American Hospital Association

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February 10, 2017

Martha Hennessy
Deputy Director, Division of Medicare Advantage Operations
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: PACE Innovation Act Request for Information

Dear Ms. Hennessy:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) request for information (RFI) regarding new models of care for the Programs of All-Inclusive Care for the Elderly (PACE). The PACE Innovation Act of 2015 provided CMS with new waiver authority to test PACE-like models for populations under the age of 55 and those who do not qualify for nursing home care.

This RFI specifically requests comments on CMS's new "Person Centered Community Care," or P3C model. This program is designed to test a PACE-like model for adults who are dually eligible for Medicare and Medicaid, have disabilities that impair mobility and require a nursing home level of care. In addition, the RFI requests comments on other populations that could benefit from this PACE-like model, as well as how the current PACE model could be adapted to better serve the needs of the current and new population groups. **In general, the AHA supports CMS's effort to move forward with innovative models of care for younger populations that could benefit from high-quality integrated medical care and community supports that are central to the PACE program.**

In developing our comments, we consulted with members currently engaged in the PACE program. Our comments focus on the following recommendations:

- Increase flexibility to allow P3C PACE-like models to collaborate with community partners, both medical and non-medical;

- Consider what quality metrics are used; and
- Strengthen the risk-sharing protections, such as stop-loss measures, in the financing model.

COLLABORATION WITH COMMUNITY PARTNERS

As CMS looks to expand PACE-like models to younger, mobility-impaired populations, it will be critical to maintain P3C flexibility to collaborate with established community partners, both medical and non-medical. Particular consideration must be given to participants with mental and behavioral health needs or chronic conditions, such as multiple sclerosis, who have established relationships with community providers. **As such, the AHA supports added flexibility for P3C PACE-like models to collaborate with community medical and non-medical partners by allowing the PACE interdisciplinary care team (IDT) to contract with these providers**. **Further, we support the ability of new participants in the program to maintain their choice of provider if they have established relationships with community care providers.**

In addition, the PACE program requires all PACE organizations to operate a PACE center that provides primary medical care services, therapies, socialization, dining and personal care attendant services. However, for younger, mobility-impaired populations, the established PACE centers may not be suitable to receive the full array of PACE services. **The AHA urges CMS to grant P3C PACE-like models flexibility to innovate as to how best to provide the PACE non-medical services, such as recreational therapy, personal attendant services, and meals and socialization.**

QUALITY METRICS

Quality measurement is important in ensuring improvement in health outcomes for PACE participants. In recent years, PACE program evaluations have shown success in several outcome areas, such as health and functional status, quality of life, length of survival and service satisfaction. In fact, PACE beneficiaries were found to be at no greater risk of readmission than the overall Medicare population, despite their very complex health conditions.[1]

For the P3C PACE-like models of care, the AHA recommends continuing the use of current PACE program quality measurement tools rather than expanding those measurement tools to include HEDIS or CAHPS, which may not reflect the complexity of care provided this new population.

[1] American Hospital Association. 2011 Committee on Research, Teri Fontenot and Alfred G. Stubblefield, co-chairs. *Caring for Vulnerable Populations*. Chicago: American Hospital Association, 2011, p. 14.

STRENGTHEN RISK-SHARING PROTECTIONS IN THE FINANCING MODEL

The initial years of testing new innovative models of care, such as the P3C PACE-like model, come with significant financial risks. However, risk-sharing protections, such as stop-loss mechanisms, would go a long way toward helping ameliorate the potential financial volatility to an organization taking on risk sharing for a medically complicated population. **The AHA supports the use of risk-sharing protections, including stop-loss measures, and encourages CMS to extend these protections throughout the entire pilot program.**

Finally, the RFI asked for comments regarding improvements to the current PACE program. The AHA believes that many of our suggestions above regarding added flexibility for IDTs and risk-sharing protections for new programs should apply not only to the P3C PACE-like model but also to the current program. In addition, we suggest that CMS consider including more robust clinical information, such as dementia diagnoses and frailty factors, in the risk-adjusted methodology it uses in determining payment for PACE organizations.

Thank you for your consideration of our comments regarding the RFI to test new PACE-models of care such as P3C for younger, mobility-impaired populations. Please contact me if you have questions or feel free to have a member of your team contact Molly Collins Offner, director of policy, at mcollins@aha.org or (202) 626-2326.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis & Development