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SUBMITTED ELECTRONICALLY
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Tim Engelhardt
Director, Federal Coordinated Health Care Office
Centers for Medicare and Medicaid Services
ATTN: PACE Innovation Act Request for Information
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: PACE Innovation Act Request for Information

Dear Mr. Engelhardt:

The American Geriatrics Society (AGS) is pleased to respond to the Centers for Medicare and Medicaid Services' (CMS) PACE Innovation Act Request for Information (RFI).

The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (NPPs) who are devoted to improving the health, independence, and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our vision for the future is that every older American will receive high quality person-centered care. In order to achieve this vision, we strive to help guide the development of public policies that support improved health and health care for seniors.

We greatly appreciate the time and resources that CMS has expended in considering how the PACE model can be adapted to address the needs of new populations, including younger adults with significant mobility limitations and others.

Our comments below emphasize support for many of the comments submitted by the National PACE Association (NPA) and the Altarum Institute, and provide additional feedback from the AGS.

Part 1: Potential Elements of the P3C Model

Potential P3C Participant Eligibility

Nursing Home Level of Care Status

To ensure access to all those who might benefit from the "Person Centered Community Care" (P3C) model, the AGS requests that CMS consider adding flexibility to broaden the following eligibility criteria outlined in the RFI:

- 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.

The AGS is concerned that this requirement is overly restrictive and that the population served by the proposed P3C model will be too small to create a viable and sustainable program. We strongly believe that populations with chronic, long-term needs who do not meet their states' nursing home level of care criteria would benefit from the model. We support the NPA's recommendation that states, with the support of P3C providers, have the discretion to enroll otherwise eligible individuals who are either:

- Certified by the state to require an intermediate care facility (ICF) level of care with one or more chronic disease diagnoses; OR
- Have a chronic disease or medical condition that is expected to last for more than 1 year, limits what a person can do, and requires ongoing medical monitoring. These individuals must also need human assistance with two or more activities of daily living (ADLs), and either: (a) have had a non-elective hospital admission within the last 12 months, with use of acute or sub-acute rehabilitation services within the last 12 months; or (b) have evidence of a need for ongoing medical management of complex systems to promote health and safety and reduce comorbid complications; with an assessment indicating need for functional support, e.g., an Expanded Disability Status Scale (EDSS) score of 7.5 and above or other comparable assessment.

We would like to note that the population described in the second bullet above is used by the Independence at Home (IAH) Demonstration to define which patients are considered eligible. This is a particularly important population to include in the model since the IAH-qualified Medicare only population represents 25% of all new long-term institutionalized older Medicare beneficiaries each year—yet receives little help in avoiding institutionalization. About three-fourths convert to Medicaid after nursing home entry, after which it becomes much more difficult to transition back into the community.

In addition to the populations listed in the RFI, the AGS believes that expansion of PACE to new communities that do not currently have PACE programs available could help hospitals and health systems, including accountable care organizations, in their efforts to manage the cost of care within an episode of care, such as the comprehensive joint replacement (CJR) and cardiac episode payment models. Those patients often receive sub-acute care at a skilled nursing facility yet would rather directly return home from the hospital with coordinated services which could provide safe recovery during an episode of 90 days after their index hospitalization.

Diagnoses

In general, the AGS agrees with CMS's proposal to define a specific population for the P3C model, and understands the advantages with regard to measuring and assessing outcomes. The mobility impairment-related diagnoses listed in Appendix A are specific spinal cord and neurological disorders which reflect serious and advanced illnesses, and therefore seem to be appropriate eligibility criteria for the model.

However, as stated above, we are concerned that the P3C-eligible population may be too narrowly defined. In addition to issues regarding the model's viability and sustainability, we believe that this narrow focus will make the model less generalizable to a broader population, which has been a criticism of the populations served by the original PACE program. We seek clarification from CMS

regarding the proportion of the under-age-55 population with Medicare and Medicaid that have been diagnosed with one of these disabilities. If this is a small proportion, then the model may have limited generalizability.

