



February 10, 2017

Tim Engelhardt
Director, Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
ATTN: PACE Innovation Act Request for Information
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C., 20201

Submitted via: MMCOcapsmodel@cms.hhs.gov

Re: PACE Innovation Act Request for Information

Dear Mr. Engelhardt:

Community Catalyst respectfully submits the following comments on the Programs of All-Inclusive Care for the Elderly (PACE) Innovation Act Request for Information (RFI).

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 it is a critical time to promote models of care that improve the health of populations with complex medical and social needs while bringing cost savings to our public health care programs. Over the decades of its existence serving older adults, the PACE model has generated savings to the Medicare program.¹ In addition, research has shown the PACE model to provide high-quality care with improved health outcomes.² We believe the PACE program embraces

¹ See the National PACE Association Key Research Findings section at: <http://www.npaonline.org/policy-advocacy/state-policy/research>

² See the National PACE Association Key Research Findings section at: <http://www.npaonline.org/policy-advocacy/state-policy/research>

values and a model of care that can be beneficial to a younger population with mobility-impaired disability. PACE supports its participants in living at home in the community; it offers a comprehensive, wide array of services and benefits from an interdisciplinary care team; and its approach is person- and family-centered.

We support the proposed expansion of access through the testing of a PACE-like model of care for individuals with both Medicare and Medicaid, age 21 and older, with disabilities that impair their mobility. Adapting this proven model to a new population, while maintaining the integrity of the core values and features of PACE, holds great promise. We provide further detail in our comments below. In addition, we support the comments submitted by the National PACE Association (NPA).

Participant Eligibility

Coverage

While we support the extension of the Person-Centered Community Care (P3C) pilot, we urge CMS to consider broadening eligibility to beneficiaries with mobility-impaired disabilities beyond those who are dually eligible. Specifically, we recommend the P3C program be accessible to the following populations:

- a) Dual eligible beneficiaries with both Medicare Parts A and B, and full Medicaid benefits; OR
- b) Medicare-only beneficiaries with both Medicare Parts A and B, but no Medicaid; OR
- c) Medicaid-only beneficiaries with full Medicaid benefits, but no Medicare; OR
- d) Individuals with neither Medicare nor Medicaid.

Further, we recommend that individuals with third-party insurance coverage should be eligible to enroll in a P3C program.

Diagnoses

We recommend that CMS extend eligibility criteria beyond reliance on the diagnoses listed in [Appendix A](#), by also taking into account functional assessments. At a minimum, the P3C eligibility criteria should expand the list of diagnoses in Appendix A and allow for an exceptions process that considers additional factors, notably functional assessments. The advantages of expanding eligibility in this manner include increased interest in model participation, and the enhanced viability of P3C programs.

Age

We agree with CMS that establishing a maximum age for enrollment in the P3C model is unnecessary. A maximum age limit would leave out certain individuals who could potentially benefit from this program. Furthermore, establishing a maximum age could interrupt continuity of care – assuming P3C participants would no longer be eligible for the model after reaching a certain age. In those areas where both PACE and P3C programs exist, it should be up to the participant to choose which program is suited to his/her needs, with assistance from community-based organizations and/or resource centers, if needed.

Potential P3C Model of Care

Community Integration

We appreciate the emphasis that CMS is placing on the importance of community integration for a younger population with mobility-impaired disability. For this population, access to activities in settings outside of the PACE center is critical to maintaining independence and choice. We expect that the P3C programs will provide non-medical community support services in a number of settings including the home, a P3C center that provides services consistent with the principles of the Medicaid home and community-based services (HCBS) settings rule, and/or an alternative care setting that would provide for the integration of P3C participants into a broader community. Like CMS, we expect that P3C participants' use of the P3C center to access non-medical community support services would be left to their discretion.

An issue for CMS to clarify is detailing how community integration will be operationalized. What requirements will the P3C organization have to meet in order to ensure the broader community is aware of the non-medical support services furnished at the P3C center? We strongly encourage contractual partnerships with community-based organization and advocacy groups to offer education about the program as well as direct services, where appropriate.

Interdisciplinary Team Members (IDT)

Central to the PACE model is its care coordination function managed through the interdisciplinary team (IDT). This should remain the heart of the P3C program, as well, with each P3C participant assigned to an IDT. With that said, we do agree with the RFI in allowing flexibilities to the IDT given the complexities and needs of the target population. For instance, we support the proposal to tailor an IDT to a participant's needs, so long as all medical, social, and long-term services and support needs are met. Finally, the P3C organizations should be required to include the participant as a member of the IDT and to participate in the planning process.

