The Honorable Renee L. Ellmers asked the following question:

I'm concerned that lack of access to appropriate care oftentimes leads to more significant costs to beneficiaries and the program, especially those with chronic conditions such as diabetes. Have you examined and/or do you have experience with the impact of access to care on cost, care needs and mortality?

Response of Tim Clontz, Senior Vice President for Health Services, Cone Health:

When individuals with chronic illnesses, such as diabetes, do not have access to care it reduces their quality of life, and over time leads to increased cost. Programs of All-Inclusive Care for the Elderly (PACE) are designed to address the chronic care needs of individuals by providing timely and appropriate treatments and supports. The level of access to care in PACE results in our participants (those enrolled in our programs) experiencing a higher quality of life, at home in their community, with medical outcomes that meet the highest standards. Moreover, by reducing the incidence of complications associated with chronic illness, PACE programs also reduce the high costs of specialists, emergency rooms, and hospitals incurred in response to these complications.

This has been our experience with the participants in our PACE programs, and it is borne out by studies of PACE programs across the country. In a 2010 study by Chad Boult and Darryl Wieland, PACE is highlighted as one of three chronic care models that include processes to improve the effectiveness and efficiency of complex primary care. [i] An earlier study found that PACE participants experienced better self-rated health status, fewer unmet needs, and improved health care management.[ii] Not surprisingly, the effectiveness of the PACE care model results in reduced hospital admissions and emergency room visits, as evidenced in a number of state-specific (Massachusetts [iii], New York [iv], Wisconsin [v]) and national studies.[vi]

Better care that avoids unnecessary hospitalizations and emergency room visits supports the longevity of people with chronic care and long term service and support needs. A study of PACE participants in South Carolina found that "PACE participants had a substantial long-term survival advantage compared with aged and disabled waiver clients." [vii] This finding is supported by a national study which found that PACE participants had a lower mortality rate than individuals in nursing homes or home and community based services provided by state Medicaid waiver programs. [viii]

Providing effective and timely chronic care helps people live longer, avoid hospitalizations, and experience a higher quality of life with better health outcomes. In the PACE care model we are achieving these results for less than or the same amount of costs as other programs. In Medicaid, states pay PACE programs on average 14% less than the costs of caring for a comparable population through other Medicaid services, including nursing homes and home and community-based waiver programs. [ix] In Medicare, payments to PACE organizations are equivalent to the costs for a comparable population to receive services through the fee-for-service program. [x]

I appreciate the opportunity to provide this information to Representative Ellmers and the committee. I would be happy to provide any additional information that would be helpful. Thank you.

[i] Boult, C. & Wieland, G.D. (2010). Comprehensive primary care for older patients with multiple chronic conditions: "Nobody rushes you through." JAMA, Vol. 304, No. 17, pp. 1937-1943

[ii] Leavitt, M., Secretary of Health and Human Services. (2009). Interim report to Congress. The quality and cost of the Program of All-Inclusive Care for the Elderly

[iii] Division of Health Care Finance and Policy, Executive Office of Elder Affairs. (2005). PACE Evaluation Summary. Accessed on May 25, 2011 at: http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/05/pace_eval.pdf

[iv] Nadash, P. (2004). Two models of managed long-term care: comparing PACE with a Medicaid-only plan. Gerontologist, 44(5), pp. 644-654.

[v] Kane, R. L.; Homyak, P.; Bershadsky, B; & Flood, S. (2006). Variations on a theme called PACE. Journal of Gerontology Series A, Vol., 61, No. 7, pp. 689-693.

[vi] Micah Segelman; Szydlowski, J.; Kinosian, B.; McNabney, M et al (2014). Hospitalizations in the Program of All-Inclusive Care for the Elderly. Journal of the American Geriatrics Society 62:320–324, 2014

[vii] Wieland, D., Boland, R., Baskins, J., and Kinosian, B. (2010). Five-year survival in a Program of All-Inclusive Care for the Elderly compared with alternative institutional and home- and community-based care. J Gerontol A Biol Sci Med Sci. July: 65(7), pp. 721-726

[viii] The Effect of PACE on Costs, Nursing Home Admissions and Mortality: 2006 – 2011 Mathematica Policy Research evaluation prepared for U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy (2014)

[ix] NPA Analysis of PACE Upper Payment Limits and Capitation Rates, July 6, 2012.

[x] The Effect of PACE on Costs, Nursing Home Admissions and Mortality: 2006 – 2011 Mathematica Policy Research evaluation prepared for U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy (2014)