February 6, 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

LeadingAge appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services' (CMS) PACE Innovation Act Request for Information (RFI). The LeadingAge community (www.LeadingAge.org) includes 6,000 not-for-profit organizations in the United States, 39 state partners, hundreds of businesses, research partners, consumer organizations, foundations and a broad global network of aging services organizations that reach over 30 countries. The work of LeadingAge is focused on advocacy, education, and applied research. We promote home health, hospice, community-based services, adult day service, PACE, senior housing, assisted living residences, continuing care communities, nursing homes as well as technology solutions and person-centered practices that support the overall health and wellbeing of seniors, children, and those with special needs.

We have organized our comments based on the questions asked in the RFI:

- **Are these eligibility criteria appropriate for a test of the P3C model under Section 1115A of the Social Security Act?**

We agree with the recommendations delineated by the National PACE Association that the eligibility criteria proposed in the RFI for the P3C pilots should be broadened in terms of Medicare, Medicaid and third-party coverage, nursing home level of care status, and the diagnoses specified in Appendix A.

LeadingAge requests that CMS consider several changes to the P3C eligibility criteria outlined in the RFI. Specifically, we recommend the following eligibility criteria:

1) With respect to Medicare and Medicaid eligibility, we do not believe that P3C eligibility should be restricted to full benefit dual eligible beneficiaries
2) Assessed by the State Administering Agency (SAA), or a designated entity, as requiring the level of care required under the state Medicaid plan for coverage of nursing facility services;
3) Have one of the mobility-impairment related diagnoses listed in Appendix A of the RFI or another mobility-impairment related to a physical disability. Diagnoses alone, rather than a combination of functional assessments and diagnoses, is inadequate to identify all of those individuals who might benefit from the P3C model. The P3C eligibility criteria should expand the diagnoses in Appendix A and allow for an exceptions process that considers additional factors, notably functional assessments, in determining eligibility.
4) Be age 21 and over;

2519 Connecticut Ave., NW | Washington, DC 20008-1520
P 202.783.2242 | F 202.783.2255 | LeadingAge.org

Expanding the world of possibilities for aging.

5) Live in the P3C organization's service area; AND,
6) Be able, at the time of enrollment, to live in a community setting without jeopardy to health or safety.

- **What are the arguments for and against imposing a maximum eligibility age for the P3C model?**

We agree with CMS that it is not necessary to impose a maximum age for the P3C model for the following reasons:

1. There may not be a PACE available in the same area served by the P3C.
2. Maximum age requirement is a barrier for continuity of care

- **Would the potential P3C model described above provide sufficient access by participants to their preferred health care and community support service providers, including specialists? Would additional requirements on P3C organizations be appropriate?**

We agree that CMS' proposed flexibility with respect to the composition and role of the IDT members will support person-centered care by incorporating both P3C staff and contracted community providers on the IDT. Supporting participants' choice of providers will require that P3C organizations contract with a network of outside entities for the delivery of medical care, as well as community supports and services.. To assure that expanded community networks sustain the high level of quality achieved in the current PACE program, we recommend that P3C applicants be required to demonstrate in their applications the process by which they will ensure effective communication among IDT members — inclusive of both P3C staff and others providing medical care and non-medical community support services to P3C participants outside the P3C center.

- **Does the governance structure under consideration, in particular the requirement for prospective P3C organizations to establish a community advisory committee, provide a reasonable way for people with disabilities to have meaningful input into how the P3C organizations plan to deliver health care and community support services? If not, what improvements or alternatives would you recommend?**

We 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. We are also pleased to see that PACE requirements related to the participant advisory committee and participant representation on the governing body are being considered for the P3C model in order to ensure that the governing body is well informed on matters of concern to participants.

- **Additional specific populations whose health outcomes could benefit from PACE-like models**

We believe that the following additional populations would benefit from a PACE-like model of care :

➢ *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*

- ➢ *Individuals with Medicare and/or Medicaid (including individuals under age 55) who have severe and persistent mental illness; and Individuals with Medicare and/or Medicaid who have intellectual or developmental disabilities (including individuals under age 55)-*

- **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?**

LeadingAge believes that expanding the diagnoses list would increase the interest in pilot participation, and enhance the viability of P3C pilots. We propose the following modifications to the approach in the RFI:

- Expand the list of diagnoses in Appendix A to include the wider range of diagnoses identified by providers serving people with mobility impairment associated with a physical disability
- CMS working with states and the P3C organizations should establish an exceptions process for individuals who do not have one of the diagnoses identified in the expanded list but who have been determined through a functional assessment to have a mobility impairment that is associated with a physical disability

- **Would a broader population make it easier or more difficult to include any innovations found successful in PACE?**

We recommend an expansion of the proposed P3C pilot's population to include additional medical conditions beyond those specified in the RFI's Appendix A, and, the enrollment of Medicare- and Medicaid- only participants, in addition to dual-eligible participants. PACE serves older adults that have multiple chronic diseases, not a single medical condition. The diversity of specialties and services provided by P3C pilot staff and contracted providers will be equipped to serve a broader population. The composition of the IDT will reflect this diversity of providers.

