet a broader need for care and services.

Providing managed care options in rural areas, which have low AAPCC's, has been a policy challenge for the policy makers and program administrators. Richland Memorial's programs have demonstrated a willingness and ability to accommodate the models to serve this population of rural Medicare beneficiaries.

Refinements of the Social HMO II Demonstration

The Social HMO II demonstration has three significant research and policy interventions which will enhance the Medicare HMO program. One improvement - the addition of long term care benefits to Medicare - was included in the Social HMO I demonstration and will be refined in the Social HMO II demonstration. The change in this aspect of the

demonstration will be to make the long term care benefit available to enrollees who are beginning to become frail, but who are not yet "nursing home certifiable". This change will enhance the program's ability to offer home and community-based services which can prevent or delay the decline in a enrollee's health and functional status.

The Social HMO II geriatric care system will fully integrate the plan's medical, acute and long term care benefits and services. Early detection of health and functional problems through risk screening processes, preventive care and services, physician and care management protocols and guidelines and a coordinating management information system will facilitate implementation of this new approach. The plan will utilize care managers to coordinate the care and to facilitate enrollee's transitions between care settings.

Implementation of a risk-adjusted prospectively determined Medicare HMO reimbursement system is the third important research and policy Social HMO II intervention. This new reimbursement approach will annually determine an enrollee's future likelihood of using Medicare services in the next year. The Health Care Financing Administration has projected that this new approach will improve the current AAPCC system and will provide incentives for HMO's to enroll more frail Medicare beneficiaries.

Linkage of Medicare and Medicaid

Federal and state health care policy for Medicare and Medicaid must recognize the importance of each program to older persons who depend on these programs for their health care. Categorical funding for these programs has been an impediment to care management and coordination of benefits across all settings. The PACE and Social HMO II models integrate these financing systems through a capitated payment to the plan. This linkage gives the plan added flexibility to address the enrollee's health care needs.

Recommendations

Legislative authorization for the PACE and Social HMO demonstrations is needed. The PACE model has been replicated through Medicare and Medicaid waivers and additional sites are being developed. This approach was necessary initially, but the program must now become a permanent provider type within the Medicare program.

Recommendation: PACE should be shifted from a demonstration to a permanent program.

The Social HMO II demonstration provides an opportunity to introduce new elements into the Medicare HMO program. The current legislative authority for the demonstration expires on December 31, 1997. The authorization needs to be extended to enable the demonstration to be fully implemented and evaluated.

Recommendation: The Social HMO II demonstration should be extended to December 31, 2001.

Thank you Mr. Chairman and members of the Subcommittee for this opportunity to submit written comments about these important health care initiatives for Medicare beneficiaries.

April 17, 1996

Philip D. Moseley, Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Bldg.
Washington, D.C. 20515

Dear Mr. Moseley:

RE: LONG TERM CARE OPTIONS (HEARING APRIL 18, 1996)

It is our understanding that the Subcommittee on Health of the Committee on Ways and Means will conduct a hearing on Long-Term Care Options on April 18, 1996. While the focus of the hearing will be the PACE and SHMO programs, this seemed like a good opportunity to make the Committee aware of a unique Long-Term Care Pilot Project that Rocky Mountain HMO is conducting in Colorado.

Rocky Mountain HMO, the Colorado Department of Health Care Policy and Finance, and the Mesa County Department of Social Services are developing a pilot project to integrate Medicaid acute and long-term care services in a health maintenance organization. The project is funded by a Robert Wood Johnson Foundation grant and will be conducted in a county in rural western Colorado. Rocky Mountain HMO will provide Medicaid acute and long-term care services under a capitated contract with the Department of Health Care Policy and Finance. The project is currently in the development phase with an anticipated start this fall.

By way of background, Rocky Mountain HMO is a nonprofit HMO that has provided services for Medicaid, Medicare, and private members for over 22 years. While our original membership was primarily in western Colorado, more recent expansions include urban areas and a statewide delivery network. Rocky Mountain HMO was selected as a SHMO in 1995.

