



UnityPoint Health

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Centers for Medicare and Medicaid Services
Medicare-Medicaid Coordination Office

RE: PACE Innovation Act Request for Information

Submitted electronically via MMCOcapsmodel@cms.hhs.gov

Medicare-Medicaid Coordination Office Capitation Model Team:

UnityPoint Health (UPH) and Siouxland PACE are pleased to provide input in response to the Centers for Medicare & Medicaid Services' (CMS) Request For Information relating to the Programs of All-Inclusive Care for the Elderly (PACE) Innovation Act. UPH is one of the nation's most integrated healthcare systems. Through more than 30,000 employees and our relationships with more than 290 physician clinics, 32 hospitals in metropolitan and rural communities and home care services throughout our 9 regions, UPH provides care throughout Iowa, Illinois and Wisconsin. On an annual basis, UPH hospitals, clinics and home health provides a full range of coordinated care to patients and families through more than 4.5 million patient visits. In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. ***Siouxland PACE started in 2008 with assistance from a CMS Rural PACE Development grant. Since 2011, Siouxland PACE has been under the ownership of UnityPoint Health – St. Luke's, a UPH senior affiliate in northwest Iowa. Currently, there are 164 Participants receiving PACE services from four northwest Iowa counties.***

As an integrated healthcare system, UPH believes that patient-centered care is best supported by a value-based payment structure that enables healthcare providers to focus on population health instead of volume-based episodic care. PACE epitomizes this principle and provides holistic, consumer-centric care in a community-based setting. We appreciate CMS' solicitation of stakeholder input and respectfully offer the following comments.

GENERAL COMMENTS

The traditional PACE model is a capitated benefit for frail elders that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE represents a unique model of managed care service delivery for a small number of very frail community-dwelling elderly (age 55 and older), whom are dually eligible for Medicare and Medicaid coverage, and whom are assessed as being eligible for nursing home placement according to the standards established by their respective States. Key elements of the traditional PACE model of care include:

- Capitated payments for the delivery of all Medicare and Medicaid services;

- Provision and coordination of care, including development of a person-centered care plan for medical, behavioral, and social services, through an interdisciplinary team (IDT);
- Integration of all medical, behavioral, and social services to foster community living and community integration;
- Use of a PACE Center to facilitate provision of medical care and social services and to foster community integration; and
- Joint CMS-state program oversight.

Siouxland PACE is one of 121 PACE Programs nationwide. PACE Organizations operate in 31 states with more than 38,000 enrolled Participants.

In this RFI, CMS is seeking input on the potential expansion of the traditional PACE model to additional populations beyond the frail elderly. For these populations, CMS is proposing deviations to some of the key elements of the PACE model (represented in underlined text above). First and foremost, ***UnityPoint Health is generally supportive of models that shift risk to provider organizations on a voluntary basis and views PACE as a viable alternative to third-party managed care arrangements.*** The characteristics of a PACE program should be the end game for population health overall – a capitated, risk-based program providing consumer-centric, holistic care coordination and services. We consider Siouxland PACE and its intense service coordination to be a valued addition to healthcare options in northwest Iowa and are investigating sponsoring its expansion in other regions within our healthcare system footprint.

While we support PACE objectives, all RFI commentators are disadvantaged pending the release of Final Rules for the traditional PACE model.¹ CMS has not updated the PACE regulations in 10 years. Without certainty as to whether CMS will adopt proposed flexibilities into the present regulatory framework, we lack a firm source of reference to compare the proposed pilots – i.e. whether the pilots align or propose more lenient/strict terms than the traditional PACE model. The absence of the PACE Final Rule makes it difficult to advocate for model expansion to other populations. ***We urge CMS to delay implementing any proposed pilot until the fate of the traditional PACE model regulations is finalized and those comments and revisions can be taken into consideration.*** We also request that CMS review the Siouxland PACE / UnityPoint Health comments submitted during the proposed PACE rulemaking stage.² These comments detail programmatic revisions to strengthen the PACE model overall and enhance outreach efforts to rural PACE Participants.

