



October 17, 2016

Andy Slavitt  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attn: CMS-4168-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

*Submitted electronically via [www.regulations.gov](http://www.regulations.gov)*

Re: Programs of All-Inclusive Care for the Elderly (PACE)

Dear Mr. Slavitt:

Community Catalyst respectfully submits the following comments on the Programs of All-Inclusive Care for the Elderly (PACE) Proposed Rule.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation is a hub devoted to teaching, learning and sharing knowledge to bring the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers, particularly those who are most vulnerable. We have been working to improve Medicaid and Medicare for consumers for more than a decade, producing tools for consumer advocates to use in state-based advocacy as well as tools for use by other stakeholders.

We believe that the PACE program embraces values and a model of care that are beneficial to older adults and especially those with multiple chronic conditions or frailty. It supports living at home in the community; it offers a comprehensive, wide array of services and benefits from an interdisciplinary care team; and it is person and family centered. However, despite its preventive, comprehensive and multi-payer attributes, there are only 118 PACE programs operational in 32 states, serving an estimated 38,000 participants. We support expansion of access to this model of care, while maintaining the integrity of the core values and features of the model.

In general, we are supportive of CMS' efforts to update the PACE regulation and believe it is important to build upon the experience that CMS, states, PACE and other provider organizations,

and consumers have accumulated since the PACE regulation underwent its last significant revision in 2006, as well as to account for current best practices and changes to the health care landscape since that time.

### **Flexibilities Related to PACE Interdisciplinary Team Members (IDT)**

We are pleased to see the flexibilities the proposed rule offers on the use of the Interdisciplinary Team (IDT). Providing this flexibility and giving enrollees choice will contribute to effective coordination of care and services. The integration of community-based providers as primary care providers (PCP) and expansion of PCPs to include nurse practitioners (NP) and physician assistants (PA) is a step in the right direction. The following should be considered in final rulemaking:

- A PACE physician (or NP, PA) must have reasonable evidence of skills in geriatric medicine, including care for patients with dementia and for patients at the end of life.
- PACE organizations must require IDT members and PACE center staff to participate in cultural competency training in order to better serve diverse participants.
- Currently, the PACE center houses the PACE IDT, but it is not essential that this be the case. We believe the PACE IDT can be located in other settings and across a range of settings, as long as processes are in place to assure effective communication among PACE IDT members and additional care providers.
- We agree with CMS' proposal to allow one individual to fulfill a maximum of two separate roles on the PACE interdisciplinary team when the individual meets the applicable state license standards and qualifications to fill each role and meet participant needs. This should be included in final rulemaking. This flexibility will allow PACE organizations to configure their interdisciplinary teams efficiently without compromising participants' quality of care. We expect this flexibility will be particularly useful for newly operational and smaller PACE organizations, including those in rural areas.

### **Participant Assessment and Plan of Care**

We are pleased to see that CMS is proposing to clarify the existing requirement that IDT members must conduct their initial comprehensive assessment in person. We also urge CMS to require that the initial comprehensive assessment be completed in time to allow the IDT to complete the care plan. Finally, we urge CMS to require PACE organizations to ensure assessments take into account participants' cultural and linguistic needs. For example, require that the assessment be completed by a staff person who speaks the same language or uses an interpreter to ensure participants' needs are appropriately met. We urge that this be explicitly stated in the final regulations.

We are pleased to see that the proposed requirements require the plan of care to:

- use appropriate interventions that meet participants' needs and move them towards measurable goals and desired outcomes.
- identify each intervention and how it will be implemented.
- identify how interventions will be evaluated to measure progress toward goals and desired outcomes.

In addition to these proposed requirements, we recommend the plan of care encourage the use of evidence-based self-management programs. Finally, the plan of care must be developed with respect for the participant's cultural and linguistic needs in mind. For example, ensuring language needs are addressed and/or culturally appropriate nutrition needs are met. We urge that this be explicitly stated in the final regulations.

## **Marketing**

The PACE program is no longer so obscure as to warrant that only employees provide information about the program. Information and materials about it should be offered by organizations like Area Agencies on Aging, Aging and Disability Resource Centers, SHIPs and other service providers for older adults. In addition, PACE organizations should be strongly encouraged to work with community-based organizations, such as advocacy groups, that have strong ties to the community to offer education about PACE.

We are pleased to see in the proposed regulations the requirement that PACE organizations have to provide printed marketing materials in English and in any language spoken by at least five percent of the individuals in the PACE organization's service area. Language is a major barrier to care and ensuring appropriate printed materials for non-English speaking participants will promote successful participation in the PACE program.

## **Medicaid Payment**

We support CMS' proposed requirement that Medicaid rates be sufficient to provide the services required under the PACE program for the population enrolled. This requirement is essential given that PACE organizations are responsible and at full financial risk for all Medicaid-covered services, including nursing home care, and that the population enrolled in PACE is a high-need, high-cost subset of dual-eligible and Medicaid-only beneficiaries. Further, state rate setting should recognize subpopulations with distinctly different cost experiences – e.g., dual-eligible versus Medicaid-only beneficiaries, beneficiaries with Medicare Part A or Part B only, differentiated age cohorts, beneficiaries with significant behavioral health diagnoses – and establish distinct rate categories accordingly. In the absence of these distinct rate categories, PACE organizations are unnecessarily at risk due to a distribution of PACE participants that is not consistent with the distribution of the subpopulations used to calculate a single, or overly broad, aggregated rate. We also urge CMS and the state develop risk adjustment methods that take into account not only clinical factors but socioeconomic factors. These payment considerations are important to help ensure that consumers who could potentially benefit the most from PACE are able to access the program

## **Monitoring of PACE**

With the many changes occurring to the PACE program, including the recent entry of for-profit PACE organizations into the market and the proposed expansion of the program, it seems ill-considered to allow audit and review at the organizations' discretion, regardless of for-profit or non-profit status. We therefore recommend audit and review for new PACE organizations be done after the first year and then every three years thereafter. Audits and reviews should be done more frequently for those PACE organizations that have performance and compliance issues; in addition, high number of grievances filed by participants should warrant additional review. We

support having this information transparent and readily available to consumers and their family members as they explore service and care options.