Enclosed are some materials describing the Rocky Mountan HMO Medicaid Integrated Care Program. We believe this is a truely innovative project with significant potential benefit. We would certainly be willing to discuss this project in more detail with you or other appropriate staff or Committee members. Please don't hesitate to contact me at 1-800-843-0719 or (970) 244-7966.

Sincerely,

Michael J. Weber
Executive Director

MJW:kjm
Enclosures
c: Rep. Scott McInnis

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MEDICAID INTEGRATED CARE PROGRAM

CONCEPTUAL DESIGN

The Medicaid Integrated Care Program was designed by Rocky Mountain Health Maintenance Organization, the Colorado Department of Health Care Policy, and the Mesa County Department of Social Services to provide integrated acute and long-term care to 8,000 Medicaid and Medicare/Medicaid clients in Mesa County, Colorado. The program is founded on an alliance of clients, families, doctors, other medical professionals, regulators, institutions, collateral caregivers and payors--all working together to create and maintain an integrated care delivery system which produces better client outcomes and lower costs.

Improved outcomes and reduced costs are achieved through careful planning, delivery and monitoring of all types and levels of care--preventive, primary, acute, home-based and institutional. The intent of the program is to assure that each client receives the right care at the right time in the right place.

OBJECTIVES OF THE MICP

- Easier client access to integrated services.
- Enhanced care coordination to eliminate gaps and duplications.
- Aligned incentives for all caregivers to encourage delivery of the most appropriate care in the proper setting.
- Innovative alternatives to traditional ways of providing care.
- Care giver collaboration to achieve better client outcomes.
- Increased home care leading to reduced nursing home residency.
- Emphasis on preventive care to reduce acute care episodes.

The program is highly client focused. Client needs are identified and assessed early. Care decisions are based on each client's particular needs. Cooperation and collaboration among caregivers result in improved client outcomes.

The program operates with common assumptions which are tested frequently to assure that all participants are reaching similar conclusions. The program employs system-wide incentives, with all caregivers sharing proportionately in financial outcomes. This allows care decisions to be based solely on client needs and the outcomes desired, never on individual provider profitability.

The program gathers and shares client information through electronic and supportive networking. Decisions are based on the collective intelligence concerning each client's condition and needs rather than on isolated observations or individual opinions which can vary from one provider to another.

Emerging knowledge about new care techniques, especially for the frail elderly, is compiled by medical specialists and disseminated throughout the system. Care for the elderly is clearly founded on proven geriatric principles.

CHALLENGES AND OPPORTUNITIES

Several challenges must be addressed in order to gain maximum benefit from the program:

- Regulations which impede innovation and result in reduced care and higher costs must be revised.
- Providers who resist risk-sharing must be persuaded to shift old paradigms.
- The system must provide meaningful outcome and financial data which prove the efficacy of the program.
- Physicians must become comfortable with a team approach to client care, with emphasis on the integration of acute, chronic and preventive care rather than solely on acute care.
- Communications systems must be established which provide physicians and other caregivers with up-to-the-minute information on individual client status.

DESIGNED CHANGES WITHIN THE MICP

From RULES to GUIDELINES

Rules create boundaries which inhibit innovation. Rules can be used to defend unacceptable performance. Guidelines, however, provide general expectations which allow caregivers to innovate in order to achieve desired outcomes. Guidelines, unlike rules, cannot be used as excuses for failure.

From COMPETITION to COLLABORATION

Competition, although the foundation of the business system, leads to winners and losers. In health care, the losers are often the clients. Integrated care emphasizes collaboration, not competition. Collaboration occurs when different parties no longer protect their own turf, but come together to create something different from and better than what existed before.

