



June 18, 2015

The Honorable Orrin Hatch  
Chairman  
Senate Finance Committee  
219 Dirksen Senate Building  
Washington, D.C. 20510

The Honorable Ron Wyden  
Ranking Member  
Senate Finance Committee  
221 Dirksen Senate Building  
Washington, D.C. 20510

The Honorable Johnny Isakson  
United States Senate  
131 Russell Senate Building  
Washington, D.C. 20510

The Honorable Mark Warner  
United States Senate  
475 Russell Senate Building  
Washington, D.C. 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner,

Thank you for your leadership in identifying policy recommendations that will improve care for Medicare beneficiaries with chronic conditions. The National PACE Association (NPA), representing 114 PACE programs in 32 states, appreciates the opportunity to share our input and views on this important matter.

As you know, chronic disease affects virtually every Medicare beneficiary and accounts for 93 percent of Medicare spending. Unfortunately, the current fee-for-service delivery system does a poor job of properly managing and controlling chronic conditions, resulting in costly complications, avoidable hospitalizations and decreased quality of life for many beneficiaries. We can and must do better.

The committee encouraged stakeholders to submit policy solutions that increase care coordination among individual providers, streamline payment systems to incentivize the appropriate level of care, facilitate the delivery of high quality care, improve care transitions, produce stronger patient outcomes, maximize efficiency, and reduce growth in Medicare spending. The committee can achieve each of these objectives by encouraging the development, expansion, and innovation of the successful Program of All Inclusive Care for the Elderly (PACE).

PACE has a long track record of providing high quality, fully coordinated care for individuals with chronic diseases and disabilities. PACE serves some of our nation's frailest and most vulnerable citizens – those requiring a nursing home level of care. The average PACE participant is 76 years old, has 4 to 5 chronic conditions and has difficulty performing at least 3 activities of daily living such as eating, bathing, dressing or moving around. Approximately half of PACE participants have a dementia diagnosis, and ninety percent are dually eligible for Medicare and Medicaid.

Despite their frailty and complexity, PACE participants enjoy a high quality of care and quality of life. Several evaluations of PACE have found that participants experience better health outcomes than beneficiaries served in other care models including fewer unmet needs, better access to preventive

services such as immunizations and hearing and vision screenings, less pain, less likelihood of depression, and fewer hospitalizations and nursing home admissions. Attachment 1 includes a summary of Key Research Findings about the PACE program.

Moreover, the PACE program has proven to be a good value to taxpayers. A recent study by Mathematica Policy Research determined that PACE costs are comparable to the cost of other Medicare options but that PACE provides better quality of care. The MPR study determined that PACE enrollees had a lower mortality rate than comparable individuals either in nursing facilities or receiving home and community based services (HCBS) through waiver programs.

Given our decades of experience serving this very challenging population, PACE programs offer policymakers a ready-made solution to improving outcomes for Medicare beneficiaries with chronic conditions. By supporting policies that allow for PACE growth, innovation and expansion, Congress can be assured that they are supporting a proven, cost-effective care model that will help achieve the goal of better care coordination for Medicare beneficiaries with chronic illness.

Specifically, NPA recommends that policymakers make the following policy changes to increase access to the successful, proven PACE program:

1. Allow PACE to serve new populations, including younger individuals with disabilities and other high-risk, high cost populations.
2. Encourage CMS to provide greater operational flexibilities to PACE programs.
3. Remove Competitive Barriers to PACE.
4. Invest in PACE growth.

### **Expand PACE Eligibility**

Currently, PACE is available only to individuals age 55 and over who meet their state's eligibility criteria for a nursing home level of care. Although PACE has historically served frail older adults, the PACE model of care is well-suited to any individual who has intensive health and long term service and support needs, including younger adults with physical disabilities, individuals with developmental or intellectual disabilities, or individuals who have complex, chronic medical conditions but who are not yet eligible for nursing home care.

Congress can address this challenge by expanding access to PACE, at the option of States and individual PACE organizations, to include:

- Adults under age 55 who are eligible for a nursing home level of care, including individuals with physical disabilities, intellectual or developmental disabilities, behavioral health needs, and other significant disabilities.
- Adults residing in nursing facilities who can transition to community residences.
- Adults who do not yet qualify for a nursing home level of care, but who have one or more severe chronic conditions in combination with some disability.
- Other individuals identified as "high-utilizers" of emergency room, hospital or nursing home care, but who – with support from PACE – can live safely in the community.

