
Audit of the Program of All-Inclusive Care for the Elderly (PACE) Hawaii

A Report to the
Governor
and the
Legislature of
the State of
Hawaii

Report No. 98-15
April 1998

THE AUDITOR
STATE OF HAWAII

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Submitted by

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Foreword

This is a report of the fiscal and management audit of the State's Program of All-Inclusive Care for the Elderly Hawaii—PACE Hawaii at Maluhia. The audit was conducted pursuant to Section 68, Act 328, Session Laws of Hawaii 1997, which directed the State Auditor to conduct an analysis of the program's personnel and fiscal accountability, accounting and reporting procedures, and disbursement and procurement procedures.

We wish to express our appreciation for the cooperation and assistance extended by the officials and staff of PACE Hawaii, the Hawaii Health Systems Corporation, and the Department of Human Services.

Marion M. Higa
State Auditor

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Chapter 1

Introduction and Background

Pursuant to Section 68, Act 328, Session Laws of Hawaii 1997, the State Auditor conducted a fiscal and management audit of the State's Program of All-Inclusive Care for the Elderly (PACE Hawaii at Maluhia or PACE Hawaii). Section 68 requested an analysis of the program's personnel and fiscal accountability, accounting and reporting procedures, and disbursement and procurement procedures. The audit was requested in response to concerns that actual costs of the program were not clearly identified.

PACE Is a Program of All-Inclusive Care for the Elderly

Today, health care providers and policy makers are challenged to provide high quality care for the growing number of older people in an environment of shrinking resources. While persons aged 65 years and over constitute about 12 percent of the total population, they account for about one-third of the nation's annual health care expenditures. Of particular concern are the needs of frail older people aged 85 and older who constitute the fastest growing elderly population group. These individuals tend to have multiple and complex illnesses, requiring long term care that encompasses more than just medical services. Such care includes social rehabilitative and personal care services that focus not only on disease prevention and cure of acute conditions, but also maintenance of function and the prevention of acute exacerbation of a disease.

One program has shown potential in other states to effectively address the needs of the frail elderly population. The Program of All-Inclusive Care for the Elderly, or PACE, is a community-based, managed care system that uses a proactive, interdisciplinary team approach to provide comprehensive long term health and social services to the frail elderly. The PACE model is characterized by the all-inclusive nature of its service delivery.

By providing services at designated centers or through home care, PACE programs seek to control costs by preventing or minimizing unnecessary and costly use of alternative forms of care such as hospitalization or nursing home care. Service delivery is coupled with a capitated or fixed monthly reimbursement, rather than the more typical fee-for-service billing system. A capitated reimbursement method is advantageous for the service provider because it provides a predictable income stream and reduces the administrative overhead associated with a fee-for-service

billing system. The client benefits because services are more comprehensive, not subject to eligibility service coverage restrictions, and provided through a single source.

Although not a requirement for services, a PACE client is typically eligible for Medicare (based on age) and Medicaid (based on financial need) services. PACE programs are thus characterized by a “dual waiver” where both Medicare and Medicaid agree to reimburse for services based upon a capitated amount. In exchange for the capitated reimbursement payment, the PACE provider provides all necessary client services, regardless of actual cost and whether such services would normally be covered by Medicare or Medicaid. Success of a PACE program thus depends on the aggressive application of preventive health practices in order to prevent or delay the need for more costly services such as hospitalization or nursing home care. But in the event the more costly services are needed, the capitated reimbursements over the entire duration of the client’s enrollment are supposed to be managed in order to cover those costs as well.

PACE programs are options to traditional fee-for-service programs

The PACE program is based upon a model developed by the On Lok Senior Health Service Program (On Lok). On Lok, a community-based long term care program for the frail elderly, traces its origins to 1971 and to leaders of San Francisco’s Chinatown-North Beach community. Following the British day hospital concept, community leaders developed a program to provide day health and social services for frail elderly adults in a community rather than an institutional setting. Providing these services in the community sought to prevent or delay more expensive institutional options.

In 1973, the On Lok Senior Health Services Program was established with the assistance of federal and state grants. Initially, adult health care services were provided in a free standing health care center, with in-home services being added in 1975. In 1978, On Lok received a Medicare funded grant from the federal Health Care Financing Administration (HCFA) to implement a demonstration program that integrated its existing services and all primary medical care for the frail elderly, including acute and chronic health services, under a single organization. Primary care services include “all medical care in clinics ..., medical specialist consultations by contract providers, hospital care, nursing home care when needed, and all ancillary services, including prescription medications, lab tests and X-rays, and durable medical equipment.”¹

On Lok’s project proved successful, demonstrating that comprehensive services could be provided while reducing the total cost of care approximately 15 percent over the traditional fee-for-service system. On Lok obtained approval in 1983 to initiate a dual Medicare and Medicaid waiver or capitated reimbursement system for long term care. Waivers

were obtained from both Medicare and Medicaid to replace the fee-for-service reimbursement. Use of waivers has several advantages that include:

1. Comprehensive services, including those not normally covered under Medicare and Medicaid, are provided to clients;
2. Administrative overhead to track and process fee-for-service reimbursements is significantly reduced;
3. A known income stream permits the PACE provider to plan more effectively; and
4. A known income stream serves as an incentive and target to provide services in a cost effective manner.

On Lok successfully demonstrated the viability of providing comprehensive services with the capitated financing scheme and in 1986, through Public Law 99-509, On Lok was granted permanent Medicare and Medicaid waivers.

PACE programs can be replicated

With its own success as an example, On Lok obtained major grants from the Robert Wood Johnson and John A. Hartford Foundations and congressional authorization to replicate its program of service delivery and financing model under the title Program of All-Inclusive Care for the Elderly or PACE. On Lok assisted in the development of the replication sites and a “PACE Protocol” which serves as the specific legal instrument for implementation of the PACE demonstration projects.² Six replication sites were initially chosen. The program was subsequently expanded to permit an additional 15 sites to implement PACE replication projects.

As of December 31, 1996, 11 fully operational PACE sites, i.e., with the dual Medicare/Medicaid waivers, and 15 partially implemented PACE programs with only the Medicaid waiver were in operation. Today, more than 70 organizations in 31 states are in some stage of PACE development.

Typically, a PACE replication site operates under a three year trial period during which a comprehensive service delivery program is developed, dual Medicare and Medicaid waivers are obtained, and the program gradually assumes the full risk of providing all services under the capitated reimbursement system. Once these goals are successfully attained, the PACE site can seek to obtain permanent Medicare and Medicaid waivers thereafter.

