

National MLTSS Health Plan Association

February 10, 2017

Patrick Conway
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2404-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: PACE Innovation Act Request for Information (RFI)

Dear Administrator Conway:

Thank you for the opportunity to provide comment on the Centers for Medicare & Medicaid Services (CMS's) PACE Innovation Act request for information.

The National MLTSS Health Plan Association is a new national organization comprised of the leading managed care organizations designed to deliver high-value, quality managed long-term services and supports (MLTSS) for state Medicaid programs and beneficiaries. Member organizations include AmeriHealth Caritas, Anthem Inc., Centene Corporation, Commonwealth Care Alliance, Humana, L.A. Care Health Plan, Molina Health Care Inc., UPMC Health Plan, and WellCare Health Plans Inc. We bring together the knowledge and experience of MLTSS health plans, a unique understanding of LTSS, and of the variety of persons of all ages with disabilities and functional limitations who need these services to pursue legislative and regulatory changes in Medicare and Medicaid that enable health plans to better serve members and help them achieve positive health outcomes.

The Programs of All-Inclusive Care for the Elderly (PACE) is designed to provide community-based medical and social services to dually eligible individuals above the age of 55 who require a nursing home level of care. The PACE model provides unique benefits to beneficiaries through an integrated care model which utilizes an interdisciplinary team (IDT) and a PACE center. The PACE center serves as an adult day health center that provides primary care services, social services, personal care and supportive services, and others. The IDT complements this centralized source of care by bringing together physicians, mental health providers, social workers, and others to coordinate and integrate the care of a person. While PACE is not limited to providing services through the center or the members of the IDT, its primary strengths derive from these features as a provider-centric model.

Through the PACE Innovation Act RFI, CMS has described its interest in expanding the PACE model to serve full benefit dually eligible individuals above the age of 21 who have certain mobility-impairment

related diagnoses (among other criteria). This model is referred to as Person Centered Community Care (P3C). To explain the rationale for the creation of this model, CMS states, "...we believe the evidence of improved quality under PACE warrants testing an adaptation of this model of care for populations that have similar need for coordination of health care and long term services and supports they now receive separately through Medicare and Medicaid."

Given this younger population with mobility impairments, the RFI proposes a series of changes to the PACE model, some of which are similar to the ones suggested in CMS's 2016 proposed rule on PACE (81 FR 54665). These changes include allowing PACE organizations (POs) to contract with community providers to form the IDT and allowing certain members of the IDT to occupy more than one role. Additional changes in the PC3 model include expanding the size of the IDT team to include providers not included in PACE's original list of eleven members and waiving the requirement that certain non-medical community support services (i.e. personal care and supportive services, recreational therapy, and meals) must be provided at the P3C center.

We applaud CMS's efforts to expand the availability of integrated services and welcome innovation to provide additional options for person-centered care. While the modifications proposed to the traditional PACE model are necessary for it to meet the needs of the younger disabled population, they also raise the need for beneficiary protections, that were not needed in a more restrictive PACE model, to ensure services are available to this population and the goals for this population of integration, rebalancing, and self-direction are advanced. The changes proposed to the formation and composition of the IDT, the disconnect from a center in delivering services, and the incorporation of community providers transform PACE from a provider-led, facility-based model to something closer to a network-based model similar to many of the managed care plans that now serve this population (MA-SNP, MMP, DSNP, or MLTSS plans). Operating PACE as a network plan necessitates an attention to network adequacy, marketing controls, and other limitations that reduce the possibility that beneficiaries are not well-served by the network.

The following sections address specific questions posed by CMS in the RFI and include broader comments on the P3C model:

Is it necessary to use specific diagnoses to limit eligibility or does the requirement to meet a nursing home level of care provide a sufficiently clinically similar population for development and implementation of a model of care and for evaluation of the model? What are the advantages and disadvantages of extending this model to a broader population of under-55 individuals who require a nursing home level of care?