In addition, ***the RFI lacks specificity regarding any preferences for current PACE Organizations in the application process and/or program implementation.*** PACE Organizations have invested significant costs in infrastructure, personnel training, community/provider relations, and marketing/reputation. This model is not simply a program, but embedded in our name and synonymous with our facility. We have concerns about the universal scalability and appropriateness of existing PACE Organizations and their infrastructure to adequately serve other proposed populations within their service areas. Likewise, we question whether additional flexibilities in “PACE-like” models will diminish participation and perceived value in the traditional PACE model. ***We urge CMS to carefully consider any deviations from the traditional PACE model for new populations and instead inquire whether proposed deviations should, in fact, be instituted in the traditional PACE model as well.*** Among these deviations, the appropriate use/role of the PACE Center in community integration and the composition of and meeting schedules for

¹ CMS-4168-P - Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE); Federal Register Vol. 81, No. 158, p. 54666 (August 16, 2016)

² CMS-4168-P - Medicare and Medicaid Programs - Programs of All-Inclusive Care for the Elderly -PACE.pdf, submitted via regulations.gov on October 14, 2016; comment tracking number 1k0-8sgj-isdk.

InterDisciplinary Teams (IDT) are requirements that need further study and explanation if pilots differ from the traditional PACE model.

Finally, ***we caution against an approach that further silos care based on diagnoses or age, rather than principles of population health.*** This RFI presents an overview of the P3C model for adults (age 21+) with a disability that impairs mobility and then lists six other potential populations for PACE-like programming. While we are pleased that CMS may be considering a PACE model for all frail adults, not just elderly, we would prefer that frail not be limited to certain diagnoses or conditions. In the alternative, if CMS wishes to target specific populations, the proposed pilot should enable existing or new PACE Organizations to consider among multiple expansion populations to meet the needs of their individual service area and to permit sufficient enrollment to allow positive operating margin and sustainable programming.

PART 1: POTENTIAL ELEMENTS OF THE P3C MODEL

The P3C pilot proposes to expand traditional PACE eligibility to target individuals age 21 and over that have a mobility-impairment related diagnosis. While we support pilots that test expanded populations, this particular population does not have sufficient population to warrant a stand-alone application in our northwest Iowa service area. As such, we support the pilot but do not offer detailed comment; however, we do encourage CMS to review the Siouxland PACE / UnityPoint Health comments submitted during the proposed PACE rulemaking process and encourage that pilots do not contain provisions that impede the traditional PACE model.

PART II: ADDITIONAL POTENTIAL POPULATIONS FOR A MODEL TEST

CMS seeks input on six additional populations for pilot populations as described at a high level in rows 1 through 6 of Table A.

TABLE A – Proposed Populations

	MODEL Participants	Age 55+	Nursing Home Level of Care	Community Supports	Medicare	Medicaid
	Traditional PACE – frail elderly	X	X	X	X	X
1	PACE Light	X	n/a	X	X	optional
2	ESRD individual receiving dialysis treatment	n/a	X	X	X	optional
3	Individuals with severe and persistent mental illness	n/a	X	X	X	optional
4	Individuals with intellectual or developmental disabilities	n/a	X	X	X	optional
5	Veterans	n/a	X	through VA	X	optional
6	Rural residents + 1, 2, 3, 4 or 5	mirror 1, 2, 3, 4, or 5 requirements			X	optional

All proposed pilots make the dual eligibility for PACE pilot Participants optional – i.e. Medicaid coverage is not required. Since PACE operates as a three-way agreement between CMS, States, and the PACE Organization, the State’s role is uncertain when Medicaid is removed as an eligibility requirement. We are concerned that a shift from dual-eligible Participants will decrease State cost savings resulting from the PACE program and attributed to avoided nursing home placements covered by Medicaid. If States have reduced or no savings potential, what is their rationale for entering into such agreements? In addition, Siouxland PACE views our State Medicaid Agency as a valued partner and the State Medicaid Agency is our main point of contact for issues related to participant service delivery and quality of care, as opposed the CMS. For Medicare-only patients, this would require a separate Technical Assistance process, in which

the same potential issue would be addressed by different resources (CMS versus State Medicaid Agency) depending upon their payor status. For example, a quality of care issue would not be addressed our State Medicaid contact but would need to be addressed by our CMS contact for Medicare-only beneficiaries. This could result in inconsistent service delivery for Participants. Lastly, for existing PACE Organizations, Medicare-only beneficiaries are not individuals that we market to presently and we would need to adjust outreach strategies and community education accordingly.

