February 10, 2017

Tim Engelhardt
Director, Federal Coordinated Health Care 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

On behalf of Altarum Institute's Center for Elder Care & Advanced Illness and the organizations listed below, we are pleased to submit comments on the Request for Information published on December 16, 2016. We congratulate CMS for developing a thoughtful, forward-looking proposal. PACE is easily the most comprehensive, person-centered, model developed to date for a geriatric population that needs both medical and long-term care. We believe it is ripe for rapidly scaling and expanding to become a major service delivery and financing platform, as the Medicare population with chronic conditions and associated functional limitations (physical and/or cognitive) rapidly expands. These beneficiaries are most cost-effectively served in a well-coordinated, capitated, interdisciplinary model of care that avoids high-cost settings whenever possible, which has long been PACE's special expertise. As a longitudinal model of care that supports an individual for the rest of his or her life in the community, PACE's success is evident in its extremely low disenrollment rates.

We would like to associate ourselves with the comments submitted by the National PACE Association (NPA) regarding the Person Centered Community Care (P3C) model. We are pleased that NPA similarly supports the approach outlined for the "at risk" Medicare population, calling for "CMS to move forward, with urgency, to develop a PACE-like pilot."

Currently Eligible (but Rarely Enrolled) Population – Medicare-Only Elderly at NH LOC

First, we note that the RFI implicitly acknowledges PACE's authority to enroll Medicare beneficiaries who are at nursing home level of care (NH LOC) under current law. Waiver authority is not required to enroll Medicare beneficiaries who meet state nursing home level of care criteria; however, this population is rarely served by PACE today. To make it clearer to the public that these Medicare beneficiaries can enroll, we urge CMS to enhance PACE explanatory materials and guidance, and actively encourage PACE programs to learn to serve this population. Doing so would allow beneficiaries who wish to pay privately for assessed long-term care (LTC) services to understand that PACE is an option. It would also incentivize PACE plans to consider seeking out these vulnerable beneficiaries – effectively offering PACE as a "buy-in" option for long-term care (LTC). In turn, this would likely benefit state Medicaid programs, for reasons explained below.

Many disabled Medicare beneficiaries eventually become dually eligible by "spending down" nearly all of their assets and income as a consequence of high medical and LTC expenditures, including those associated with nursing homes and other high-cost settings. As the U.S. age wave accelerates, the importance of slowing spend-down to Medicaid will become an urgent issue both for states and for tens

of millions of American families. PACE plans that enroll NH LOC Medicare beneficiaries paying privately can develop tiered rates for LTC services based on a beneficiary's assessed needs – but none have so far done so. Fortunately, significant work on tiering (as well as on quality measures and other key parameters) was taken up by an NPA workgroup of PACE providers and researchers in 2016. The workgroup's report can be found here.

At this juncture, more on-the-ground work is required to refine the workgroup's model for PACE plans opting to serve a Medicare-only population. Rapid-cycle learning among PACE providers for serving the private-pay Medicare population could be substantially accelerated if CMS were to provide technical assistance -- both in states with existing PACE programs for dually eligible beneficiaries, and in states without PACE, where two-way agreements between PACE plans and CMS would constitute the contractual agreement. Technical assistance could include work on actuarial estimates of costs to inform tiered payment levels, predictive models for variable payments, or both. It could also include guidance on available sources of private long-term care insurance or other "stop-loss" coverage for families and re-insurance for PACE plans; appeals procedures and other beneficiary protections; expansion and improvement of services; the supply and availability of community-based LTC services, and how providers can participate in improving and prioritizing services for identified gaps. It may also be possible for CMS to work collaboratively with foundations that have an interest in expanding PACE more broadly, including potential arrangements for financing a portion of privately-paid LTC costs for some Medicare beneficiaries who do not have resources sufficient for their care needs but who do not qualify for Medicaid.

A Request for Proposals (RFP) offered by CMS for PACE sites enrolling both dually eligible and Medicare-only NH LOC beneficiaries would provide much-needed information about how to monitor spend-down rates. The literature is currently thin and relatively uninformative on spend-down trajectories, and no methodology has been developed to track the tendency of a delivery system to use up personal assets (and thereby qualify for Medicaid) or to be more conservative with personal resources. Such an RFP for PACE could and should also analyze quality of care and quality of life reports from enrollees, and the cost-effectiveness of PACE providers.

A second option for Medicare beneficiaries who need a mix of medical and LTC services is an arrangement in which a Medicare Advantage plan offers to contract with a downstream entity (a PACE or PACE-like plan) in order to provide services to the portion of its enrollee population that has complex needs – i.e., individuals with chronic conditions and functional limitations. This option, which is available under current law, would also benefit from CMS technical assistance and funding for evaluation, but the expansion does not require CMMI model testing (though that would be welcome).

For the remainder of this letter, we will focus primarily on Part II of the RFI, "Additional Potential Populations for a Model Test."

Expansion: "At Risk" Medicare Population

Beyond the Medicare NH LOC population, there is a large and growing population of Medicare beneficiaries who are "at risk" of becoming NH LOC. This is the population that researchers believe will grow exponentially during the baby boomer age wave. It is the cohort of Medicare beneficiaries who have a need for some LTC, but who do not meet state NH LOC eligibility requirements. Surveys have found

that 19% of Medicare beneficiaries currently report needing long-term care (LTC).[1] Very often, however, they find it difficult to secure such services, due to insufficient supply (i.e., home care aides), concerns about high costs, or lack of information about how to access available services. Beneficiaries who are financially eligible for Medicaid, but who do not meet NH LOC requirements, are generally not able to purchase LTC privately and rely upon Medicaid programs and services. Yet if their ongoing, often daily, needs for assistance with basic activities are unmet, many are likely to wind up in crisis – admitted to hospitals and nursing homes, where costs are highest.