In recognition of the continued success of the PACE demonstration program, Congress established PACE as a permanent Medicare benefit and a state option under Medicaid as part of the Balanced Budget Bill of 1997. In addition, the number of authorized PACE sites was increased to 40 during the first year after enactment, with an additional 20 sites permitted in each succeeding year.

Hawaii is one of the PACE replication sites

In 1991, the Department of Health proposed that the State of Hawaii participate in a PACE replication program and become one of the 15 PACE replication sites authorized in the Omnibus Reconciliation Act of 1986. The department proposed that the PACE replication site be part of the department's Maluhia Hospital which already functioned as a long term health care facility. The Legislature in Section 32, Act 296, Session Laws of Hawaii (SLH) 1991, provided that a portion of the funding appropriated to Maluhia Hospital be used for a PACE demonstration project. The project was named PACE Hawaii at Maluhia (PACE Hawaii).

In the following year, the Legislature authorized the creation of a five year PACE demonstration project in Act 211, SLH 1992. At that time the Legislature noted that the PACE demonstration project would demonstrate "the viability of a cost-effective statewide program offering quality community-based long-term care."³ The demonstration project was scheduled to terminate as of June 30, 1997.

In the act, the Legislature further described the following specific goals of the PACE demonstration project:⁴

1. Maintain eligible persons at home as an alternative to long-term institutionalization;
2. Provide optimum accessibility to various important social and health resources that are available to assist eligible persons in maintaining independent living;
3. Coordinate, integrate, and link such social and health services by removing obstacles which impede or limit improvements in delivery of these services; and
4. Provide the most efficient and effective use of capitated funds in the delivery of such social and health services.

PACE Hawaii is unique as a replication program

PACE Hawaii is unique among PACE replication programs nationwide because it is the only one sponsored by a state government. The PACE protocol, a document which serves as the "site specific legal instrument for the implementation of the PACE demonstration," requires that the

PACE site be a 501(c)(3) corporation. However, On Lok's executive director specifically exempted Hawaii from this requirement to test the project in a public rather than private not-for-profit environment.⁵

Originally PACE Hawaii was identified as a Department of Health program located at the Maluhia long-term health care facility, which is one of 12 state-run community hospitals. PACE Hawaii is a department of Maluhia Hospital, which is in turn part of the Hawaii Health Systems Corporation. The corporation was established in 1996 to provide more autonomy and flexibility to state-run community hospitals. The corporation is an instrumentality and agency of the State, and is attached to the Department of Health for administrative purposes only.

PACE Hawaii provides most of the care at an adult day health center and provides some services in clients' homes. A recently completed 40 unit apartment project located on the grounds of Maluhia Hospital is available to qualified PACE clients who are unable to function in their own home. The apartment project, The Harry and Jeanette Weinberg Senior Residence at Maluhia, was built and is managed independently of PACE Hawaii; however, as the provider of day care services at Maluhia, PACE Hawaii also provides medical and personal care services to all eligible residents of the apartment complex. PACE Hawaii hired five additional staff in FY1996-97 to provide 24 hour service, seven days a week to operate the apartment complex.

In accordance with PACE protocol, medical and personal care services focus on the individualized care needs of each participant. Regular monitoring by an interdisciplinary team is conducted to prevent major health problems. PACE Hawaii's objective is to avoid or delay use of costly care such as hospitalization or nursing homes through the proactive delivery of its services.

At present, eligible PACE Hawaii participants must be age 55 or older, reside in urban Honolulu, qualify for Medicaid benefits, and have health problems that qualify them for nursing home placement. State Medicaid criteria for nursing home eligibility to either an intermediate care facility or skilled nursing facility level of care are applied. An intermediate care facility provides 24-hour supervised care by non-skilled personnel and ensures the general availability of skilled nursing care during the day on weekdays. A skilled nursing facility provides continuous 24-hour skilled nursing services. Persons accepted into the PACE Hawaii program agree to let PACE Hawaii become the sole provider of medical and social services. PACE Hawaii in turn agrees to provide all services necessary for the care of that person.

Staffing for PACE Hawaii is generally in accordance with PACE protocol. The protocol specifies the types of services to be provided, but does not stipulate the manner in which these services should be offered.

The replication site is free either to hire staff or contract with outside providers if deemed more appropriate. Currently, PACE Hawaii has 40 staff members in 36.5 full time equivalent (FTE) positions. Of the 40 staff, 28 are full time and remaining 12 are part-time. All positions are exempt from civil service. Since PACE Hawaii is a department of Maluhia Hospital, all employees are technically state employees under the Hawaii Health Systems Corporation.

The Legislature, through Act 338, SLH 1997, extended the PACE demonstration project for another five year period ending June 30, 2002. The Legislature also created more specific annual financial and management reporting requirements for the project. PACE Hawaii currently estimates that its expenditures for the fiscal year ending June 30, 1998 will be approximately \$2 million. PACE Hawaii expenditures are reported in Maluhia Hospital's budget, which has been incorporated into the Hawaii Health Systems Corporation program budget (HTH 210) since 1996.

Objectives of the Audit

1. Determine and describe how the PACE Hawaii program is organized, financed, and managed.
2. Assess whether the program has sufficient management controls to promote the cost effective delivery of services.
3. Make recommendations as appropriate.

Scope and Methodology

We reviewed relevant state statutes, mission and functional statements, policy manuals, contracts, documents, and records of the PACE Hawaii program. We also reviewed policies and requirements of On Lok and the Department of Human Services that relate to the PACE Hawaii program. In addition, we reviewed reports and documents from the National PACE Association and other PACE sites.

We interviewed personnel of PACE Hawaii, the Department of Human Services, Maluhia Hospital, and others. We also interviewed personnel from On Lok, National PACE Association, other PACE sites, and other states' human services and health departments.

Our work was performed from June 1997 to March 1998 in accordance with generally accepted government auditing standards.

Chapter 2

PACE Hawaii Has Yet to Demonstrate Its Viability

Despite six years of effort, PACE Hawaii has not been able to demonstrate its viability. Although PACE Hawaii is implementing service components of the PACE program as intended, it has failed to implement and adhere to fundamental financial requirements. Thus it cannot offer all services provided by a full fledged PACE site and cannot demonstrate that it successfully operates within the parameters of the model. Inconsistent support from the Department of Human Services has slowed progress. Furthermore, PACE Hawaii's management has insufficient controls and measures to document program performance. PACE Hawaii cannot reliably substantiate its cost and revenue measures, and falls short of fulfilling its role as a state-sponsored demonstration project.