Senators Tom Carper (D-DE) and Patrick Toomey (R-PA) recently introduced S. 1362, legislation that will allow CMS to test the PACE model with new populations such as younger people with disabilities,

individuals at-risk for needing nursing home care and others. Originally offered as an amendment to S. 871, the SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013, this non-controversial, bipartisan legislation was scored as revenue neutral by the Congressional Budget Office. By enacting this common-sense measure, the Senate can take immediate action to improve the ability of high-risk, high need beneficiaries to access PACE's effective model of care.

### **Operational Flexibility**

Despite its strong track record, PACE only serves approximately 35,000 participants in 32 states. This is partially due to strict federal regulations imposed on PACE. The construction of the PACE center, staffing requirements, and lengthy start-up processes demand large, up-front capital investments; it costs approximately \$4-6 million to bring a PACE program to market.

With new operational flexibilities and innovations, however, PACE can play an increasing role in providing high-quality, cost-effective care for frail, costly populations. NPA believes that many of these flexibilities can be achieved through regulatory changes and administrative processes, without additional Congressional authority. Specifically, NPA has been working with CMS to implement regulatory changes that would:

- 1) Allow PACE organizations, as an alternative to operating a PACE Center, the option to offer services in other settings, such as adult day health centers or senior centers, that support PACE participants interaction with one another and with the PACE interdisciplinary team members.
- 2) Allow PACE organizations to integrate community physicians and nurse practitioners as members of the PACE interdisciplinary team.
- 3) Provide operational flexibility to configure the PACE interdisciplinary team based on the needs of the individual participant, including greater flexibility in the use of nurse practitioners as primary care providers.

NPA has been in dialogue with CMS for more than 3.5 years about the need for these regulatory reforms. Regrettably, CMS has not adhered to its own timeline for updating PACE regulations, which have not been updated since 2006. In its fall 2012 *Regulatory Agenda*, CMS published that a Notice of Proposed Rulemaking to revise the PACE regulation would be issued in July 2013. Since then, this deadline has been extended to December 2013 and again to August 2014. NPA recently learned that a revised regulation may not be released for comment until September of 2015.

Over the eight years since the current regulation was put in place, PACE organizations have operated against the backdrop of a rapidly changing health care system, including expanded managed long term services and supports, financial alignment demonstrations for dual eligible, ACOs and patient centered medical homes. The delay in updating the PACE regulation as these new models have been rolled out constrains PACE's ability to grow, in a time of unprecedented opportunities to serve dually eligible individuals, increases costs unnecessarily, and limits PACE organizations' ability to offer beneficiaries access to a proven model of care.

Congress should implement policies to ensure that PACE is able to serve more beneficiaries, with greater efficiency. Evolving the PACE program to meet the current care delivery landscape will achieve all three of the Committee's bipartisan goals and address several of the identified policy areas in need of reform. Because PACE is a Medicare benefit and a Medicaid state option, PACE regulations require that all PACE organizations operate under a three-way program agreement between CMS, the State and the PACE

organization. States generally set eligibility requirements, rates, and limitations on the number or programs or beneficiaries that can be served.

While the law was intended to ensure that states can appropriately manage their Medicaid programs, it has also had the effect of restricting PACE access for individuals who are eligible for Medicare, but not Medicaid. For example, eighteen states do not have a PACE benefit. This denies access not just to dually eligible beneficiaries, who rely on the state to pay their premiums, but also restricts access for Medicare beneficiaries who would otherwise pay for PACE out of their own pocket.

Furthermore, PACE organizations have no flexibility in how premiums are set for Medicare beneficiaries, who are not also Medicaid eligible, seeking to enroll in PACE. These Medicare beneficiaries must pay the equivalent of the Medicaid rate, which averages \$3,500/month. This precludes the ability of PACE programs to reflect the market's interest in rates that are more discretely aligned with the PACE participant's specific level of need, within the broader level of care determination that he or she is nursing home eligible. Congress should work to ensure that PACE organizations have flexibility in rate setting, which will allow PACE organizations to charge rates that align with private-pay participants' preferences and are responsive to market forces.

PACE participants are required to enroll in the PACE Part D plan, rather than retaining their ability to select the Part D plan this is right for them based on their own preferences and financial means. Congress should allow Medicare beneficiaries to choose the Part D plan that is right for them.