We agree with the RFI in supporting the autonomy of P3C participants by allowing them to maintain their primary care provider through contractual relationships between a P3C organization and said provider. As in the current PACE model, contracted providers should be required to engage in IDT meetings, whether in-person or virtually, as necessary, to share information and facilitate timely interventions as needed. We recommend that members of the IDT have access to comprehensive information needed to support care management and care delivery, and that each IDT include a dedicated P3C staff member who coordinates IDT meetings. Finally, as we noted in [our comments](#) to the PACE notice of proposed rulemaking regarding flexibilities in the composition of the IDT, primary care providers employed by, or contracted with, the P3C:

- must have reasonable evidence of skills in geriatric medicine, including care for patients with dementia and for patients at the end of life
- must participate in cultural competency training in order to better serve diverse participants
- must be trained in inclusive, independent living and recovery philosophies

Assessment and Person-Centered Service Planning

We are pleased to see that PACE's person-centered service planning process is maintained under the P3C program. We are also pleased that CMS is encouraging P3C organizations to contract with conflict-free community-based organizations with expertise in independent service planning that provide participants with an advisor to assist participants in self-advocacy in the service planning process. As the RFI states, this is the type of advisory role similar to that provided by the [Independent Living Long-Term Services and Supports Coordinator](#) (IL-LTSS) in the Massachusetts One Care program. We strongly urge CMS to *require* these independent advisors, rather than simply encouraging their engagement.

We urge CMS to require P3C organizations to ensure assessments take into account each participant's cultural and linguistic needs. For example, CMS should 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. The IDT must also develop the care plan keeping in mind the participant's cultural and linguistic needs. For example, a care plan should explicitly address how language needs will be addressed and/or culturally- appropriate nutrition needs are met.

Finally, we recommend the care plan include the use of evidence-based self-management programs, as appropriate.

Choice of Providers

We support CMS allowing P3C organizations to contract with outside organizations, agencies and individuals for the delivery of services. This will help maintain continuity of care, which is vital for participants who have well-established provider relationships. We strongly encourage CMS to require P3C organizations to establish robust provider networks, inclusive of the types of providers needed by this target population, with knowledge of their needs and clinical history. Types of providers could include behavioral health, mental health/substance use disorder, long-term services and supports, and/or other specialty providers. The provider network should also reflect the cultural and linguistic diversity of the region being served.

The PACE Center

As noted above, we support CMS allowing P3C organizations flexibility with regard to how and where P3C participants may receive non-medical community support services. This is important for a younger population with disabilities to maintain robust choice. We also support CMS encouraging P3C organizations to explore partnerships with community-based organizations, especially Centers for Independent Living, to provide alternative locations for delivery of non-medical community support services. Other examples of alternative locations we support include adult day centers, senior centers and activity areas in residential communities.

Governance

We are pleased to see that CMS is considering maintaining the PACE model requirement to establish a participant advisory committee to provide advice to the governing body on matters of concern to participants. We strongly urge CMS to move forward with this.

We also support CMS' interest in requiring prospective P3C organizations to establish community advisory committees with the objective of giving individuals with disabilities and other stakeholders the opportunity to advise prospective P3C organizations in the development of their applications.

Both types of committees hold the potential to provide a meaningful feedback loop, allowing participants to articulate their needs and to facilitate buy-in and integration into the program.

Other

The P3C model will serve individuals varying widely in age, including a younger adult population that has not been served in the original PACE program. To support the ongoing independence and wishes of the participants served in the P3C model, it must employ different approaches. For example, younger participants are more likely to use technology to access health information and may want/need the ability to engage online with their IDT. We recommend that P3C applicants include policies in their applications around the use of technology to deliver information and facilitate communications with P3C participants.

Adequate Reimbursement

Establishing a sustainable P3C model requires that a P3C organization be appropriately reimbursed for services furnished. Given the uncertainty of rate-setting approaches for the P3C participant population, we strongly support the use of cost-outlier protections and risk corridors. The risk-sharing mechanisms proposed in the RFI, both the individual outlier protection and the risk corridors, are crucial to ensuring the viability of P3C programs. As CMS points out in the RFI, P3C programs are susceptible to inaccuracies in rate-setting and new programs are particularly vulnerable to very high individual costs while enrollments are still low. Furthermore, based on the experience in the Financial Alignment Demonstrations, many new participants enter the program with a number of health conditions that were not previously identified or that had not been adequately addressed in the fee-for-service system.³ We would expect a similar experience for P3C organizations. As a result, costs likely to be incurred by the P3C program will not be fully reflected in the FFS diagnoses and encounters which are the basis of their risk-adjusted payments. This further supports the importance of risk sharing.