Summary of Findings

1. PACE Hawaii's implementation has been hampered by inconsistent state agency support. As a result, PACE Hawaii has not been able to implement the full fledged PACE model.
2. PACE Hawaii lacks sufficient management controls to demonstrate that a state-sponsored PACE replication program is viable. Unless improvements are made, PACE Hawaii will not serve as a meaningful assessment of the PACE program for Hawaii.

PACE Hawaii Is Not Yet Fully Implemented

After six years of operation, PACE Hawaii has not yet implemented the full service model called for in the PACE replication program. In accordance with PACE protocol, PACE Hawaii's objective is to offer a comprehensive program that provides all medical, social, restorative, and supportive care needed by a frail elderly individual in a cost effective manner. Services are to be provided in a community-based, rather than institution-based setting. Cost effectiveness is supposed to be demonstrated by the program's ability to provide all required services for a known but fixed reimbursement amount while accumulating sufficient cash reserves to operate in a fiscally responsible manner for the duration of each client's enrollment.

Comprehensive, cost-effective delivery of services is an essential PACE element

The key to a successful PACE program is the ability to offer comprehensive services to clients while operating under fixed revenues. Upon acceptance into a PACE program, clients agree to let PACE be the sole provider of all services needed. Comprehensive services provided by PACE include all acute and long-term care and cover a broader range of

services than those normally covered by Medicare and Medicaid benefits. Services are provided in the PACE center, the home, or inpatient facilities. Each PACE center includes a day health center (with all the services offered by a typical, free-standing adult day health center) and a full service medical clinic. In addition, PACE commits to providing a lifetime of needed services to its clients.

Services to be provided to a PACE client are determined by an interdisciplinary team consisting of primary care physicians, nurse practitioners, clinic nurses, home health nurses, social workers, occupational and physical therapists, dietitians, health workers, recreation therapists, and transportation workers. The entire team serves as the care manager. The team assesses individual participant needs, formulates appropriate treatment plans, allocates appropriate resources (including contract services), directly delivers needed services, monitors the effectiveness of treatment plans, and adjusts care plans without going through third party payers or providers. PACE enrollees who qualify for dual waivers pay no added fees for any health and social services provided. However, clients who are qualified only under the Medicare waiver (based on age) and not Medicaid (based on financial need) must pay for that portion of the monthly fee not covered by Medicare.

Primary care services provided by PACE include all medical care in clinics adjoining the adult day health centers, medical specialist consultations by contract providers, hospital care, nursing home care when needed, and all ancillary services, including prescription medications, lab tests, and x-rays. Primary medical care is provided by staff physicians who participate actively on the interdisciplinary team. They manage patients with acute and chronic illnesses in the clinics and provide continuity of care as attending physicians for hospitalized participants.

Nationally, PACE replication sites have generally been successful in providing services to clients who qualify under the dual waiver system. However, the number of PACE sites and total number of clients served have been limited. In addition, although PACE programs can accept a variety of payment arrangements from clients, they have not had much success in attracting clients other than those who qualify for the dual Medicare/Medicaid waivers.

PACE Hawaii's development is slower than normal

The PACE protocol developed by On Lok is designed to gradually phase in the services offered to its frail elderly clients. This ensures that services are properly implemented and that the PACE organization is fully prepared to assume the full care responsibilities. A 1995 evaluation of PACE replication programs noted that the complete development of a program to full dual waiver capitation status varied from two to four years, with approximately two years being most frequent.

PACE Hawaii's development has been much slower than other PACE replication sites. After six years of operation, PACE Hawaii still operates under only the single Medicaid waiver rather than the dual Medicaid/Medicare waiver. Consequently, PACE Hawaii does not offer the full comprehensive level of services for a fixed or capitated rate that characterizes a PACE program. Further, PACE Hawaii is not yet in a position to demonstrate whether the PACE model can effectively deliver comprehensive, cost effective services for the frail elderly in Hawaii.

While PACE Hawaii has proceeded to establish the infrastructure and services necessary to replicate the PACE program, it has been unable to implement the complete PACE financial model. The first major waiver for the capitated Medicaid payment was not implemented until May 1995. Delays in implementation of the first PACE waiver agreement were primarily due to actions of the Department of Human Services in its role as state administrator of the Medicaid program.

Development of the Medicaid waiver agreement was delayed

In 1991, PACE Hawaii replaced Maluhia's day hospital program and established operations of the day care services for the elderly at Maluhia. In authorizing the creation of the PACE demonstration project within the Department of Health, the Legislature specified that the Department of Human Services support the project by cooperating to obtain necessary federal waivers.

The PACE Hawaii director expected the Medicaid waiver agreement to be executed in the ensuing year, and thus, proceeded to expand the day care staff from 9 positions to over 20 positions. Administrative personnel and additional specialists and care providers were hired to expand existing day care services to fit the comprehensive services of the PACE model.

However, the Medicaid waiver agreement was not developed by the Department of Human Services and executed until March 1994, almost three years after PACE Hawaii started operations. Furthermore, PACE Hawaii was unable to initiate the capitated reimbursement agreement for another year because the Department of Human Services failed to develop appropriate administrative rules to administer the waiver agreement. PACE Hawaii and the department were prohibited from implementing the waiver agreement until appropriate administrative rules were adopted and implemented. The Medicaid capitation agreement did not go into effect until May 1995, or about four years after PACE Hawaii was established. During that period, PACE Hawaii services were limited in scope and PACE Hawaii operated essentially as a typical fee-for-service Medicaid provider. However, the program did assume the added responsibility for securing needed services for clients that were not offered directly by PACE Hawaii under the single Medicaid waiver.

The Department of Human Services attributed the four year delay for the PACE Hawaii program to its concentration of effort and available resources on the implementation of its QUEST project. Given the size and impact of QUEST relative to the small, focused PACE program, the department elected to focus on QUEST and did not develop and execute the PACE waiver agreement and administrative rules. The department further noted that implementation of the PACE program required adjustments in Medicaid's MMIS, or computer information, system. The adjustments were needed to implement PACE's capitated reimbursement approach. The department stated that such changes could not be implemented until the QUEST project had been initiated.