Separately, CMS should identify the rate of behavioral health co-morbid illnesses that this under age 55 population faces. Likewise, it is possible that this population has a very high level of co-morbid medical problems, when compared to an older PACE cohort. Further, challenges in addressing multiple co-morbid illnesses, advanced/end stage illness, severe debility, and concurrent behavioral health needs would make this a very difficult population for whom to provide care.

Age

With respect to establishing a maximum age for enrollment in the P3C model, the AGS agrees with CMS that this is not necessary. First, to the extent that P3C programs are developed in service areas that do not also have PACE programs, establishing a maximum eligibility age for the P3C model would mean that no PACE or PACE-like model would be available to otherwise eligible individuals beyond a certain age. Moreover, establishing a maximum eligibility age would not promote 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, we believe that beneficiaries age 55 and over who meet eligibility criteria for both programs should have the option to choose between them. We would not expect beneficiaries enrolled in the P3C program to shift to PACE in great numbers after having established a relationship with their P3C service delivery system and service providers or vice versa. Further, it would be relatively easy to monitor any shifting that occurs between programs and ensure that, if movement occurs, it is the participant's choice. Generally, any restriction on age would further decrease the number of participants eligible for the model.

Potential Adaptations of the PACE Model of Care to Better Serve the P3C Population

Interdisciplinary Team

The AGS appreciates the flexibility afforded to P3C organizations to innovate in the composition of the interdisciplinary team (IDT), provide for more streamlined operations, and respond to individual preferences of participants. However, we are concerned that the current list of required IDT members is too robust. We recommend that CMS require P3C applicants to designate a small core team (e.g., a primary care physician and social worker) and permit P3C organizations to add other team members at their discretion, based upon each individual patient's needs, rather than requiring that all of the proposed IDT members participate for all patients.

In terms of additional IDT members, we request that CMS consider providing the flexibility to add a "handyman." An article published in the *Journal of the American Geriatrics Society* by Dr. Sarah L. Szanton and colleagues describes the CAPABLE (Community Aging in Place, Advancing Better Living for Elders) model which features a patient-directed team intervention.¹ In the model, a nurse, occupational therapist, and handyman worked together to assess and address the barriers in the home environment of care. The novel aspect of addressing the home environment (with a modest budget) through activities such as installing wheelchair ramps and grab bars, resulted in

¹ Szanton SL, Wolff JL, Leff B, et al. Preliminary Data from Community Aging in Place, Advancing Better Living for Elders, a Patient-Directed, Team-Based Intervention to Improve Physical Function and Decrease Nursing Home Utilization: The First 100 Individuals to Complete a Centers for Medicare and Medicaid Services Innovation Project. *J Am Geriatr Soc* 63:371–374, 2015.

initial outcomes of improved function. Separately, we request that CMS consider adding specialists in rehabilitation.

Potential Payment Methodology for P3C Organizations

Medicare Parts A and B

The AGS supports the NPA's recommendations regarding CMS's proposal to use the 2017 Medicare Advantage (MA) risk adjustment model for the P3C population.

Although current PACE capitation rates are based on the pre-Affordable Care Act MA county rate methodology, the latest study (Mathematica, 2013) on the relationship between PACE and fee-for-service (FFS) costs for a comparable population indicated that PACE and FFS costs were not statistically different, despite the fact that PACE county payment rates were generally higher than FFS. This implies that the PACE risk adjustment model would not adequately risk adjust payments for the exclusively nursing home care population enrolled in PACE if it were applied to the lower MA county benchmarks.