Many of these vulnerable beneficiaries are frail elders – who are not most clearly categorized by having specified medical diagnoses, but rather by functional status. When a person has 2 or more limitations in Activities of Daily Living or presence of cognitive impairment requiring constant supervision, their need for LTC is substantial. This cohort, as estimated by the number of older adults over the age of 85, is now growing rapidly, from 4.2 million in 2000 to 9 million by 2030, and then doubling again to 18 million by 2050.[2,3] For maximum impact and value for taxpayers, therefore, we recommend that an ensuing RFP not focus on diagnosis, but on geographic populations of functionally impaired elders, and that the scope be widened to include key factors that can modify functional status --notably the suitability and safety of housing, and the presence of family care. In addition, the progression of illness and prognosis for life expectancy is of central salience to a PACE geriatric model, since beneficiaries in this phase of life have necessarily varied treatment preferences and goals that often have to align with their likely course and prognoses for survival and function.

Accordingly, with regard to the six bulleted categories featured in Part II, we recommend that the agency prioritize the population described in the first bullet: "older individuals with Medicare (with and without Medicaid) who do not require nursing home level of care, but require additional non-medical supports to remain in the community." We also suggest that this category be expanded to include certain younger individuals with advanced illness, such as those with early onset dementia, who could greatly benefit from an expanded PACE model.

Expansion: Additional Factors to Consider

In the context of ongoing work on PACE, we recommend that any RFP issued by CMS for the Medicare population allow determinations of eligibility to be made by the PACE interdisciplinary team (IDT) rather than the state Medicaid office. We urge that assessments routinely take into account the labor of family caregivers, and that care plans include measurement of the effects of services provided on family members (and other volunteer caregivers). These measurements should be calibrated to include the beneficiary and family's confidence (or lack thereof) in the care team, and whether the services that are being provided align with their goals and expectations.

To incentivize PACE plans to become locally-anchored providers, taking responsibility for the community population, we believe CMS should include requirements in an RFP for expanding PACE

[1] Davis K, Willink A, Schoen C. Medicare Help at Home. *Health Affairs Blog.* April 13, 2016. Available at http://healthaffairs.org/blog/2016/04/13/medicare-help-at-home/. Accessed January 25, 2017.
[2] Administration on Aging, Administration for Community Living. Projected Future Growth of the Older Population, Population 85 and older by sex 1900 to 2050. Retrieved from https://aoa.acl.gov/Aging_Statistics/future_growth/future_growth.aspx
[3] Ortman JM, Velkoff V, Hogan H. An aging nation: The older population in the United States. Washington, DC: US Census Bureau. Retrieved from http://www.census.gov/library/publications/2014/demo/p25-1140.html

providers to begin developing systems that monitor community well-being, and to cooperate with hospitals, public health, Area Agencies on Aging, advocates and other stakeholders in establishing planning processes that support substantial local populations of frail elders. Requiring PACE programs to make an annual report of their activities on behalf of the well-being of all frail elderly people in their service area would aid both transparency and public accountability.

In other flexibilities, with regard to Part D coverage, because current premiums are far higher than many Medicare-only beneficiaries would wish (or be able to afford) to pay, we recommend that PACE plans be allowed to offer a choice to these beneficiaries of Part D providers in their area, in a manner similar to Medicare Advantage plans. We recommend relaxing of rules that make PACE start-ups unnecessarily costly (i.e., change the requirement that the full IDT be employed before final readiness review, before any PACE participants are enrolled and before professional education and limited publicity, as well as the prohibition on contingent contracts with IDT members prior to final approval). Cost-effective PACE expansion can also be enhanced by permitting beneficiaries to enroll in PACE plans on a provisional basis during assessment and Medicaid eligibility investigation, including during discharge from hospitals and skilled nursing facilities.

Finally, use of the PACE Center could be optional for expansion populations with regard to socialization, and for provision of certain medical services as approved by the IDT. 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 remains in close contact across the team. If the modifications suggested in this letter are accepted and implemented, we believe that PACE can become a major Medicare provider – a force for change and accountability – to show how it is possible to adequately address the needs of a rapidly growing population of frail elders who require a carefully calibrated mix of medical and LTC services to stay out of crisis. PACE has an established track record of high-quality, efficient and comprehensive services designed to address the changing needs of beneficiaries living in the community through to the end of life.

Thank you for your attention and dedication to this key program. We would be pleased to meet with agency staff whenever appropriate.

Sincerely,

Aging & Independence Services of Northeast Indiana, Inc.

American College of Physicians

American Geriatrics Society

Center for Elder Care & Advanced Illness, Altarum Institute

Coalition to Transform Advanced Care (C-TAC)

Compassion & Choices

Jade Gong, Jade Gong & Associates

Jay Vanston, MD, Palliative Care Physician, Cooper Univ. Hospital, Camden, NJ

Jennie Chin Hansen, former CEO, On Lok Senior Health Services (the first PACE program)

Jewish Healthcare Foundation

Kyle Allen, Riverside Health System

LeadingAge

Medicare Rights Center