Medicaid cap restricts PACE Hawaii's development

With the May 1995 initiation of the Medicaid waiver, PACE Hawaii started receiving a capitated payment amount of \$2,100 per month per client as the first major component of the PACE financial model. However, the Department of Human Services, citing budgetary restrictions, limited PACE Hawaii's enrollment under the Medicaid waiver agreement to 46 clients, or well below PACE Hawaii's projected break even point of 70 clients.

The 46 client cap remained in place until July 1997, when the Legislature in Section 67, Act 328, SLH 1997, appropriated additional general funds to support expansion of PACE Hawaii to accommodate 90 clients. The additional funding should permit the program to surpass the projected break even point, apply for the Medicare waiver, and implement the dual waiver reimbursement system — the key financial element in the PACE replication model.

Medicare waiver not pursued

The Medicaid cap on the number of clients also prevented PACE Hawaii from pursuing the Medicare waiver. PACE Hawaii's director noted that while there was no specific provision in the PACE protocol preventing the project from pursuing the Medicare waiver, the limit on the number of clients made a Medicare waiver economically unfeasible. To progress to the dual waiver status required that PACE Hawaii increase the level of services offered. Providing additional services under the 46 client cap would only increase program costs without any prospect of obtaining the additional clients needed to approach the projected break even point. Thus PACE Hawaii elected not to pursue expansion to the dual waiver status until it became feasible to reach the projected break even point of 70 clients. PACE Hawaii's director reports that since the increase in Medicaid funding was appropriated by the Legislature, PACE Hawaii's client base has been increasing. As a result PACE Hawaii is now drafting a proposed Medicare waiver application request.

The Medicaid cap on the number of clients also points to the vulnerability of a PACE program. Should a future cap be placed on PACE Hawaii that is below its break even point, concerns about the fiscal soundness requirement of the PACE protocol may come into play. PACE Hawaii must compete with other programs for Medicaid funding. Even under the full dual waiver system, Medicaid continues to be the primary revenue source for the program. PACE programs must therefore rely upon continued support and commitment from the state Medicaid agency. Given that PACE Hawaii must compete with other service providers for Medicaid funds, it is not certain what the impact of other new or expanding programs, or even the expansion of additional PACE programs, will have on continued Medicaid support. Since the failure to maintain client levels above an identified break even point could have potentially serious effects upon PACE Hawaii's viability, the need for continued legislative intervention should be identified. The present expansion of the PACE Hawaii program to reach and potentially surpass the projected break even point was achieved only by a specific legislative proviso.

PACE Hawaii's Management Controls Are Insufficient and Cannot Demonstrate That a State-Sponsored PACE Replication Program Is Viable

Cost and revenue controls necessary to demonstrate self-sufficiency are lacking

PACE Hawaii lacks the documentation, record keeping, and evaluation measures necessary for a demonstration project as well as the requirements of the national replication project authorized under the federal Omnibus Reconciliation Act of 1986. PACE Hawaii's orientation is directed toward the establishment of a PACE program and not toward the broader and legislatively mandated objective of testing the viability of the PACE concept for Hawaii. Consequently, management controls such as record keeping, and tracking and monitoring of costs and expenditures, are either insufficient or lacking. Further, PACE Hawaii is failing to adequately identify and assess the impact of the program on the State.

As a demonstration project, PACE Hawaii is failing to demonstrate the viability of a PACE program in Hawaii because it does not adequately track and maintain essential cost information that demonstrates program performance. PACE programs should operate within the capitated reimbursement payment received through the dual waiver payment program. PACE Hawaii presently functions only under the single Medicaid waiver and is unable to substantiate the adequacy of the Medicaid capitation rate.

Justification of Medicaid capitation rate cannot be verified

In 1994, PACE Hawaii and the Community Long Term Care Branch of the Department of Human Services' Health Care Administration Division (now known as Med-QUEST Division), entered into an agreement that established the Medicaid waiver agreement amount at \$2,100 per client

per month. This rate remained fixed until July 1, 1997 when the reimbursement was increased to \$2,201 per client per month, to reflect a 4.8 percent cost of living adjustment.

The Medicaid capitation rate is negotiated with each specific state Medicaid agency. While the capitation rate is based on a percentage of what the Medicaid agency would pay for a comparable frail long term care population, considerable variation exists in how the rate is actually determined. In 1994, a study on PACE replication sites noted that the monthly Medicaid capitation payments varied from \$1,486 to \$4,465, with an average of \$2,361. The range in the reimbursement rates was due in part to differences in geographic location as well as variations in how the Medicaid agency determined comparable costs for PACE services. Since each PACE site is financially at risk for services provided, it is important that each PACE site assess the reasonableness of comparable cost factors that the Medicaid agency uses to develop the proposed capitation rate.

We requested documentation from PACE Hawaii and the Department of Human Services that would support the determination of the original Medicaid capitation payment amount. Neither agency could provide documentation on the negotiations or how the capitation rate was determined. We were thus unable to verify whether the capitation rate payment was a realistic reflection of the actual costs of the services provided. This also meant that PACE Hawaii could not verify that a fundamental and critical revenue component of its program is reasonable. We believe this information is fundamental to a demonstration program and failure to maintain such information leads to confusion about the program's progress.

For example, the PACE Hawaii director noted that the Medicaid capitation rate was fixed by the Medicaid service agency, leaving little alternative for PACE Hawaii but to accept the rate. However, the program specialist responsible for reviewing the Medicaid waiver stated that the original \$2,100 capitation rate was proposed by PACE Hawaii, and was lower than the actual capitation rate that the Department of Human Services was willing to accept. Human services staff recalled that they had concluded that a \$2,500 reimbursement rate was reasonable, but also lacked any documentation to substantiate their recollections. Since neither agency could produce documentation to support the established capitation rate, we were unable to assess the accuracy of their reimbursement rate.

PACE Hawaii not identifying all program costs

One of the indicators of a successful PACE program is self-sufficiency. That is, revenues collected through the capitated payments are sufficient to offset expenses and accumulate a reserve to ensure financial stability.

For example, On Lok never experienced any cost overruns in its execution of the full fledged PACE model, and was able to annually place five percent of its operating revenues in a risk reserve account.