- **Would states seek flexibility in modifying eligibility criteria on a state-specific basis?**

With respect to whether states should have flexibility to modify P3C eligibility criteria on a state-specific basis, we recommend that this be allowed since the threshold for nursing home (NH) level of care varies considerably across states and, as a result, beneficiaries with similar medical and non-medical needs may qualify as NH certified and for the P3C program in one state but not in others.

- **Do the potential adaptations to the PACE model of care, especially the flexibility to reconfigure the array of services provided at a P3C center, serve to maximize P3C participants' integration into the community consistent with the principles embodied in the Medicaid HCBS setting rule at 42 CFR § 441.530? If not, what improvements would you recommend?**

We supports giving P3C organizations flexibility in designing their delivery systems and care coordination processes, subject to requirements that those systems and processes support person-centered care and effective care coordination. We propose standards for the P3C organizations that, regardless of how or where services are provided, maintain the essential functions and effectiveness of the IDT.

We are pleased CMS is providing P3C organizations flexibility to innovate in the delivery of care to the wide range of individuals who would be served by the proposed P3C model, but in line with the concerns we have for the implementation of the HCBS settings rule for non-residential providers, we believe guidance on Community Integration from CMS must be timely, practical and clearly written so there are no misinterpretations by providers, states and PACE participants. The HCBS Settings rule was finalized three years ago, and CMS has still not defined the term, integration. We suggest CMS establish standards to operationalize *community integration*—specifically, what responsibilities does a P3C organization have to make the *broader community* aware of the non-medical support services furnished at the P3C center (for public access)? Additionally, how will P3C organizations be assessed by CMS in identifying whether P3C organizations are found to be compliant with the community integration standards?

• **Are the elements of the PACE model of care that we are considering retaining for the P3C model appropriate for P3C participants? Should we retain elements of PACE that are not proposed for retention here?**

We believe the collaboration with the PACE model of care interdisciplinary team is essential to ensure that the participant directed care is informed by the fullest understanding of the services and supports available to support the participant's independence and their medical care needs. The Person Centered Community Care (P3C) pilot described in the RFI has the potential to improve significantly upon the quality of care currently available to its target population by holding a single entity:

1) responsible for working with eligible beneficiaries to develop comprehensive person-centered service plans
2) operationally and financially accountable for the full range of needed Medicare and Medicaid services. The P3C pilot, with the inclusion and considerations of the comments below, will assist CMS in achieving the Triple Aim of decreasing healthcare costs, while improving quality of care and overall population health.

We are concerned that the broader P3C provider system being promoted under the P3C pilot will compromise a key element of the PACE model, care coordination. We want to emphasize the importance of a P3C organization's ability to convene all the IDT, if needed, to meet a participant's needs.

We are in alignment with CMS in supporting the autonomy of a P3C participant by allowing participants to maintain their primary care provider through contractual relationships between a P3C organization and said provider.

We recommend that social work services be included in the list of services that a P3C center must furnish. Social workers play an integral role in the IDT, and we expect that they will be instrumental in establishing a network of supports and services for P3C participants under the P3C model.

Given that P3C participants have the option to receive care entirely by contracted providers, we reiterate our expectation that contracted providers be engaged in IDT meetings, as needed. Moreover, given that each participant will be assigned to an IDT, we recommend that each IDT include a dedicated P3C employed staff member (e.g., social worker) who would be responsible for coordinating IDT

meetings—this is especially important if all services are provided by contracted employees.

• **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?**

The RFI states that a P3C center, at a minimum, must employ primary care providers and other specified staff. We have some concerns around staffing a P3C center with primary care providers who may be rarely utilized given that many P3C participants may potentially opt to receive services from contracted providers.

We recommend that social work services be a mandatory service to be furnished at P3C centers. Social workers play an integral role in the IDT, and we predict that they will be instrumental in establishing a network of supports and services for P3C participants under the P3C pilot.

• **How can we best ensure that providers that contract with P3C organizations are integrated into the IDT and service planning process? What mechanism, if any, should we use to encourage P3C participants to contract with community-based providers from which beneficiaries are currently receiving services?**

LeadingAge supports giving P3C organizations significant flexibility in designing their delivery systems and care coordination processes, subject to requirements that those systems and processes support person-centered care and effective care coordination.

CMS' proposed flexibility with respect to the composition and role of the IDT members will support person-centered care by incorporating both P3C employed staff and contracted community providers into the team. In addition, supporting a choice of providers will require that P3C organizations contract with an extensive network of community based organizations for the delivery of medical care, as well as community supports and services.

Again, LeadingAge appreciates the opportunity to comment on this Request for Information (RFI). We hope our comments will be helpful to you. Thank you.

Sincerely,

Cheryl Phillips, MD

Senior VP Public Policy and Advocacy