Administrator Seema Verma
U.S. Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

We write in strong support of Programs of All-Inclusive Care for the Elderly (PACE) and to express our concerns about existing regulatory impediments to PACE’s ability to continue to provide care efficiently and effectively. We write to inquire about the status of the proposed rule issued by the Centers for Medicare and Medicaid Services (CMS) on August 2016 (CMS-4168-P), that would revise and update current PACE requirements. Additionally, we would like to request a status update on the Person-Centered Community Care (P3C) model pilot, as CMS has yet to request applications. We urge swift action so that this proven and innovative model can continue to provide effective care and that more individuals who stand to benefit from the PACE model may be served.

As you know, PACE is a proven care model delivering high-quality, comprehensive, integrated and coordinated community-based care to both Medicare and Medicaid beneficiaries 55 years of age or older, who meet the criteria for a nursing home level of care, but wish to live at home. At present, there are 122 PACE organizations operating with 239 centers in 31 states, serving over 42,000 elders and those living with disabilities every day. Multiple studies show that people receiving care from PACE organizations live longer, experience better health, have fewer hospitalizations and spend more time living at home than those receiving care through other programs. Additionally, PACE has already incorporated many of the reforms promoted by Medicare, including coordinated care and integrated financing, and has proven to be a good value to taxpayers, while increasing the quality of life for many of our nation’s elders, persons living with disabilities, and their families.

However, the existing regulatory framework for PACE is over a decade old and in need of reform to allow for maximum program efficiencies. The necessary changes include: (1) allowing PACE organizations to include community physicians as part of their hallmark interdisciplinary teams (IDT); (2) using nurse practitioners and physician assistants as primary care providers, which would be cost saving and improve quality of care; (3) providing services in settings other than the PACE Center, and; (4) configuring the IDT to meet the needs of individual participants. The proposed rule would provide PACE with badly needed operational flexibility. On June 7, 2017, the Ways and Means Committee held a bipartisan hearing examining the PACE program and discussed the need for the various reforms included in the proposed regulation to reduce costs and improve the quality of care for our seniors. We strongly urge CMS to prioritize promulgating a final rule soon so that PACE programs may be afforded the operational flexibility needed to expand and serve more frail seniors and those living with disabilities.

Likewise, we ask CMS to prioritize the P3C model test and other pilots, which Congress authorized in 2015 through Public Law 114-85. The P3C pilot will explore the feasibility of PACE-like entities to care for dually-eligible individuals, aged 21 and older, who live with disabilities that impair their mobility and require a nursing home level of care. We ask CMS to proceed with these pilots expeditiously.

In closing, we strongly urge CMS to promptly take action to finalize the PACE regulation and move forward with implementation of the P3PC model pilot. Thank you in advance for your timely response to our concerns.

Sincerely,

Christopher H. Smith

Elsie Svin

Earl Blumenauer

Lynn Jenkins

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