In order to demonstrate self-sufficiency, PACE Hawaii's revenues must more than offset incurred costs. Since PACE Hawaii has not reached the full dual waiver status, it is unable to demonstrate the viability of a full PACE program. However, PACE Hawaii should be identifying all costs from which revenues can be compared and the viability of the program can be determined. We found that PACE Hawaii does track some costs, but that cost data are incomplete.

Cost per participant cannot be tracked

Although PACE Hawaii does report its revenues and expenditures in a monthly statement of revenue and expenditures, it does not formally track these costs back to individual participants to determine the cost per participant. Because PACE Hawaii does not effectively track its program costs per participant, it cannot reliably determine the amount of adjustments needed to ensure that revenues cover program costs.

PACE Hawaii's director contends that tracking individual client costs may be counter-productive, noting that this is equivalent to the administrative overhead associated with a fee-for-service system which the PACE protocol seeks to avoid. However, the director also stated that once the Medicare waiver is in place, there will be a need for such information. We note that since PACE Hawaii functioned on a fee-for-service basis until May 1995, tracking costs per client should already have been in place in order to correctly bill for services rendered. Furthermore, costs per client comprise an essential component in evaluating service delivery. While costs should not be used as a reason to curtail services, they can help demonstrate that services are being provided in the most effective and efficient manner possible.

As no per participant costs were developed, we used PACE Hawaii's monthly revenue and expenditures report to estimate the program's cost per participant for its Medicaid eligible clients. Monthly expenditure and census figures for the months of May 1995 through May 1997 were reviewed. We found that per participant costs ranged from \$2,515 to \$3,266 per month, with an estimated average per participant cost of \$2,849. During this period the Medicaid capitation rate was \$2,100 per month per participant. PACE Hawaii costs exceeded revenues by an average of \$749 per participant per month during the period of review. We also found that PACE Hawaii failed to include rent costs and meal costs in its Statement of Revenue and Expenditures.

Rent and meal costs not included in program costs

PACE Hawaii does not include rent costs and meals costs when accounting for the program's total expenditures. To obtain an accurate cost picture of the PACE Hawaii program, program managers need to include all costs in the revenue and expenditure statements. The self-sustainability of the program cannot be determined until all costs associated with the program such as rent and meals are identified.

PACE Hawaii uses about 4,320 square feet of space at the Maluhia Long Term Care Health Center. However, the program does not pay any rent to Maluhia. PACE Hawaii has estimated the cost of using this space at about \$2.00 per square foot. Thus, the estimated monthly rent for this space is about \$8,640 per month. We believe that the rental cost should be reimbursed back to Maluhia Hospital and included in the program's total cost.

We also found that meal costs were not included in PACE Hawaii's program costs. Program participants receive a lunch meal when they attend PACE Hawaii programs. Meals provided to PACE Hawaii clients are supplied by the Maluhia Hospital cafeteria without reimbursement. Meal costs should be reimbursed to the hospital and accounted for in the monthly statements.

PACE Hawaii does track the number of participants who receive lunch meals while attending PACE programs. Its census reports show that monthly lunch counts ranged from 613 lunches to 896 lunches per month for the period May 1995 to May 1997. PACE Hawaii's accountant estimated each lunch cost \$4.00. Unaccounted for monthly lunch costs, thus ranged from \$2,452 to \$3,584. Adding lunch costs to our estimated cost per participant resulted in an estimated cost per participant range of \$2,574 to \$3,333 per month, or an additional cost ranging from \$474 to \$1,233 per patient per month.

In its most recent report to the Legislature, PACE Hawaii reported that the average cost per participant was currently \$2,755 per month. The same report estimates that Medicaid client nursing home costs were approximately \$2,916 per month. However, we found that PACE Hawaii's average cost per client including meals for the period May 1995 to May 1997 was \$2,917 per month or essentially the same as the reported Medicaid nursing home costs.

In order to assess the viability of the PACE program in Hawaii, the program needs to accurately identify program costs versus alternative services costs. All expenses such as rental costs and meal costs should be included in the expenditures. Failure to do so understates true costs and hinders a meaningful assessment of the program. To become a truly self-sustaining program, the program must identify and account for all costs.

If Maluhia Hospital, as a policy decision, does not choose to differentiate all costs associated with PACE Hawaii because the program is a department of the hospital, it should clearly identify these cost exceptions.

Break even point was not established until 1997

PACE Hawaii did not determine a break even point—the point at which revenues collected match expenditures—until 1997, six years after the program was initiated. A break even point is significant because it identifies when a program will attain self-sufficiency, one of the goals of a PACE replication program. PACE Hawaii presently states that its break even point is 70 clients. This break even point was initially proposed by the Department of Human Services program specialist who reviews PACE Hawaii based upon PACE Hawaii’s projected expenditures for 1997. The program specialist noted that the estimate was developed as a basis for determining the additional level of support that could be provided to PACE Hawaii through the state Medicaid program to reduce PACE Hawaii’s losses.

The program specialist also noted that after review, PACE Hawaii agreed that based upon current projected expenses, the proposed break even point of 70 clients was realistic. This number was used as a basis to help determine the additional funding necessary to permit PACE Hawaii to seek the full fledged dual waiver financing arrangement. Prior to establishment of this break even point, PACE Hawaii apparently never formally determined a break even point, targeting instead a suggested national goal of 120 clients as the target for dual waiver status. PACE Hawaii’s operations were thus targeting success based upon an arbitrary target number of clients which has little relationship to achieving financial self-sufficiency.

PACE Hawaii’s orientation fails to recognize role as a State demonstration project

As the only state sponsored PACE replication site, PACE Hawaii is faced with several factors that distinguish it from other PACE programs. However, PACE Hawaii does not account for these differences in its reporting. As a result, PACE Hawaii fails to adequately address the unique issues it faces as a state agency.

Projected cost savings do not reflect full state role

PACE Hawaii fails to recognize that as a state sponsored agency, the full cost of services will be a state responsibility. In its most recent report to the Legislature, PACE Hawaii notes the FY1996-97 average Medicaid cost for skilled nursing home care averaged \$2,917. Citing the PACE capitated rate of \$2,100, PACE Hawaii contended that “PACE is able to care for the same type of Medicaid client with a twenty-eight percent savings to the state.”¹

For the typical PACE program, this statement could be accurate. PACE replication sites are generally privately sponsored and the full risk for the cost of medical services and care rests with the PACE organization once the full dual waiver program is in place. In this situation, a state would be responsible only for its share of the Medicaid capitated payment. For example, PACE Hawaii reported that for the fiscal year ending June 30, 1997, the program incurred a net loss of \$523,875. This amounts to a loss per client of approximately \$754 per month based upon PACE Hawaii's current census of 58 clients as reported in its latest report.²

Since PACE Hawaii is a state agency, the State is responsible not only for its share of the Medicaid capitated payment, but any additional cost that is in excess of the payment. All of PACE Hawaii's expenses are costs to the State after federal reimbursement. In fact, since PACE Hawaii has not yet operated at a profit, the State has realized no savings. In addition, PACE Hawaii lacks the information necessary to demonstrate that the cost of providing the services is less than what the State would have incurred through use of a nursing home or other medical service.