From PAPERWORK to PEOPLEWORK

Governments have inundated the system with paperwork. Nurses spend more time on paperwork then on providing patient care. There is no clear evidence that any of this paperwork has improved client well-being or outcomes. Unnecessary and wasteful paperwork must be abolished.

From ASSUMPTIONS to FACTS

Client care is often based on assumptions rather than facts. Caregivers must challenge assumptions, and discard those which are not supported by evidence. Care planning must be based on factual expectations as evidenced by research and valid information, not on antiquated beliefs or customs.

From CONTROL to TRUST

The inherent desire for governments to control has created a fragmented system which impedes progress, encourages fraud and abuse, and has done little to protect the client. The MICP emphasizes trust rather than control to accomplish its objectives. Participating providers are trusted to provide high quality care at reasonable prices, and not to game the system. Any provider who proves unworthy of this trust will be barred from participation in the program.

From UNAWARENESS to KNOWLEDGE

The most intelligent person is the one who understands that there is always more to learn. A continual search for new knowledge is a fundamental element of a good system. Members of a good system are never satisfied with what they now know, but are forever seeking to learn more. The MICP seeks to be a learning system. Participants within the system are continually updating their knowledge based on new and innovative approaches to providing care to the clients.

From the STATUS QUO to INNOVATION

Providers and caregivers in a dynamic healthcare system are never satisfied with the current state of affairs. Instead, they are continually searching for better ways to do what they do, and for better outcomes for their clients.

From PROFIT FIRST to PEOPLE FIRST

A business enterprise cannot survive without profitability. However, long-term profitability and long-term survival depend on meeting customers' needs. If a customer's needs are properly addressed, profit will follow. Providers who seek to reduce or withhold care in the interest of increased profits will not be tolerated.

From WE CAN'T to WE MUST

The current system has caused people to become defeatists. People are told that something can't be done, and they believe what they are told. This negativism must be abolished. Caregivers must instead be encouraged to work together to create new and better ways to serve their clients.

Earl Elicker, MSA
Integrated Care Program Design
Rocky Mountain HMO

MEDICAID INTEGRATED CARE PROGRAM

The Medicaid Integrated Care Program (MICP) will optimize the health, independence, and well being of those clients who have persistent and ongoing medical or functional problems. The program will primarily serve the frail elderly and the chronically disabled but can also assist any client who needs non-acute as well as acute care. The MICP addresses a wide variety of client needs (medical, functional, emotional, social, and cognitive) and develops care plans directed at fulfilling these needs. A primary objective of the program is to provide the right care at the right time in the right place. By assuring that proper care is provided as soon as it is needed, the MICP seeks to prevent unnecessary hospitalizations and emergency room visits, and to delay or eliminate the need for nursing home admission.

Within the MICP, the management of care is linked across time, place and profession. Efforts are made to detect and correct problems early--before they become difficult to remedy. The activities of all care givers - physicians, nurses, institutions, family, and others - are coordinated to assure that the care provided is necessary, adequate, timely, and consistent with other services the client may be receiving. In all cases, the program endeavors to help clients retain independence and functional capability, and to avoid unnecessary and unwanted institutionalization.

Historically, health care has focused primarily on acute care - seeking to cure disease or repair injuries. While an acute care emphasis continues to be vital, it does not adequately address the needs of people requiring longer term care. If a person's long-term care needs (proper nutrition, healthy living conditions, adequate exercise, health education, personal care, etc.) are not adequately addressed, the person may become ill or incapacitated, sometimes critically. When this happens, the person typically must seek an acute care solution.

The MICP integrates acute and non-acute services in order to serve a variety of patient needs. The program offers easy access to integrated care, formalized care coordination, patient-specific care plans, regular monitoring of progress, early detection procedures, and a team approach to managed care.

Easy Access

The program is accessed by a simple inquiry to the care coordination unit by the client, the family, a doctor, or any other concerned party. Clients are screened to determine needs, and those determined to be at-risk are assigned a care coordinator who assesses the client for deficits, prepares a plan of care, and initiates services. The care coordinator addresses all the needs of the client and plans all care. The client works directly with this one individual, not with a myriad of agencies.