In addition, to address this uncertainty, we recommend that CMS undertake analyses to determine the impact of the different Medicare rate-setting methods it is considering. Specifically, the proposed use of the Medicare Advantage (MA) risk adjustment factors and benchmarks may significantly underpredict the costs of serving the P3C population. This method should be compared to the current PACE methodology to assure that the resulting reimbursement adequately reflects the cost of the P3C participant population.

Finally, because P3C participants are more likely to require high-cost wheelchairs and other durable medical equipment, we urge CMS to account for these costs in the stop-loss program.

³ This was an issue in the One Care program in Massachusetts, and, as a result, CMS and the State made changes to the financing structure to reflect the additional service and complexities in managing a dually eligible population with disabilities. See: <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/2015/150923-masshealth-presentation.pdf>

We do not support any reductions to the capitation rates to fund stop-loss protections, as such reductions would essentially result in less funding for services needed by P3C participants.

Quality-Based Payments

We support adjusting P3C payments based on performance on specific quality measures. We recommend the following measure categories for CMS' consideration: hospital admission rates, preventable admissions for ambulatory-care-sensitive conditions, days in the community, conditions suspected to result from lack of care or care management, involuntary disenrollment, any validated tools that assess community integration, choice/control, experience of care, care planning and care coordination.

Proposed Quality Outcomes for Evaluation of P3C Model

We urge CMS to consider including measures that address care coordination, care planning, goals of care, community integration, reduction of health disparities, consumer engagement, participant experience, and rebalancing from institution to community living. Furthermore, we encourage the use of patient-reported outcome (PRO) measures as well as qualitative input from consumers, such as through focus groups or feedback provided through advisory committees.

Operational Structure

Application and Readiness Review

We support the application process as explained in the RFI. We strongly encourage stakeholder input on the draft of the P3C application before posting the final version. We request that CMS provide clarity around the length of the pilot in order to better understand when applications will no longer be accepted.

With respect to the readiness review process, we urge CMS and states to allow for sufficient time to ensure that the P3C organization is ready to enroll this new population. The RFI does not clarify the timeframe in which the review process would take place. We would encourage CMS to look at the Financial Alignment Demonstrations (FAD) as examples of why it is critical to allow for sufficient time to conduct a readiness review. Many FADs experienced significant challenges at the onset of implementation due to lack of readiness by the health plans, which resulted in delays in conducting initial assessments and development of care plans, among other difficulties.

Monitoring and Enrollment Process

In addition to what is outlined in the RFI regarding monitoring, we strongly encourage reporting of data to the public. We also recommend that data that is reported be stratified by race, ethnicity, language, gender, age, disability status and sexual orientation.

We strongly agree with CMS that the P3C enrollment process should continue to be voluntary, as it currently is in the PACE program. We encourage CMS to require P3C organizations to develop outreach and education plans that involve partnerships with community-based organizations and advocacy groups that have strong ties to the target populations.

We also encourage CMS to require that P3C organizations provide materials in English and in any language spoken by at least five percent of the individuals in the P3C 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 program.

Additional Potential Populations for a Model Test

Generally speaking, we support the expansion of a PACE-like model to "at risk" Medicare populations outlined in the RFI. There are number of factors to consider when expanding to additional populations and it is important to maintain flexibilities around *where* a participant receives services, including non-medical community support services based on their needs. As noted above, we support wider use of alternative community sites that may be more conveniently located to some beneficiaries' homes, so long as the IDT can staff those sites and remain in close contact across the team.

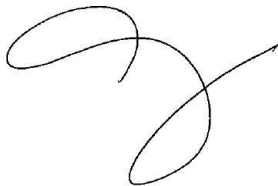
Factors to consider when expanding to additional populations include:

- type of assessment needed for the target population
- composition of the IDT
- continuity of care and choice of providers
- collaborations the PACE organization has or will develop with the local community (hospitals, advocates, other stakeholders, etc)

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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 with any questions. As always, thank you for your time and attention to these issues.

Respectfully submitted,



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