PACE Hawaii's reporting is inadequate

PACE Hawaii's reporting to the Legislature is inadequate. As a result, the Legislature has been unable to adequately track, monitor, and understand PACE Hawaii's progress and development. When the Legislature established the PACE demonstration project under the Department of Health in 1992, it required that a comprehensive status report be submitted annually on the project. PACE Hawaii was unable to provide copies or demonstrate that annual reports for 1992 and 1996 were indeed submitted to the Legislature. Annual reports were submitted for the years 1993, 1994, 1995, and 1997. However the reports for 1993 through 1995 provided no detailed financial information. Financial information should be both basic and essential for a program that intends to be cost effective in the delivery of its services.

The 1997 annual report does contain financial information. However, this was a result of a specific legislative directive upon extending the demonstration period for an additional five years.³ Even with the additional reporting requirements, the reporting remains incomplete.

Implications of "full risk" not adequately identified

PACE Hawaii has not adequately identified the implications of assuming "full risk" for care of its clients. A characteristic of a full-fledged PACE program is that it assumes full risk for the care of its clients. All required medical and health services must be provided regardless of actual cost. The risk assumed is that the total cost of care for a client over the full term of the services provided will be less than the total capitated reimbursement payments. Funds collected when expenses are less than

the capitated reimbursement are deposited in a risk reserve account which each PACE site is required to establish. The reserve funds are used to offset expenses for periods when the cost of services may exceed the capitated reimbursement. Generally this occurs when the client's condition declines to the point that nursing home, acute, or other institutionalized care is required.

Where the PACE site is privately sponsored, the risk associated with this situation is the sole responsibility of the PACE program. The state's responsibility is limited to providing the capitated Medicaid reimbursement payment. In PACE Hawaii's situation, the State of Hawaii is ultimately placed in the position of assuming full risk for the client's care, regardless of the cost. PACE Hawaii notes that when it reaches the full-fledged PACE model, i.e., the dual Medicare/Medicaid waivers, that "it will be financially responsible for all health and long term care costs including acute hospitalizations."⁴ PACE Hawaii, as a department of Maluhia Hospital, is now part of the Hawaii Health Systems Corporation. An objective of the corporation is to be financially independent of the State. The extent to which Maluhia must subsidize the PACE Hawaii program will also negatively impact the corporation's efforts to achieve financial independence. However, despite the corporate relationship, PACE Hawaii is still a state-sponsored program, and the State still ultimately assumes complete responsibility for the cost of care for each of PACE Hawaii's clients.

Nationally, the number of full fledged PACE programs is limited, but they have demonstrated the ability to successfully operate under the dual waiver reimbursement system. Since PACE Hawaii has yet to operate under the dual waiver system it cannot demonstrate that its costs will be less than the revenues it receives. The Hawaii Health Systems Corporation and ultimately the State will remain responsible for costs that exceed PACE Hawaii's revenues. This is of particular concern because of PACE Hawaii's failure to correctly identify all costs of the program.

Dual waiver reimbursement amount questionable

Finally, we note that PACE Hawaii currently anticipates that upon approval of the Medicare waiver, the project will receive a total monthly capitation payment of \$3,201 per client per month. This is based upon a projected \$1,000 payment from Medicare and the existing \$2,201 Medicaid reimbursement. With these reimbursement rates and increased number of clients, PACE Hawaii estimates that it should start realizing a profit in May 1998, with the fiscal year ending June 30, 1999 as the first year when revenue will exceed costs and the required risk reserve account will be established. In anticipation of this, PACE Hawaii is currently planning the expansion of its operations at Maluhia.

However, the Department of Human Services program specialist who reviews PACE Hawaii's program contends that the present Medicaid waiver reimbursement rate is not fixed. Upon PACE Hawaii's receipt of the Medicare waiver, the state Medicaid office will re-evaluate the Medicaid waiver amount to determine whether the rate should be adjusted. It is possible that the Medicaid rate will be reduced. The program specialist stated that PACE Hawaii's "profits" should be realized only from the clients that exceed the break even point. PACE Hawaii must therefore be in a position to defend the appropriateness of its existing Medicaid reimbursement amount, a position that we have already noted cannot be defended.

Conclusion

Nationally, the PACE program concept has demonstrated the potential to provide comprehensive and cost effective delivery of services to the frail elderly, particularly for those who are both Medicare and Medicaid eligible. PACE Hawaii has yet to demonstrate that it too can successfully implement the PACE model of health care for the frail elderly. PACE Hawaii is failing to ensure it has sufficient information to demonstrate the viability of a PACE program in Hawaii in general, and the viability of a state-sponsored PACE program in particular. PACE Hawaii must take steps to fulfill its obligation as a demonstration project if State sponsorship is to be continued.

Recommendations

1. The Legislature should not approve any further expansion of the PACE Hawaii program until PACE Hawaii is able to satisfactorily demonstrate that program objectives are sufficiently met to warrant state support.
2. The Legislature should require PACE Hawaii and Hawaii Health System Corporation to submit a report substantiating that, at a minimum:
 - a. Dual waiver or full implementation of the PACE program model has been achieved.
 - b. An evaluation mechanism is in place to assess the program's ability to meet its objectives.
 - c. All program costs and revenue controls necessary to evaluate self-sufficiency are implemented.
 - d. The cost per participant is realistically determined. All program costs should be included in this determination.

- e. A determination of the adequacy of the Medicaid capitation rate to cover cost of care has been completed.
- f. A determination of the level of commitment from the Department of Human Services to support the PACE program relative to other Medicaid sponsored/supported programs should be completed.