Care Coordination

A designated care coordinator will be responsible for coordinating and monitoring all care--skilled and unskilled--provided to a client. The care coordinator works with the patient, the primary care physician, specialists, nurses, the family, and other care givers to assure that the client's needs--whether acute, sub-acute, or long-term--are being properly addressed.

The care coordinator begins the care process by investigating the client's circumstances, i.e., medications, physician directives, home environment, family support, transportation needs, and any other aspect of the patient's situation which are pertinent to developing a care plan for the client.

Care Plan

Based on each client's assessment, the care coordinator develops a care plan which details all of the services needed by the client to improve or stabilize function and health and, whenever possible, to sustain independence.

The care coordinator reviews the care plan with a Care Team (geriatrician, advanced practice nurse, pharmacist, etc.) and with the client's primary care physician to gain concurrence with the level and frequency of services planned. The Care Team assists the care coordinator in developing a schedule of expected outcomes against which actual outcomes are compared. The schedule of expected outcomes allows the care coordinator to monitor the progress of the client and to modify the care plan when actual outcomes do not meet expectations.

Once the care plan and the schedule of outcomes is finalized, it is presented to the client and the family for acceptance and implementation.

Monitoring of Progress

Following implementation of the care plan, the care coordinator regularly monitors the client's condition and adjusts the services being provided if outcomes do not meet expectations. The care coordinator receives feedback from all care givers regarding services provided, and keeps the primary care physician and other care givers fully informed of the client's progress. In this manner, the care coordinator, the client, the doctor, the family, and others providing care become a knowledgeable team working together to provide the best care to the client.

Early Detection Procedures

Integrated care is not only directed at coordinating all services needed by the client, it also seeks to identify and correct emerging conditions which, if not addressed, may become serious. A person who is not eating properly or who forgets or neglects to

take prescribed medications may end up in the hospital. A person who is not being helped with bathing or toileting may eventually require institutionalization. A person who becomes weakened by inactivity may become prone to falls and fractures. Integrated care seeks to prevent these critical episodes through early detection and correction of the underlying problems.

The care coordinator solicits pertinent information from all care givers, as well as directly from the client. Any change in the client's condition or circumstances which could eventually result in a critical episode is addressed immediately. For example, modifications may be made to the client's home to improve safety. Meal planning and preparation may be adjusted to improve nourishment. Exercise programs may be started to help the client increase strength and decrease the risk of falling.

A Team Approach

The MICP builds a team of care givers--doctor, nurse, social worker, care coordinator, other professionals, family members, and, of course, the client--all working together to help the client maintain independence, stay functional, avoid hospitalization, and prevent or delay the need for unwanted institutional commitment.

Through coordination of services, early attention to problems, monitoring of progress, and sharing of information the team can achieve the results which are most desired by the client.

Features of the Medicaid Integrated Care Program

- Client's have easy access to an integrated continuum of care, including prevention, acute care, specialized short-term care, transitional care, and long-term care services.

- Care planning is client specific and includes self-help assistance to enable clients to optimize functional independence and well being.

- Care is centrally managed and is fully coordinated with primary care physicians and others to achieve and maintain continuity of care. Care givers work together to avoid duplication of care and to fill gaps in required services.

- Emphasis is placed on:

  - Finding new methods to prevent hospital and nursing home admission.

  - Strengthening the role of primary care physicians in managing the full array of medical and social services.

- Increasing the use of home-based and assisted living services in lieu of institutionalization.

- Expanding the use of wellness education and similar activities to prevent or delay the onset of illness or disability.

- Developing an information network to improve decision making by providing all care givers with up-to-date information regarding all services being provided to each individual patient.

Earl Elicker
Integrated Care Program Design
April 1996

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