We have a similar concern with respect to the predictive accuracy of the MA risk adjustment model for a population predominantly made up of nursing home eligible beneficiaries that would enroll in a P3C program. In PACE, the higher PACE county benchmarks make up for the shortcomings of the risk adjustment model. If CMS utilizes MA county rates as the basis for payment in the P3C model, it will be imperative to ensure that the risk adjustment model accurately predicts payments for the P3C target population. In order for this to happen, we believe it will be necessary for CMS to specify a payment methodology (inclusive of the county benchmarks, risk adjustment model, and acuity adjustor) on the basis of the cost experience of the P3C target population, i.e., younger adults who meet the P3C model eligibility criteria related to diagnosis and mobility/functional limitations who also are certified eligible for nursing home level of care.

With respect to CMS's proposal to use the 2017 MA risk adjustment model for the P3C population, while we appreciate that the model improves payment accuracy for dual eligibles residing in the community relative to previous MA risk adjustment models, we remain concerned that it does not adjust payments for persons with dementia. Because there is no maximum age for P3C participants, it is possible a considerable number of them will have dementia. A recent analysis of Medicare beneficiaries aged 55-64 enrolled in PACE found that 26% of those with a medical diagnosis listed in Appendix A of the RFI also had a diagnosis of dementia. We recommend that CMS add Hierarchical Condition Category (HCC) codes for dementia to the v. 22 model.

With regard to whether CMS should pursue Option 1 or Option 2 to set P3C rates, we recommend that CMS conduct a sensitivity analysis to identify the approach which leads to payment rates that most accurately reflect FFS costs for the P3C target population.

Lastly, we are concerned that if the MA payment methodology is adopted, with no establishment of quality bonus payments for P3C organizations, payments to P3C organizations could be lower than payments to MA plans, particularly in double bonus counties. At the outset of the P3C pilots, it may be instructive to consider the approach to quality bonus payments applied to low enrollment MA plans as a basis for establishing quality bonus payments to the P3C organizations.

Proposed Quality Outcomes for Evaluation of P3C Model

The AGS appreciates CMS's efforts to ensure that the P3C model is delivering cost-effective quality care through ongoing monitoring and evaluation of P3C organizations. However, we want to take this opportunity to comment that services provided directly by P3C staff can be difficult to capture through claims-based encounter data approaches, and as such evaluating the P3C model on select encounter data is concerning to us. While we find the measures to be adequate, we anticipate considerable associated administrative cost. P3C organizations may need to hire additional staff to accommodate the data requests. When NPA solicited comments from their members, one member noted that collecting and reporting the requested data for CMS evaluation, separate from calls and other proceedings with CMS, will take approximately over 8,000 hours (or, almost 4 FTEs) per year.

CMS may want to consider including measures that address care coordination, care planning, and goals of care. Furthermore, given the autonomy of the P3C population, we encourage the use of patient-reported outcome (PRO) measures, as applicable.

The AGS also recommends that CMS review a recent article on quality measures published in the *New England Journal of Medicine* entitled "Reimagining Quality Measurement."² The following are lessons learned from the article that may be relevant to the P3C model: a) number of healthy days per month; b) number of mentally-healthy days per month; and c) achieved goal consistent with the patient's goals. The main concepts relevant to the P3C population are that quality measures should address those who have common and uncommon diseases, patients with multiple coexisting illnesses, the efficient management of symptoms even when the diagnosis is uncertain, and the individual patient's preferences and goals for treatment and health outcomes.

Potential Risk-Sharing Methodology

The risk-sharing mechanisms proposed in the RFI, both the individual outlier protection and the risk corridors, are crucial to ensuring the viability of the 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, it is our experience in the PACE model that new PACE participants enter the program with a number of health conditions that were not previously identified or that have been inadequately addressed in the FFS system. We would expect a similar experience for P3C organizations. As a result, costs incurred by the P3C program will not be reflected in the FFS diagnoses and encounters which are the basis for their risk-adjusted payments. This further supports the importance of risk-sharing. Furthermore, P3C participants will likely require high-cost wheelchairs, advanced technology devices to promote independence, and other durable medical equipment (DME). We urge CMS to account for the latter costs in the stop-loss program.