Notes

Chapter 1

1. Catherine Eng, MD, et al, "Program of All-Inclusive Care for the Elderly (PACE): An Innovative Model of Integrated Geriatric Care and Financing," *Models of Geriatric Practice*, vol. 45, no. 2, February 1997, p. 224.
2. Health Care Financing Administration (HCFA) and On Lok Senior Health Services, *PACE Protocol*, Revised 3/29/90, p. 1.
3. Section 1, Act 211, Session Laws of Hawaii 1992, p. 557.
4. *Ibid.*, p. 558.
5. HCFA, *Pace Protocol*, Revised 3/29/90, p. 1.

Chapter 2

1. State of Hawaii, Hawaii Health Systems Corporation, Maluhia, PACE Hawaii at Maluhia, *Report to the Nineteenth Legislature, State of Hawaii 1998, In Compliance with Session Laws of Hawaii 1997, House Bill 120 Relating to Program of All Inclusive Care for the Elderly, (PACE)*, December 1997, p.8.
2. *Ibid.*, p.2.
3. Section 2, Act 338, SLH 1997.
4. State of Hawaii, Hawaii Health System Corporation, *Report to the Nineteenth Legislature*, p. 9.

Responses of the Affected Agencies

Comments on Agency Responses

We transmitted drafts of this report to the Hawaii Health Systems Corporation and the Department of Human Services on April 17, 1998. A copy of the transmittal letter to the Hawaii Health Systems Corporation is included as Attachment 1. A similar letter was sent to the Department of Human Services. The response of the Hawaii Health Systems Corporation is included as Attachment 2. The Department of Human Services elected not to respond to our draft report.

The Hawaii Health Systems Corporation acknowledges and concurs that PACE Hawaii has yet to demonstrate the cost-effectiveness and viability of the PACE model for Hawaii. The corporation emphasizes that inconsistent support from the Department of Human Services has limited the ability of PACE Hawaii to implement the full model. The corporation also identified specific actions that would address several of the specific recommendations contained in our report. We note that these are in response to the recommendations in the report and not “the Legislature’s requirements” as indicated in the response.

The Hawaii Health Systems Corporation disagrees with the language used in several specific statements made about PACE Hawaii’s insufficient management controls. The corporation contends that PACE Hawaii follows Generally Accepted Accounting Principles and that all of PACE Hawaii’s costs other than the rent and meal costs identified in our audit are properly stated. However, the concern in our report was that PACE Hawaii did not report all program costs, and not that costs reported are not accurate. This is of particular concern because we found that when meal and rent costs are included, PACE Hawaii’s projected average cost per client was essentially the same as what the program reported as the average Medicaid nursing home cost, i.e., no cost savings were being demonstrated.

The corporation also noted that PACE Hawaii is in full compliance with requirements of the national PACE Protocol, the federal Health Care Financing Administration, and monitoring requirements by the departments of health and human services. We note that these requirements generally deal with monitoring the nature of the services provided and do not focus on costs. Those provisions of the PACE Protocol relating to fiscal responsibility apply to the full PACE model service provider which do not yet apply to PACE Hawaii.

The corporation further contends that with the exception of two documents, PACE Hawaii has consistently produced all records and

documents requested by the State Auditor. This is not true. During the course of the audit a number of inquiries were made for reports, documentation, and other evidence to demonstrate management's tracking of the project. Those records either could not be provided, did not exist, or had not been executed. Our report states that PACE Hawaii is unable to demonstrate that reports of 1992 and 1996 were submitted to the Legislature. Despite the corporation's statement, it still has not demonstrated that a 1996 report was submitted. The corporation misses the point of our concern about the lack of documentation for the Medicaid capitation rate. The concern is that PACE Hawaii is unable to substantiate the reasonableness of a fundamental element in its financing structure as evidenced by its lack of documentation, and not an inability to provide the documentation itself.

Finally, the corporation contends that while it is important to track cost per client, it is inappropriate for a capitated system. The corporation suggests that use of a DATAPACE which monitors a client's utilization and evaluates service is more appropriate. While we acknowledge that there may be any of a number of ways to evaluate costs, PACE Hawaii's continued focus primarily on service delivery is inadequate. The success of the PACE replication program is based upon delivery of quality services while controlling costs. We continue to believe that PACE Hawaii lacks the controls necessary to adequately monitor and track program costs.

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917



MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

April 17, 1998

COPY

Mr. Thomas M. Driskill, Jr.
Chief Executive Officer
Hawaii Health Systems Corporation
3675 Kilauea Avenue
Honolulu, Hawaii 96816

Dear Mr. Driskill:

Enclosed for your information are three copies, numbered 9 to 11 of our draft report, *Audit of the Program of All-Inclusive Care for the Elderly (PACE) Hawaii*. We ask that you telephone us by Monday, April 20, 1998, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Wednesday, April 22, 1998.

The Department of Human Services, Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

HAWAII HEALTH SYSTEMS CORPORATION

3675 Kilauea Avenue ■ Honolulu, Hawaii 96816 ■ Telephone: (808) 733-4020 ■ FAX: (808) 733-4028

April 22, 1998

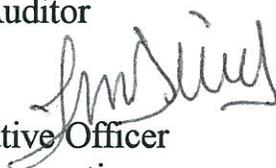
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OFFICE OF THE AUDITOR
STATE OF HAWAII

TO: Marion M. Higa
State Auditor
Office of the Legislative Auditor

FROM: Thomas M. Driskill, Jr. 
President and Chief Executive Officer
Hawaii Health Systems Corporation

SUBJECT: RESPONSE TO THE AUDITOR'S REPORT – AUDIT OF PACE
HAWAII

Thank you for the opportunity to comment on the draft PACE audit. Per your April 17, 1998 memorandum, attached is the final response report on the audit of PACE Hawaii. I think you will agree that the response our staff has provided will add great value to the audit report.

If you or your staff have any questions, please feel free to call me at 733-4151; Audrey Suga-Nakagawa, Director of PACE, at 832-6112; or Jerry Walker, Administrator of Maluhia, at 832-6150.

