NASUAD
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United for Aging and Disabilities

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

February 10, 2017

RE: PACE Innovation Act Request for Information

Dear Dr. Conway:

On behalf of the National Association of States United for Aging and Disabilities, please accept these comments regarding the recent Request for Request for Information that you published seeking feedback on the PACE Innovation Act. NASUAD represents the nation's 56 state and territorial agencies on aging and disabilities. Our members are responsible for the administration of a wide range of long-term services and supports (LTSS), including state-funded services, Older Americans Act programs, and Medicaid LTSS. Our membership has significant interest in the PACE program, as a number of the state aging and disability agencies administer PACE and many other agencies collaborate with their state's PACE programs. NASUAD supports visionary state leadership, the advancement of state systems innovation and the development of national policies that support home and community based services for older adults and individuals with disabilities.

We believe that the flexibilities you propose in the Person Centered Community Care (P3C) model could offer some interesting opportunities to experiment with new methods of delivering services and supports in an integrated, holistic fashion across Medicare and Medicaid services. Our members have long been interested in approaches that reduce the confusion, burdensome transitions, and administrative complexity that dual eligible beneficiaries face when accessing the full array of primary, acute, and long-term services and supports. However, we do have some specific concerns about the model as it is currently proposed.

<u>Option for State-Driven P3C Models</u>

We suggest providing additional operational flexibility that enables states to truly experiment with options for integrating and improving care provided to these participants. Currently, the proposed P3C demonstration would rely on specific sites to develop the service model, apply to CMS (with support from the state entity), and

deliver the full array of P3C services. In this model, the site itself would then receive Medicare and Medicaid funding, thus serving as the integrating entity between the two programs. We recognize that this is based on the existing PACE model, but note that there are opportunities to develop and test alternate models for delivering these types of supports.

Specifically, we believe that the model should include an option for a state to increase its role in the provision of supports and to serve as the integrating entity. For example, in a "state as integrator" model, the state Medicaid agency could apply to serve as a P3C entity and receive the Medicare payments for enrolled participants. The state could then operationalize the PACE model by contracting with providers to deliver the services and supports, or by leveraging existing networks of managed care entities to coordinate and deliver the services and supports. In this scenario, the state would serve as the point of accountability to CMS for the provision of care and for ensuring the health and welfare of program participants regardless of whether it uses a fee-for-service or capitated delivery model.

NASUAD does not suggest that this model supersede the P3C proposal. Rather, we request that CMS establish different options for states and providers to serve as integrating entities, thus allowing for robust experimentation between different ways of delivering supports. Under this flexibility, there could be several different models operationalized for P3C supports. These include:

- A site-based P3C model, similar to that proposed in the initial RFI, but with modifications as provided below;
- Enabling a state Medicaid and/or LTSS agency to serve as the integrating entity and point of accountability, with services delivered under a FFS model; or
- Enabling a state Medicaid and/or LTSS agency to serve as the integrating entity, and contract with a managed care plan.

<u>Comments on P3C Model as Proposed</u>

In addition to our suggestions regarding operational flexibility with the model, NASUAD has several comments and concerns with the P3C demonstration as it is currently proposed.

PACE vs. MLTSS

We have concerns about the potential for the PACE model to be deconstructed into a *de facto* Managed Long-term Services and Supports (MLTSS) plan without the same requirements as formal MLTSS managed care organizations set forth in regulation. For example, the RFI would allow PACE programs to decentralize their services and have a participant's physician contract to provide care. Similarly, community-based LTSS would be provided outside the PACE center. This type of change creates many of the same flexibilities that MLTSS plans have regarding developing networks of providers to deliver services and supports. Yet in this arrangement, MLTSS regulatory requirements would not be placed upon the P3C sites in the same manner that the rules currently apply to plans. For example, MLTSS plans have strict network adequacy requirements while PACE programs do not appear to have similar requirements in this model.

PACE programs would also not be subject to the same marketing restrictions, stakeholder engagement requirements, reporting transparency, and beneficiary protections that MLTSS plans must adhere to. Similarly, state rate-setting would be subject to upper payment limits under the P3C model, but would not have the same level of actuarial soundness requirements as MLTSS programs require. These types of policy challenges could create inequities regarding the services delivered, access to care, and payments across different LTSS programs.

CMS also indicates that they will administer the procurement/selection of PACE sites. Though states have some ability to act as gatekeepers, as the protocol indicates that P3C centers must have agreement of their state agency prior to CMS approval, this could place states in a challenging position. If a state has administered a MLTSS procurement and negotiated rates with its plans in a transparent manner, a competing entity might be able to leverage this opportunity to secure many of the same benefits as the MLTSS plan without the same level of rigor, regulatory requirements, and financial oversight. We strongly encourage CMS to hold PACE plans to the same financial, quality, and network adequacy standards as MLTSS plans are expected to meet. Similarly, we believe that states should play a larger role in the selection and approval of P3C plans, rather than having CMS be the sole entity responsible for approving P3C applicants.