CMS lists a series of mobility-impairment diagnoses in Appendix A of the RFI that would qualify an individual to be eligible for the P3C model. Using this list of diagnoses would limit the scope and potential benefit of the P3C model. Therefore, CMS should replace the diagnoses criterion with criteria based on an assessed functional need.

The goal of the P3C model is to serve a younger population with mobility impairments. Individuals with functional limitations that otherwise satisfy the eligibility criteria would be excluded from participating if they have a diagnosis that is not in one of the seven diagnostic categories. Using diagnoses as the basis for eligibility in the first place imposes a medicalized model of care for a population whose needs are not primarily medical. Restricting the diagnoses to these seven categories further precludes many younger people with significant mobility

restrictions and needs for supports and services from having access to a program that could be of great benefit to them.

Younger individuals with disabilities are less likely than older persons to have functional limitations generated by a chronic medical condition, have frequent contact and positive experiences with medical care, and be inclined to define themselves in terms of their disability. They face life long functional limitations for which they need assistance.

Using an assessed functional need would expand the model to all individuals who might benefit from P3C and apply a more appropriate social model of care. In addition, expanding the pool of eligible individuals would address the concerns associated with a limited pool of participants CMS mentions later in the RFI (e.g. low initial enrollment would lead to difficulties gauging the sufficiency of payment rates).

If CMS continues with diagnosis-specific eligibility, expansion to some populations listed (especially individuals with End Stage Renal Disease) is more appropriate than for others. In particular, we do not see the applicability of the model for people with intellectual/developmental disabilities or people with severe and persistent mental illness whose needs may be better met in other models.

Does the overlap in P3C and current PACE eligibility raise issues of concern that should be addressed? What are the arguments for and against imposing a maximum eligibility age for the P3C model? In particular, we would be concerned that differing payment levels might incentivize organizations to shift participants between PACE and the P3C model. What protections and/or monitoring and corrective action strategies might be necessary to identify and prevent inappropriate shifting of participants?

We recommend that the P3C model be limited to individuals under 55 to limit the potential of inappropriate shifting of participants. Imposing an age cap would also increase confidence in the results achieved by the model.

CMS states, in a subsequent portion of the RFI, that it wishes to implement a payment rate methodology different from PACE's methodology. This includes differences in developing the Medicare Parts A, B, and D payment rates and implementing a unique "acuity" adjustment as opposed to PACE's "frailty" adjustment. Any sort of asymmetrical payment methodology paired with overlapping eligibility criteria between PACE and P3C (since P3C only imposes a minimum age requirement) creates the potential for organizations to shift individuals between PACE and P3C in order to maximize their payment rate, rather than enrolling individuals based on which model is more appropriate for their needs. To avoid this issue, CMS should eliminate the overlap between the populations and impose an upper age limit as an eligibility criterion.

The validity and appropriateness of the P3C model would also be reinforced by imposing an upper age limit. As previously stated, CMS's rationale for creating the model is to serve younger individuals with physical disabilities. By including older individuals in the case mix, CMS introduces a population of individuals that goes beyond the purpose of the model and will create difficulties in evaluating the success of the model. And, as CMS calibrates the model towards a younger population of individuals, the effectiveness of P3C with respect to those above 55 may diminish since the two populations have a distinct set of preferences and needs.

Do the potential adaptations to the PACE model of care provide sufficient flexibility for P3C organizations to innovate in the delivery of care to meet the needs and preferences of P3C participants? If not, what improvements would you recommend? Additionally, would any of the potential adaptations proposed here undermine the advantages of the PACE model of care delivery? If so, which ones and how?

We agree with the rationale provided by CMS to allow P3C organizations to provide services outside of the P3C center given the needs and preferences of this new population. However, if this flexibility is provided, we believe the requirements for the P3C organizations should then include necessary beneficiary protections for a network model, such as network adequacy and marketing.

