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January 28, 2016

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
221 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Building
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Building
Washington, D.C. 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

Thank you for the opportunity to comment on the policy options put forward by the Bipartisan Chronic Care Working Group to improve care for Medicare beneficiaries with chronic conditions. InnovAge has been a provider of the Program of All-inclusive Care for the Elderly (PACE) since 1989, as one of the initial demonstration projects for PACE. There are currently 16 PACE programs in 32 states, serving about 35,000 mostly dually-eligible beneficiaries. We are the second largest provider of this program in the country, serving nearly 3,000 beneficiaries in Colorado, New Mexico and California.

Many of the options discussed in the paper highlight ways to improve care for chronically ill Medicare beneficiaries by advancing team-based care or expanding programs to help beneficiaries remain in their homes through the delivery of high-quality health care services. We see ourselves reflected in these goals: by offering cost-effective, high quality care to help clinically-complex, frail elderly beneficiaries remain safely in their homes, PACE is considered the gold standard care model for seniors and consistently garners high satisfaction and quality measure ratings.

Despite this reality, the growth of PACE has been limited since its inception. As a PACE provider organization committed to the growth of this model of care, we believe that a key impediment to continued expansion of PACE is operational inflexibility imposed by CMS. For example, CMS recently put new, cumbersome limitations on the PACE application process, such that PACE organizations only have four opportunities throughout the year to submit applications to establish new PACE programs or expand existing service areas. Similarly, CMS requires PACE organizations to undergo a lengthy waiver approval process for simple contract changes, such as the use of community physicians or nurse practitioners (a practice that is allowed by states, but not by CMS without a waiver). Perhaps the most notable example of operational

inflexibility is CMS' ongoing requirement that beneficiaries must wait until the first of the month to enroll in PACE – a difficult obstacle for beneficiaries who urgently need medical and social support as they transition out of an acute-care setting.

While we remain hopeful that some of these issues can be addressed through the rule-making process, legislation is likely needed in order to address some of these issues and to signal Congress' continued interest in nurturing this program. As you work to transform your draft options into a legislative work product, we urge you to consider adding several provisions that would eliminate barriers which inhibit the growth of this important program and would allow PACE to be an option for more of our frailest chronically-ill Medicare beneficiaries:

Medicare-only contracts. We recommend that access to PACE be improved for Medicare beneficiaries with chronic conditions by authorizing PACE organizations in states without PACE to operate under a contract with Medicare. Currently, PACE organizations can operate only in states that have added the PACE program to their state Medicaid plans and that agree to enter into three-way PACE program agreements with PACE organizations and CMS. Currently, 18 states have not elected to offer PACE as a state option and, in these states, no Medicare beneficiaries have access to the program. Further, some states have added PACE to their Medicaid plans, but are not authorizing new PACE programs to serve additional communities. As a result, in these states, Medicare-only beneficiaries' access to PACE is unnecessarily limited.

Part D Plan Selection. We recommend allowing Medicare-only beneficiaries who enroll in PACE to choose a distinct Part D plan, rather than requiring beneficiaries to enroll in the PACE organization's Part D plan. Because PACE is required to provide all Medicare and Medicaid benefits, a Medicare-only beneficiary is limited to the Part D plan offered by the PACE program for his or her prescription drug coverage. Medicare-only beneficiaries, unlike dual-eligible beneficiaries, are required to pay a monthly premium for their Part D coverage and should be able to select the Part D plan of their choice that best meets their needs and preferences.

Premium Flexibility for Medicare only beneficiaries. We recommend allowing PACE organizations more flexibility in determining the premiums charged to Medicare-only beneficiaries. Existing regulations limit PACE organizations' ability to establish the premiums charged to Medicare-only beneficiaries by requiring them to be set in accordance with the Medicaid rates paid for dual-eligible beneficiaries. This limits PACE organizations' ability to establish rates that reflect consumers' interest in rates based on the range of care they need. Generally, PACE Medicaid rates for dually-eligible individuals are not adjusted for risk or need. This flexibility would allow PACE to serve a significant proportion of chronically-ill Medicare beneficiaries who need a nursing home level of care but would prefer to remain safely in their homes.

Community Providers. We recommend requiring CMS to grant automatic waivers to allow PACE programs to utilize community providers. Currently, CMS requires a lengthy waiver process even though the practice is permitted by states and is necessary to grow the PACE program in under-served areas.

Mid-Month Enrollment. Finally, we recommend that PACE organizations be able to enroll beneficiaries into PACE at any point during the month on a pro-rated basis. Typically, beneficiaries and their families are making a decision about PACE enrollment when a beneficiary is transitioning from an acute-care setting to a more permanent care setting, such as a skilled nursing facility, a home-based setting with home-health services, or PACE, etc. For beneficiaries, these decisions may occur at any point during the month and the inability to enroll in PACE until the first of the month creates unnecessary barriers to enrollment. We urge the Committee to include a provision to allow mid-month enrollment into PACE.

The Committee's stated goals are to increase care coordination among individual providers, streamline payment systems to incentivize the appropriate level of care, facilitate the delivery of high quality care, improve care transitions, produce stronger patient outcomes, maximize efficiency, and reduce growth in Medicare spending. The Committee can achieve each of these objectives by encouraging greater access to PACE for Medicare beneficiaries, at capitation rates that are more attuned to beneficiary needs and properly reflect the resources required to allow these beneficiaries to choose to remain safely at home.

Thank you for the opportunity to comment on the Committee's work product. We believe that PACE can offer effective solutions for chronically-ill, complex Medicare beneficiaries. Thank you for your consideration of our recommendations. If you have questions, please contact me at 303-548-3246.

Sincerely,



Beverley Dahan
Vice President of Government and Legislative Affairs