Attachment

**Response to the Audit of the
Program of All-Inclusive Care for
the Elderly (PACE) Hawaii**

Prepared by:

**State of Hawaii
Hawaii Health Systems Corporation
PACE Hawaii at Maluhia**

April 22, 1998

Upon review of the Audit Report of the Program of All-Inclusive care for the Elderly (PACE) Hawaii received on April 17, 1998, the Hawaii Health Systems Corporation submits the following response:

The Hawaii Health System Corporation acknowledges and concurs with the State Audit Report that PACE Hawaii has yet to demonstrate its true cost-effectiveness and viability because it has not implemented the full service model which operates with both Medicaid and Medicare capitated reimbursements. Currently, it still operates with Medicaid capitation and is applying for the Medicare reimbursements in 1998. In these past six years, the PACE Project in Hawaii had faced many unforeseen delays in the program implementation. The causes of the delays were primarily attributed to the Department of Human Services, which had been concentrating its effort on the implementation of its Quest Project and did not have the extra time and resources to execute the PACE contract, create administrative rules and modify its computer information system to implement the PACE capitated reimbursement system in a more timely manner. In addition to the Quest Project, the Department of Human Services as well as all other state agencies and programs had been deeply affected by the State's declining economy and were forced to limit its funding to service providers such as PACE Hawaii. This specifically meant that DHS imposed a cap of only 46 clients which was clearly financially insufficient for PACE to break-even and offset its expenses. This financial restriction had been rectified as of 1997 when the State Legislature in Section 67, Act 328, appropriated additional funds to support the PACE project to accommodate more clients and implement the dual Medicare and Medicaid reimbursement system and become a full-fledged PACE model.

The Hawaii Health Systems Corporation, however, disagrees with the following language used in the Auditor's report and inferences which can be drawn. The statements that "PACE Hawaii's management has insufficient controls and measures to document program performance. PACE Hawaii cannot reliably substantiate its cost and revenue measures. . .", and "Management controls such as record keeping, tracking and monitoring of costs and expenditures are either insufficient or lacking" are very misleading and implies that a reliable accounting and evaluation system is not in place. Though internal charges for meals and rent have not been included in PACE's Revenue and Expenditure reports, all other costs and revenues are properly stated on the accrual basis and in compliance with Generally Accepted Accounting Principles. (The rent and meals costs were documented in Maluhia's cost reports but will not be included in PACE Hawaii's financial statements). Control of monthly expenditures is monitored through PACE's financial statements which analyze actual

(1)

expenditures, budgeted expenditures and variances by individual revenue and expenditure category. Extreme variances from the budget are reviewed by both PACE management and the Maluhia Business Manager on a monthly basis. Analytical review procedures which test financial statements for reasonableness are also done monthly. PACE's audited financial statements have received unqualified opinions from Maluhia's external auditors.

In addition to adhering with Generally Accepted Accounting Principles, PACE Hawaii has been in full compliance with all other necessary management controls and tools as required by the National PACE Protocol, the federal Health Care Financing Administration, the State of Hawaii Department of Health (DOH)/Hospitals and Medical Facilities Branch and the Department of Human Services (DHS)/Contracts Monitoring Branch. The program has been audited by both the Department of Health and Department of Human Services surveyors and received a range from satisfactory to outstanding ratings for the quality of PACE services, management controls, and compliance to the Medicaid contract and facility license.

During the past ten months of this legislative audit, PACE Hawaii has consistently produced all records and documents requested by the state auditor. The only exceptions have been two documents that originated six to seven years ago. These include DHS's calculation of the Medicaid capitation rate of \$2100 for PACE and a copy of the 1992 PACE Report to the State Legislature. Contrary to the auditor's report, the 1996 PACE report was submitted. It would be misleading to state that PACE Hawaii's management controls are insufficient based upon two missing documents dating back seven years.

While PACE Hawaii acknowledges the importance of tracking costs per client, it is pertinent to point out the different perspectives and methodologies in calculating the cost-per-participant. The Legislature is seeking cost data in a methodology similarly used in the fee-for-service financing system. In this system, a patient is charged for every billable treatment and procedure being provided by the health care provider. Because the service provider's billing process is structured to record and bill for these services, it is able to produce a cost per participant report under this system. It is important to note that the fee-for-service billing system is a laborious administrative process and prohibits or limits many services to patients.

In a capitated financing system such as PACE's, the reimbursement is based on a flat monthly payment per person regardless of the number of treatments and procedures. One of the advantages of a capitated system is that it permits PACE to provide services that are normally not billable in the

traditional fee-for-service but are critical preventive health care measures. As a result, PACE participant will have numerous service contacts which include many non clinical treatments and services such as transportation, social activities, maintenance-level physical and occupational therapies.

The volume of these service contacts makes it difficult to allocate accurate cost per client and to implement a system to capture such information would be costly and exceed the benefits derived from such a system. This is why PACE Hawaii does not track each individual's cost but takes the average cost of a participant care instead. The PACE model focuses on managing its financial costs by keeping each participant as healthy as possible through aggressive preventive health practices, frequent monitoring of the participant's status and prudent use of the team's resources. Its evaluation system, DATAPACE, is programmed to monitor the participant's service utilization not necessarily from a cost perspective but more from a quality perspective to insure that the program is meeting the standards of the PACE model.

To meet the Legislature's requirements, the Hawaii Health Systems Corporation and PACE Hawaii will take all necessary steps to meet the recommendations as stated in the state auditor's report and will specifically implement the following measures:

- 1) Apply for the dual Medicare and Medicaid capitated reimbursements and become a full-fledged PACE site;
- 2) In addition to building a risk reserve to protect PACE's financial base, the program will explore the feasibility to purchase reinsurance policies with other PACE sites across the nation to insure against any overcosts when the program is under dual Medicare and Medicaid capitations. This will minimize the financial risks to the State.
- 3) Enhance its current evaluation systems which monitor PACE's service utilization and its revenues and expenditures, and provide monthly analysis of the total cost per participant.
- 4) Continue to work closely with the Department of Human Service and maintain their support and commitment to PACE Hawaii by fulfilling its obligation to provide quality health and long term care services to the frail elderly in this community.

Despite the numerous delays and challenges which have faced the PACE Hawaii Project these past several years, the program has continuously

maintained its commitment to serve Hawaii's frail elderly population by providing quality health care services. The program has strived to raise the quality standards of a managed care model that integrates both acute health and long term care. PACE Hawaii has enjoyed many successes especially with the establishment of the Harry and Jeanette Weinberg Senior Residence at Maluhia, which is considered as Hawaii's first assisted living for the frail elderly in the lower economic group. While PACE Hawaii has yet to demonstrate self-sufficiency, it appreciates the opportunity to apply for the dual Medicare and Medicaid waivers to become a full-fledged PACE site. Both the Hawaii Health Systems Corporation and PACE Hawaii are committed to demonstrate the cost-effectiveness of this nationally proven model in the State of Hawaii.