CMS states that it wishes to provide P3C organizations flexibility in the composition of the IDT “...to respond to the needs of the population of focus, provide for a more streamlined operation of the IDT, and respond to the individual preferences of participants.” CMS subsequently provides the following rationale for allowing the P3C center to provide certain services outside of the P3C center: “...advocates for people with disabilities have expressed opposition to any PACE-like model where people with disabilities would congregate and socialize separately in a PACE center who use is exclusively for PACE participants, because that very congregation may impede community integration. “

We agree with this rationale. As greater flexibility is introduced, the existing requirements in PACE designed for a center-based model need to be modified to apply to a more flexible approach and avoid a potential for consumer abuse. The movement beyond a center and the lack of network adequacy requirements for community providers raises the possibility that eligible participants will be unable to have adequate and timely access to qualified providers who are well integrated with their larger care system. In addition, a lack of marketing requirements allows for the development of an inappropriate provider referral relationship. Since P3C programs would be subject to the same marketing requirements as PACE programs, P3C programs would be able to process enrollments themselves (as opposed to a third-party in the case of MLTSS plans) and contracted network providers can inappropriately guide individuals into the P3C program. This concern is further exacerbated by the asymmetrical payment rate methodology previously referenced, which creates more potential for providers to guide individuals into whichever program pays the highest capitated rate.

CMS also states that a P3C organization “...should describe in its application ways in which the delivery of services will support community living consistent with the principles of the Medicaid HCBS setting rule.” These principles include ensuring that people with disabilities have access to their community and have relationships with people outside of their immediate surroundings, ensuring people with disabilities are able direct their life decisions (from basic decisions such as when to eat a meal to where to work), and to guarantee an individual’s right to privacy, dignity, and respect. However, there is no specific reference within the RFI to the specific principles of the HCBS settings rule nor does CMS clarify whether P3C organizations will be directly responsible for maintaining compliance with the HCBS settings rule. CMS should clarify its position on this issue.

We are interested in testing adaptations of the PACE model of care for individuals with complex medical needs whose current interactions with the health care delivery system too often result in suboptimal

care, poor health outcomes, and high costs. In particular, we believe there is potential for adaptations of the PACE model of care to integrate a range of services currently provided in a fragmented manner.

The Association supports CMS's continued search for integrated and coordinated care models. CMS should maintain two guiding principles as it creates more models of integrated care: ensuring regulatory consistency and ensuring beneficiary's have an understanding of the different models of care.

As CMS considers expanding the PACE model to additional populations, it should apply a consistent regulatory framework to ensure that differences in the models and confusion about these differences does not open a potential for beneficiaries to be poorly served or harmed in the process. To the extent that CMS creates more flexibility in provider networks, age and disability qualifications, and care models, it should apply more rigorous assurances of network adequacy, beneficiary safeguards, and compliance requirements similar to those that apply now to existing MA-SNP, MMP, MLTSS, etc.

In addition, for these different models to be properly evaluated in relation to other approaches to integrated care, they should be held to a similar set of standards and requirements so that the results can be appropriately standardized. Inappropriate differences in regulatory burden, payment methodologies, and compliance standards can lead to skewed evaluations and thus should be avoided.

Finally, as CMS creates different pilots to treat similar populations, it should work to create an understanding among beneficiaries about the differences between models, the unique benefits of each model, and how the models would change the care experience for the beneficiary. If the existing models of care converge, this will create further confusion as CMS expands the portfolio of integrated care plans.

We commend you on this effort to further develop and refine the PACE program and we appreciate the opportunity to comment on this new model. We welcome any opportunity to meet with members of CMS to discuss how to ensure P3C reaches its full potential and how to implement the program in such a way that beneficiaries continue to receive the high-quality care they are used to and deserve.

Sincerely,

A handwritten signature in black ink, appearing to read "G. Lawrence Atkins". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

G. Lawrence Atkins
Executive Director