The PACE Light population (#1) is the only proposed pilot population that maintains the traditional PACE model age requirement; however, PACE Light is a significant departure from current programming in that it targets the Participant's need for community support services without requiring a nursing home level of care. We support this pilot population as a glide path for traditional PACE Participants. On an annual basis, we have individuals who meet this pilot criteria – their health status is on a downward trajectory, but they do not require nursing home level of care criteria. We would advocate for a PACE Light pilot that incorporates service delivery flexibility, such as allowing PACE Organizations to offer a menu of services from which pilot Participants can select. Under this pilot, we envision circumstances whereby pilot Participants may select to receive only PACE day center services rather than a more comprehensive service package. We encourage CMS to work with current PACE Organizations and the National PACE Association to further identify this pilot population and assure that the regulatory framework enables service delivery flexibility.

Siouxland PACE already serves individuals proposed in pilot populations #5 (Veterans) and #6 (Rural Residents) that are age 55 and above. We should reiterate that Siouxland PACE has its origins as a CMS Rural PACE Development grant recipient, so a rural population is one that we are particularly adept at serving. As for Veterans, they are included within our Participants, but are not provided special programming based on this status. Siouxland PACE did request and receive a Veterans Administration (VA) Partnership Waiver. The VA Partnership Waiver authorizes Siouxland PACE to partner with the local Veterans Administration in Sioux Falls, South Dakota, for assistance when Veterans do not meet individual Medicaid requirements, providing an additional effort to serve the area Veterans. For both Veterans and Rural Residents, our services are beneficial and have been well received by these Participants and their families. We wholeheartedly support the inclusion of these two populations within a pilot to remove age limitations. Since these populations are currently being served by Siouxland PACE, we also recommend that any programmatic flexibilities for these pilots be extended to the traditional PACE model as well.

Siouxland PACE is extremely proud of the PACE brand and our services. We understand the desire to expand the traditional PACE model successes and best practices across service lines when feasible. That said, we have reservations about pilots that solely target populations with End Stage Renal Disease (ESRD) receiving dialysis treatment, persistent and severe mental illness, or intellectual or development disabilities. Although these condition-specific populations may be high cost and extremely appropriate for a capitated service delivery model, their conditions universally require specialized treatment and services, and the PACE Center model may not be appropriate, particularly when combined with traditional PACE Centers and their Participants (or even populations proposed in pilots #1, #5 or #6). As an existing PACE Organization, we would not be able to leverage much of our existing and extensive resources in support of these proposed populations. For these populations, the professional skill sets are different, the staffing and training needs are different, and the day centers may not be easily shared given inherent Participant differences. While it is possible for existing PACE Organizations to partner with established service providers to provide PACE services (i.e. partnership between PACE and ARC), governance for a joint program and its marketing to vastly diverse populations may create confusion. Instead of a partnership, it seems more likely that these pilots will result in new PACE Organizations being established as stand-

alone PACE Organizations to service narrow populations. Should communities support multiple separate condition-specific PACE Organizations? What impact will these new pilot organizations have on existing Traditional PACE Organizations in the same service area?

Catering to condition-specific populations also seems contrary to overall population health strategies, which are foundational to the traditional PACE model and individualized consumer-centric (and not disease-centric) care. The ESRD population has very specific medical treatment needs, which would benefit from a specialist-led IDT instead of an IDT led by a primary care provider. As for the persistent and severe mental illness and the intellectual or development disabilities populations, specialists as opposed to a PACE Medical Director may be the most appropriate medical leader for the IDT and care planning on an ongoing basis. These latter populations also have existing strong advocacy and service organizations in place and in many cases already have mature care coordination services and community-based service relationships. In addition, federal programming and funding is available to encourage de-institutionalization for these populations (for example, Money Follows the Person), and the CMS Innovation Center is piloting the Comprehensive ESRD Care Model and other general payment reform initiatives that may impact these populations. Before implementing these condition-specific PACE pilots, we recommend that CMS canvas other federal pilots and programming for these populations and seek stakeholder input from these experienced service providers to determine how best to model a capitated service delivery system.

On behalf of our PACE Participants, Siouxland PACE and UnityPoint Health appreciate the opportunity to provide input in response to this RFI. In addition, ***Siouxland PACE is a member of the National PACE Association (NPA). We support the comments submitted by NPA and are committed to participating with the NPA to further strengthen services and supports for the PACE population.*** Siouxland PACE and UnityPoint Health look forward to participating in future PACE rulemaking and other stakeholder forums. To discuss Siouxland PACE comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Executive Director of Regulatory Affairs, Government & External Affairs at cathy.simmons@unitypoint.org or 319-415-9229.

Sincerely,



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