### **Remove Competitive Barriers**

When the PACE program was first authorized under the *Balanced Budget Act of 1997*, there were few other integrated care models available to individuals with complex chronic diseases or disabilities. In recent years, however, many states and the federal government began expanding the use of managed care as a way to finance and deliver LTSS and health care services. While new models have the potential to benefit consumers and payers alike, it is essential that state and federal policies create a level playing field that allows all models – including PACE -- to compete and thrive. The following federal changes would allow PACE organizations to compete more effectively with these new care models:

- **Contracting with other payers** – PACE organizations may be able to offer a range of health and long-term services to other entities such as Accountable Care Organizations, financial alignment plans, Medicaid managed care plans, and Medicare Advantage plans. It is unclear, however, whether PACE organizations can provide these types of services under current law. Congress should clarify that nothing in current statute prevents a PACE organization from entering into agreements or contracts with other payers.
- **Expedite PACE Enrollment** -- There are several barriers to PACE enrollment that do not exist for nursing homes or managed care plans. Financial and clinical eligibility determination processes can take many weeks to complete, and individuals can only enroll on the 1<sup>st</sup> of the month. However, individuals can access nursing home care without delay, and are able to enroll in managed care plans without having to endure lengthy clinical eligibility processes. PACE should be as accessible to beneficiaries as nursing home care or enrollment in managed care plans. Congress and CMS should collaborate with State agencies to identify process changes and other strategies to expedite clinical and financial eligibility determinations for PACE and other home and community-based programs.

## Invest in PACE Growth

Since passage of the Affordable Care Act, states and CMS have invested considerable resources in developing new policies and initiatives to achieve the health care “triple aim” of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. One such model, the financial alignment demonstration, supports states as they develop service delivery and payment models that integrate care for the nation’s nearly 9 million “dual eligibles,” using either capitated models (e.g., managed care plans) or managed fee for service (which allows states to share in savings). Eleven states are participating in this financial alignment demonstration.

While this initiative has demonstrated some promise in improving care coordination and outcomes, there is still significant uncertainty about its ability to deliver high quality care at a reduced cost, especially for frail beneficiaries. Out of the 1.7 million people eligible to participate in the 11 states with financial alignment demonstrations, only 26% or 450,844, have signed up as of May 1. Notably, PACE organizations have achieved a market penetration in their services areas of on average 10% and as much as 25%. This has been achieved without the benefit of passive enrollment which has channeled people into the financial alignment demonstrations.

Unfortunately, the Affordable Care Act did not authorize CMS to include PACE in the financial alignment demonstrations. As a result, PACE has not been well integrated into the design of state approaches to managed care for people with chronic illnesses who need long term services and supports. Several policy changes would address this issue. The first, allowing CMS to test PACE with new populations, was noted above. This change would remove existing barriers within CMS and at the state level that currently prevent PACE from being coordinated with the financial alignment demonstrations.

Second, Congress can enact legislation to help mitigate some of the risk of starting-up a PACE program. Specifically, PACE organizations assume full financial risk for all their participants without limits. A high-cost individual could create significant financial challenges for a fledgling PACE organization. This is especially problematic in rural areas and for new programs with relatively few participants. Congress should enact legislation to provide newly operational PACE organizations with time-limited cost outlier protection for participants who incur exceptionally high acute care costs.

Finally, and quite simply, Congress and CMS can make PACE development a priority. In recent years, PACE has not received significant attention or resources within the agency or states because it is not “new.” Some policymakers have determined that PACE is too small to merit additional resources. But in many cases, PACE is small because regulations stifle its growth, or because the agency and states have not invested the resources necessary to promote the program.

A number of states illustrate the potential for PACE to serve more Medicare beneficiaries who need long term services and supports as they seek to manage their chronic illnesses. Specifically, California, Massachusetts, Michigan, New York, North Carolina, Pennsylvania, and Virginia have made significant investment in PACE development and growth. While they represent only 21 percent of PACE programs, these states account for almost two-thirds of PACE enrollees. If CMS offered leadership and resources to support PACE development in the states – much as the agency did for states participating in the financial

alignment demonstrations – we would most certainly see significant increases in access to PACE programs, possibly resulting in enrollment growth that is comparable to the financial alignment demonstrations.

In closing, as Congress and CMS continue their efforts to improve care for chronically ill beneficiaries, we encourage you to look to PACE as a proven alternative to the current system, and support the following policies that will allow for its growth and innovation:

1. Enact legislation that allows PACE to serve new populations, including younger individuals with disabilities and other high-risk, high cost populations.
2. Provide greater operational flexibilities to PACE programs.
3. Promote PACE competitiveness by allowing PACE to set more competitive rates, contract with other organizations, and promptly enroll individuals.
4. Invest in PACE growth as a priority.

Thank you for your consideration of these recommendations. If you have questions about the PACE program or need additional information about these recommendations, please contact us at (703) 535-1565.

Sincerely,

A handwritten signature in blue ink, appearing to read "Shawn Bloom". The signature is stylized and cursive.

Shawn Bloom  
President and Chief Executive Officer