JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

February 10, 2017

Tim Engelhardt, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
Sent electronically via email to: MMCOcapsmodel@cms.hhs.gov

Re: PACE Request for Information

Justice in Aging appreciates the opportunity to respond to the above-referenced RFI concerning possible expansion of the PACE program model and modifications to PACE regulations.

Justice in Aging is an advocacy organization with the mission of improving the lives of low income older adults. Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

We appreciate the thoughtful analysis reflected in the RFI and are fully supportive of careful exploration of opportunities to expand the PACE model, both by expanding the current PACE program and by experimentation with variants of PACE. Our comments are limited and focus on issues of beneficiary impact. They are drawn primarily from our experience in the implementation of the dual eligible financial alignment demonstration, as well as our work on the implementation of the HCBS Settings Rule.

Part 1: Potential Elements of the P3C Model

The P3C Model: Well-run PACE programs have been an effective way to integrate care for high need older adult Medicare beneficiaries, most of whom are dual eligibles. PACE has allowed individuals to receive the array of services they need while continuing to live in the community. Many of the lessons learned in the PACE program have helped in the design of other models of integrated delivery of care. Justice in Aging welcomes initiatives to expand opportunities for more individuals to have PACE as an option to meet their needs, including the initiative to pilot the P3C model for persons with disabilities.

1.a Potential P3C Participant Eligibility

Stability for the beneficiary: The RFI asks about the benefits and drawbacks of setting an upward age limit for the P3C model. It also asked about concerns that differing financial payments may incentivize providers to shift participants between P3C and PACE. We share those concerns. In developing the design of a P3C model we ask that, at a minimum, CMS require that individuals in a P3C program who

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age into eligibility for PACE must be allowed to remain in the P3C program if they wish to do so. PACE programs are essential to the social life of their members and programs are part of the "home" for participants. Beneficiaries with a social/medical home should not be required to break both their continuity of care and their bonds of friendship just because they are aging. As with nursing facility residents, transfer trauma has real costs for frail individuals. The P3C program should be designed to avoid this result.

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

Community Integration: We appreciate the strong focus on community integration, which we believe is essential for both the PACE and the P3C populations. We are pleased that the January 16, 2014 HCBS Settings Rule has helped form the basis for rigorous standards of community integration. We encourage CMS to use the requirements of the Rule as a baseline for the P3C model, including using the P3C Request for Applications (RFA) and the P3C Program Agreement (the agreement between the P3C organization, CMS, and the SAA) to ensure community integration is fully addressed in the care/service planning process, the delivery of community supports, and the functioning of the IDT.

IDT: Throughout the design of a P3C program, person-centered planning should be the guiding principle. Thus IDT composition should be responsive to the preferences of the beneficiary, as well as the beneficiary's particular needs and circumstances.

Wheelchair and DME Competencies: We appreciate the specific inclusion of a requirement for wheelchair and DME competencies. Issues with wheelchair repair and adjustment are among the most common and serious problems that advocates see in DME. We urge CMS to draw on the experiences of the disability community and work closely with disability advocates to develop specific contract requirements with respect to timeliness of wheelchair repair and battery replacement, availability of temporary equipment during a repair, and related matters.

Comprehensive Assessment and Person-Centered Service Planning: We encourage CMS to ensure that consumers have the necessary information, skills, and supports to fully participate in the service-planning process and increase their efficacy as self-advocates. We urge CMS to ensure that service-planning processes are truly individualized, and not simply service plans that rely exclusively on functional assessments and are nothing more than a recitation of Medicaid-approved services, a problem that we see too often. Service plans should be written in plain language that beneficiaries can understand and that reflects their person-centered goals.[1]

Choice of Providers: We appreciate that CMS is proposing to add flexibility concerning providers for newly-enrolled P3C participants. The experience of the dual eligible financial alignment initiative has shown that a primary concern among beneficiaries in choosing a care model is being able to retain

[1] For examples of how states are implementing person-centered planning requirements of the January 16, 2014 Final Rule, as well as recommendations regarding person-centered planning, see Justice in Aging, G. Orlowski and J. Carter, *A Right to Person-Centered Care Planning* (April 2015), available at http://justiceinaging.org/wp-content/uploads/2015/04/FINAL_Person-Centered_Apr2015.pdf.

relationships with trusted providers.[2] We urge provisions that establish both robust continuity of care protections and avenues for providers to participate in the P3C program by contract so that they can continue longer term in the relationship with their patients.

The RFI also discussed a requirement for P3C organizations to promote self direction of personal care attendant services but did not directly discuss care continuity in the context of personal care. We urge that care continuity protections be specifically extended to these providers as well. For many persons with disabilities, self direction of their personal care, including deciding on a choice of provider and training that provider about their needs has been a hallmark of a successful care plan. Further for beneficiaries with limited proficiency in English, the ability to choose and retain providers who are both language concordant and culturally competent is important. We ask that P3C sponsors should be required to provide care continuity for these providers as well and create paths for them to be employed longer term.