We do not support any reductions to the capitation rates to fund stop-loss protections, as it would essentially result in less expenditure on P3C participants, who have complex medical conditions with varying needs.

The AGS is also concerned that the community-based organizations that are frequently involved in the provision of home- and community-based long term services and supports do not bill Medicare themselves today. CMS should provide for a serious role for community-based organizations, allowing them to be part of contracting and gain-sharing in alternative payment models, including

² McGlynn EA, Schneider EC, Kerr EA. Reimagining Quality Measurement. *N Engl J Med* 371:2150-2153, 2014.

PACE, but in doing so should also clarify its enforcement priorities for community-based organizations.

Quality-Based Payments

The AGS supports moving forward with the development of a quality-based payment approach for P3C organizations. CMS should identify a comparable population to allow for quality performance comparisons. We recommend the following measure categories for CMS' consideration: hospital admission rates, admissions with specific diagnoses that indicate lack of care management (preventable chronic ambulatory care sensitive conditions), days in the community measure, conditions suspected to result from lack of care or care management, involuntary disenrollment, any validated tools that compare community integration, choice/control, experience of care, care planning, and care coordination.

Part II: Additional Potential Populations for a Model Test

The AGS appreciates the opportunity to provide comments on the design and implementation of a PACE-like model for the six populations specified in Part II of the RFI, and any additional populations that would benefit from a PACE-like model of care not listed in the section.

We support the Altarum Institute's recommendation 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." As noted by the Altarum Institute, there is a large and growing population of Medicare beneficiaries who are "at risk" of nursing home placement. This is a cohort of Medicare beneficiaries who need some long-term care services and supports, but do not meet the state nursing home level of care eligibility requirements.

We ask CMS to move forward, with urgency, to develop a PACE-like model for this population. Of note, the NPA and a number of stakeholders worked to develop the [At-Risk Medically Complex Framework](#), intended to provide an operational guide to serve individuals at-risk of needing nursing home level of care via a PACE-like model. The Framework has been shared with CMS and we encourage CMS to reference the At-Risk Medically Complex Framework in development of the pilot. The Framework addresses eligibility criteria, service delivery, payment, and quality measurements. We would be happy to meet with CMS staff to discuss these ideas in more detail.

In general, we are supportive of CMS's efforts to implement the PACE Innovation Act, and believe it is important to build upon the experience that CMS, states, and PACE organizations have accumulated over time. It is particularly important to provide PACE organizations greater operational flexibility in ways that will allow them to be more efficient and expand without compromising the quality of care for which PACE is well known. We believe that PACE serves as a gold standard for geriatrics best practices and we urge CMS to be as flexible as possible in the adoption of policies that will support the growth of PACE as a model of care.

The P3C pilot should make it easy for existing PACE organizations to expand their services to include the new enrollees, rather than force either new, de novo organizations, or have current programs set up separate parallel organizations to serve the population. Expanding services to new enrollees would consolidate all the PACE experience applied to this population; proposing organizations would be required to show that they have competency in serving the new population. It would also mean interpreting the home and community-based services (HCBS) rule as applying

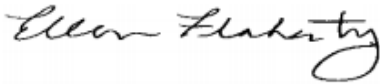
to residence, and not every site where care is delivered (since most PACE centers are closed to members).

Furthermore, as noted above, we caution CMS against limiting eligibility to patients without third-party insurance coverage, and against using control groups that would not receive PACE services despite being eligible for them. Both of these policies, if adopted, will yield populations of enrolled patients that are smaller and more susceptible to financial losses for high-cost patients, which could discourage investment in start-up operations. PACE is an excellent model of care that should be able to expand with appropriate regulatory flexibility. CMS should give PACE the flexibilities afforded to other programs that serve large and diverse populations.

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Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Anna Mikhailovich, amikhailovich@americangeriatrics.org.

Sincerely,



Ellen Flaherty, PhD, APRN, AGSF
President



Nancy E. Lundebjerg, MPA
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