## **Data Collection and Reporting**

We urge CMS to require PACE organizations to collect and report data by sociodemographic factors such as age, race, ethnicity, primary language, gender identity, and sexual orientation and disability status. We strongly urge CMS to adopt their priorities from the Equity Plan for Improving Quality in Medicare<sup>1</sup> for PACE, too, which prioritizes the collection and reporting of data by the above sociodemographic factors.

## **Other Considerations**

- The ACA has enabled CMS to explore and promote new models of care via demonstrations to integrate care for some of the most high-need, high-cost consumers. We strongly urge that some of this work, including the PACE program, be integrated into the work of the Medicare-Medicaid Coordination office (MMCO). MMCO's role in developing and overseeing the financial alignment demonstrations makes sense as a home for expanding the PACE model and sharing best practices for other integrated care models. We also emphasize the importance of the robust model of consumer and stakeholder engagement that has been instituted as part of the oversight of the financial alignment demonstrations and would like to see similar engagement around PACE models as well.
- We support provisions in the financial alignment demonstrations and PACE that require consumer advisory councils and participant advisory committees, respectively, and encourage CMS to support efforts to recruit, train and support consumers and consumer advocacy organizations, to build strong consumer engagement from the ground up.
- Allow PACE organizations greater flexibility to use alternative care settings (e.g. adult day care centers, senior centers, activity areas in residential communities, etc.) for nutrition, socialization and observation; this should not take away from also allowing participants to use their main PACE center, as well, where participants will continue to receive medical attention. The use of alternative care settings would support expansion for those PACE participants who may not need a full array of services but can stay in the continuum of care that PACE is so good at delivering.
- We believe that for-profit PACE programs should reinvest a portion of their profit back into their communities to improve access to services and/or community health. This could include a community health needs assessment (CHNA) of their service area and an implementation strategy to address priority community health needs. As a part of this process, CMS should require input/collaboration from community residents, especially seniors/people eligible for PACE; AAAs; other social service providers and clinicians in the CHNA process. In addition:

(1) As part of the review process:

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<sup>1</sup> <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/equity-plan.html>

- a. Require a health impact study to assess the impact of the conversion on the accessibility and quality of services provided by the for-profit PACE organization to its participants.
- b. Require a robust public hearing process to solicit comments on the impact of the conversion.

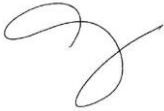
(2) As a condition of approval:

- a. Require a monitoring plan to oversee the level and quality of services provided to PACE participants.
  - b. The monitoring should also include an assessment of enrollment/ disenrollment practices to ensure the for-profit PACE organization is not engaging in “cherry picking” of participants.
  - c. This should include an independent ombudsman program funded by the for-profit PACE organization.
  - d. This should also include regular public reporting of participant complaints.
- We urge CMS to allow for two-way agreements between CMS and PACE and the provision of PACE-like services to new frail-elderly populations who have only Medicare insurance and who are interested in participating in PACE. Under a two-way agreement, PACE programs would be able to enroll other populations including participants covered by long-term care insurance and private-pay individuals, who would pay either the Medicaid LTSS rate or a tiered equivalent for bundles of services appropriate to the participant.
  - Related to the above comment, CMS should encourage states to set reasonable levels of disability to be able to use PACE so that a person with varying degrees of specific needs can receive tailored care. A person who will need a sheltered setting due solely to dementia and wandering (and without serious co-morbidities) might well be able to stay at home with family if he or she had the supervision of a PACE Center during the workday. States have come to rely mostly on dependencies in activities of daily living to set their PACE eligibility, but the statute only requires that the PACE participant “require the level of care provided in a nursing facility.” In order to accommodate participants with a variety of progressive disabilities associated with aging, PACE programs probably will need to be able to use tiered pricing for bundles of services. Already, some states use a predictive algorithm to pay a variety of capitated rates, depending upon risk for LTSS costs. Other states could adopt this strategy or could set a series of rates, and then Medicare-only beneficiaries could pay those rates to buy into PACE.
  - Permitting beneficiaries to enroll in PACE plans on a provisional basis during assessment and Medicaid eligibility investigation [whether enrolling direct from the community or following an inpatient stay in a hospital or a skilled nursing facility].
  - Revising quality measures to reflect what is most important to frail and disabled elderly people as a group and what is most important to this particular frail or disabled elderly person and his or her family; in addition, ensuring data from the quality measures are publicly reported.

We appreciate this opportunity to comment, and we welcome the opportunity to provide additional input on these issues in the future.

Please do not hesitate to contact me at [ahwang@communitycatalyst.org](mailto:ahwang@communitycatalyst.org) with any questions. As always, thank you for your time and attention to these issues.

Respectfully submitted,

A handwritten signature in black ink, appearing to be 'AH' or similar initials, written in a cursive style.

Ann Hwang, MD  
Director, Center for Consumer Engagement in Health Innovation