Reconfiguration of PACE Centers: The RFI proposes permitting use of different sites for delivery of different services in the P3C program, offering more flexibility than is currently in place for PACE programs. We support this flexibility, and note that any day center, through the PACE or P3C program, should be encouraged to promote community integration to the maximum extent possible.[3]

The RFI further notes that transportation availability is a necessary an element of that model. We urge CMS to be particularly attentive to transportation arrangements when conducting readiness reviews and to set exacting transportation standards in contracts. Advocates report that throughout the Medicaid delivery system, both in managed care and fee-for-service, reliable non-emergency medical transportation (NEMT) is the exception rather than the rule. Those current problems suggest that heightened scrutiny of the transportation element is warranted.

Governance: We strongly support having a community advisory committee that starts well before the first individual is enrolled in a P3C. Having consumer input in the design phase can immeasurably help to avoid problems in implementation. Based on experience in the dual eligible financial alignment demonstrations, we urge that structured avenues for stakeholder input, including particularly input from consumers and advocates, should be established before provider organizations are chosen for the pilot. Opportunities to participate in development of RFPs and contracts, including the opportunity to review contract language should be provided. Such opportunities were not consistently available in the development of the three way contracts in the dual eligible demonstrations but, when opportunities were offered, they did strengthen the quality of the end product.

Further, to ensure genuine opportunities for consumer participation, it is important that organizations be required to ensure that transportation and other accommodations are available. In addition there should be active efforts to include a diverse range of consumers, including those with limited proficiency in English.

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[2] See, e.g., C. Graham, P. Liu, and S. Kaye, *Evaluation of Cal MediConnect, Key Findings from a Survey of Beneficiaries* (Aug. 17, 2016),available at http://www.healthresearchforaction.org/hra/evaluation-cal-mediconnect

[3] For recommendations on promoting community integration in center settings, see Justice in Aging's comments to CMS regarding how the HCBS Settings regulations can best be implemented for older persons who receive HCBS in day services centers, available at http://www.justiceinaging.org/wp-content/uploads/2016/10/HCBS-and-day-services-centers-for-older-adults-letter-to-CMS-final.pdf.

Finally, we note that the stakeholder process in the Massachusetts One Care dual eligible demonstration is a particularly valuable model, especially for a new program to serve persons with disabilities. The multi-stakeholder Implementation Council used in the One Care demonstration has been an effective tool. Massachusetts consumer advocates would be a good resource for in depth perspective on lessons learned about how to structure effective and constructive consumer participation in design and implementation of a new delivery system for people with disabilities.[4]

Ombudsman: We did not see any discussion about provisions for an ombudsman function in this demonstration. Experience in the dual eligible demonstration has shown that a program-specific ombudsman program can spot systemic issues early as well as help resolve individual beneficiary issues.

1.d Proposed Quality Outcomes for Evaluation of P3C Model

We encourage CMS to continue its efforts to establish common quality measures for HCBS, including PACE and P3C. We believe quality measures must look at a broad array of outcomes that are important in a person's life, including health and safety, community integration, self-determination and choice, and consumer satisfaction. We recommend, among others, standards from the HCBS Consumer Experience Survey and the National Core Indicators Aging and Disability Survey.

1.e Potential Operational Structure for P3C

Monitoring: One lesson learned from the dual eligible demonstration is that program rollout always presents unexpected challenges that need to be addressed quickly. Though periodic reporting and reviews are important, troubleshooting and ongoing communication is essential, particularly in the early stages of a program. It is critically important that CMS ensure that both state and federal entities designate specific individuals within their agencies to oversee the program, commit adequate resources to program development and oversight, and establish clear communications channels for stakeholders and program operators.

Enrollment Process: We appreciate that CMS is proposing an entirely voluntary enrollment process. One model cannot meet the different needs of these populations and it is very important that beneficiaries be able to choose the program that can serve them best. To preserve genuine choice, we urge that beneficiaries who would be eligible for P3C not be passively enrolled into other models. In our view, passive enrollment does not promote beneficiary choice for any beneficiary but, for those with high needs, it is particularly inappropriate.

[4] See Community Catalyst, *Elevating Consumer Voices in Massachusetts Delivery System Reform*, available at www.communitycatalyst.org/initiatives-and-issues/initiatives/aca-implementation-fund/stories-from-the-states/elevating-consumer-voices-in-delivery-system-reform; and Kaiser Family Found., Early Insights from One Care: Massachusetts' Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries (May 12, 2015, available at kff.org/report-section/early-insights-from-one-care-massachusetts-issue-brief-8725/

We also appreciate that the RFI includes no discussion of any enrollment lock-ins. It is critically important that, as with the current PACE program, participants have the option to leave the program at any time that they decide that it does not meet their needs. We appreciate that CMS recognizes this.

Thank you again for the opportunity to comment. We hope that CMS will continue to engage the stakeholder community as it explores PACE expansion models. If you need additional information, please do not hesitate to contact me at JGoldberg@justiceinaging.org.

Sincerely,

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