P3C Participant Eligibility Criteria

The eligibility criteria proposed by this model may create complications when applying them to state LTSS systems. Many State LTSS programs utilize functional assessments as a way of determining participant eligibility. The P3C model, in contrast, uses a list of qualifying criteria to establish eligibility for the supports. This will create challenges with identifying individuals receiving supports who are eligible for the demonstration, as individuals eligible for the P3C model may not be eligible for other Medicaid LTSS programs, and vice-versa. We do not believe that the model should be used to expand eligibility for LTSS, nor do we think that there is value in excluding potential participants who could benefit from P3C services.

We also believe that using an eligibility system based upon medical listings is taking a step backwards from the progress made towards functional assessments that drive person-centered eligibility and service delivery systems. The focus on clinical conditions will likely lead to a programmatic design based upon a medical model of care instead of the preferred person-centered delivery system. NASUAD therefore suggests that CMS use an eligibility criteria based upon the existing state HCBS eligibility requirements, tools and processes.

P3C Services and the HCBS Settings Requirements

The P3C model calls for services and supports to be compliant with the CMS HCBS final rule, which establishes new standards for what constitutes a community-based support. However, we believe that the application of these integration standards will present challenges with a PACE model. The RFI notes that the centralized nature of PACE is perceived as inconsistent with community-integration standards and makes some changes to accommodate this

disconnect. However, the RFI still requires a set of core services at the PACE center, as well as noting that CMS is considering an expectation that any P3C center and alternative care setting, "[are] selected by the individual from among setting options including non-disability specific settings. The setting options are identified and documented in the participant-centered service plan and are based on an individual's needs and preferences."

The very nature of the PACE program makes it unlikely that there will be many, if any, alternate "non-disability specific" settings for individuals to receive this type of care. The P3C provider is required to provide a significant array of services in the center itself, including person-centered service planning; primary care; therapies; mobility services; etc. It appears that the requirement of centralized services, including the mandated colocation of service planning and direct care, is inconsistent with the HCBS final rule.

In contrast, if the PACE center is to completely decentralize and provide fully integrated services and supports, then there would be little to distinguish this model of care from a MLTSS plan. Thus, if the integration standard is to be met by establishing an array of community-based LTSS, we reiterate our recommendation that CMS institute a fair application of MLTSS standards to the P3C models operating in this demonstration.

P3C Payment Systems

The P3C demonstration includes several different proposals for establishing monthly payment rates. We would caution CMS from being overly prescriptive with the payment methodology, as challenges with rate-setting were cited by a number of states that pursued an integrated Medicare-Medicaid program under the Financial Alignment Demonstration. We believe that payment mechanisms and risk corridor arrangements must be established in an equitable manner that meets the needs of both CMS and the states. We also strongly recommend that savings derived from this demonstration be shared equally between state and federal partners. Lastly, as noted earlier, the PACE payment system differs from MLTSS rate development and does not carry the same level of scrutiny or actuarial soundness requirements. NASUAD believes that the nature of this model necessitates fair and equitable application of the actuarial soundness requirements currently placed upon Medicaid managed care plans.

P3C Quality Measurement

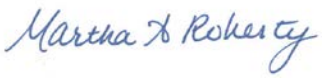
Quality measurement should be developed in conjunction with the states and with existing LTSS measures under consideration. We suggest utilizing the NCI-AD for the P3C model, as it touches upon a wide range of health, social, and individual outcomes relevant to the population included in this demonstration. We also suggest developing an array of potential outcome measures for LTSS and allowing states to select relevant ones based upon the unique components of their LTSS system.

NASUAD notes that one area of specific concern with existing PACE models is the lack of encounter data provided to state agencies. This dearth of reporting leads to challenges with

state oversight and quality reviews; creates challenges with developing appropriate payment methodology; and limits the ability of state agencies to monitor health and wellness of participants. Regardless of the ultimate model design for P3C, NASUAD strongly recommends that CMS require program participants to report encounter data to both the state and Federal agencies administering the program. This should include services *provided* by the PACE entity as well as those purchased.

We thank you for the opportunity to comment on this model of care. NASUAD is greatly interested in working on developing new and innovative models to improve care for dual eligible participants, particularly those who require LTSS, and we believe this RFI may afford such opportunities even beyond that originally contemplated. We look forward to working with you on the P3C model and other proposed options, as well as other future initiatives to integrate and improve care for dual eligible individuals. If you have any questions about our comments, please feel free to contact Damon Terzaghi of my staff at (202) 898-2578 or dterzaghi@nasuad.org.

Sincerely,



Martha A. Roherty
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