AGS | THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals.
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SUBMITTED ELECTRONICALLY VIA
http://www.regulations.gov

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS—4168—P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE) (CMS-4168-P)

Dear Mr. Slavitt:

The American Geriatrics Society ("AGS") appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Proposed Rule for Programs of All-Inclusive Care for the Elderly (PACE) published in the Federal Register on August 16, 2016.

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 patient-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. Our mission is to advance efforts that promote high quality of care and quality improvement for vulnerable elders.

In general, we are supportive of CMS' efforts to update the PACE regulation and believe it is important to build upon the experience that CMS, States and PACE organizations have accumulated since the PACE regulation underwent its last significant revision in 2006. It is particularly important to provide PACE organizations greater operational flexibility in ways that will allow them to both 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.

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

Subpart E – PACE Administrative Requirements

Part D Program Requirements (460.3)

AGS agrees with CMS that it is important to clarify that PACE organizations that offer qualified prescription drug coverage and meet the definition of a Part D plan sponsor must follow the Part D rules, including having a compliance plan in place and having written agreements with first tier and downstream entities, in addition to the PACE program's rules. AGS also supports the proposal to establish compliance oversight programs in PACE organizations. **CMS should finalize these proposals.**

However, AGS is 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 currently bill Medicare themselves, and thus are unfamiliar with the many requirements and potential penalties that might apply to them. AGS has previously commented to CMS that high-cost patients need social and supportive services in order to stay reasonably well and out of the hospital – housing, food, caregiving, substance abuse harm reduction, transportation, and so forth. In programs such as the Chronic Care Model (CCM) and the Community-Based Care Transitions Program, the value of highly skilled community-based organizations in providing these services has come to be recognized and valued. Clinical-community linkages are particularly important for older adults with multiple chronic conditions and add value in regards to managing chronic conditions, preventing hospital (re)admissions, activating beneficiaries and diversion/avoiding long-term residential stays.[1]

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 PACE. Written contracts will help to ensure that community-based organizations understand the compliance rules that will apply to them, and gainsharing will give them incentives and resources to be able to develop compliance programs. **CMS should clarify in the Final Rule the agency's intentions with regard to enforcement for community-based organizations.**

Application Requirements (460.12)

AGS supports CMS' proposal to modernize the application process for entities that seek to become new PACE organizations or expand existing PACE organizations' service area or number of sites. Submitting and exchanging application information electronically will be less burdensome for PACE organizations and CMS.

AGS also supports CMS' proposal to review PACE organizations' proposed service areas to avoid duplication of services and avoid impairing the financial and service viability of an existing program. The development of new alternative payment models is attracting interest from for-profit entities that could put providers who have been involved in PACE for many years out of business. **CMS should finalize this proposal.**

[1] Parekh, A., and Schreiber, R. How Community-Based Organizations Can Support Value-Driven Health Care. Figure 1. Health Affairs Blog. July 10, 2015.

Contracted Services (460.70)

AGS supports participant-directed home and community based settings options within the requirements of the PACE regulation, rather than the Home and Community Based Settings rule. As noted by NPA, this recognizes the PACE program's current home and community-based focus and assures participants' access to the PACE center as an option for primary care, rehabilitative care and activities.

AGS supports the proposal to require contractors to comply with requirements of the PACE program related to service delivery, participant rights and quality improvement activities. As noted above, however, AGS is 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 currently bill Medicare themselves. 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 PACE, but in doing so should also clarify its enforcement priorities for community-based organizations.

Subpart F – PACE Services

Service Delivery (460.98)

CMS has requested comment on potential changes to PACE center requirements and ways to revise current regulatory requirements to allow greater flexibility with regard to alternative care settings in which IDT members provide PACE services while still ensuring that PACE participants can receive the full range of services and benefits that has made PACE such a successful model for this population.

AGS supports the changes identified in this section in order to allow flexibility to provide care in response to participants' needs and preferences as well as in a variety of settings, especially in rural areas where care options are so limited. As noted by NPA, this proposal supports choice by PACE participants regarding how and where they would like to participate in activities and access PACE program services while allowing the PACE program to grow more efficiently and more nimbly.

While AGS fully supports expansion of these programs, we are concerned about the scaling of these programs that will likely require full loading of the staff and IDT before a PACE organization can begin to enroll beneficiaries. From a business perspective the PACE organization has to capitalize its startup costs, which may also include paying staff and benefits for 30-60 days before it begins to collect revenue. CMS should consider scenarios that would enable PACE programs to reduce the costs of start-up. One suggestion would be to have contingent contracts, rather than full-time ones, with the IDT, permitting operation of temporary and transitional PACE centers and by allowing some advertising and public and professional education ahead of final approval.

Interdisciplinary Team (460.102)

AGS supports the NPA's expanded definition of primary care provider on the PACE interdisciplinary team to include nurse practitioners, physician assistants and community-based physicians in addition to PACE physicians. This allows participants in the PACE program more options for how and from whom they can receive their primary care services while maintaining the integrity of the PACE program's interdisciplinary team which is central to its effectiveness.

AGS also urges CMS to ensure that the physicians, nurse practitioners, and physician assistants leading the PACE team and providing and overseeing care to PACE participants are competent in geriatrics principles. These competencies may include, for example, person-centered care and goals setting,

palliative and end of life care, geriatric pharmacology and prescribing, and cognitive and behavioral disorders. The list of minimum geriatric competencies for internal and family medicine residents might be a good place to start: http://www.americangeriatrics.org/files/documents/Min.Ger.Comp.pdf.

Participant Assessment (460.104)

CMS has also proposed to give PACE organizations much greater flexibility in the IDT team composition. **AGS supports CMS' proposals to allow greater flexibility with regard to how individual IDT members participate in assessments and care planning with the objective of varying the composition of the IDT for individual participants based on their care needs.** This makes the most effective use of the IDT members' time, balancing the needs of assessing and care planning with the direct delivery of services to PACE participants.

Additionally, an individual physician or NPP may have several different roles or tasks to perform – administrator, medical director, attending, private practice – and we believe it makes sense for PACE organizations to have flexibility to recognize this in their staffing particularly in rural areas and parts of the country that don't currently have PACE.

Subpart J - Payment

Medicaid Payment (460.182)

CMS is proposing new language that would ensure that the Medicaid rate is reasonable for the population being served under the PACE program. We support CMS' efforts in this regard and appreciate the opportunity to provide feedback on alternative payment methodologies.

The current Medicaid single rate is too high and presently discourages Medicare patients from enrolling in PACE. One option would be for CMS to grant flexibility now for tiered rates to allow Medicare patients to pay based upon an assessed level of needs. **AGS would also like to see additional flexibility to make PACE available to the large population of non- Medicaid, non dual-eligible seniors in need of a high-quality, coordinated model of care that will provide the support necessary to live safely and with dignity at home rather than in a nursing home.** There is a Medicare-only population that can also benefit from PACE expertise in providing geriatric care.

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Again, thank you for the opportunity to comment. If you have any questions, please do not hesitate to contact Alanna Goldstein, Director of Public Affairs and Advocacy, at agoldstein@americangeriatrics.org.

Sincerely,

Nancy E. Lundebjerg, MPA
Chief Executive Officer