November 29, 2019

The Honorable Richard Neal
Chairman
Committee on Ways and Means
U.S. House of Representatives

The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
U.S. House of Representatives

The Honorable Danny Davis
Co-Chair
Rural and Underserved Communities Task Force
Committee on Ways and Means
U.S. House of Representatives

The Honorable Jody Arrington
Co-Chair
Rural and Underserved Communities Task Force
Committee on Ways and Means
U.S. House of Representatives

The Honorable Teri Sewell
Co-Chair
Rural and Underserved Communities Task Force
Committee on Ways and Means
U.S. House of Representatives

The Honorable Brad Wenstrup
Co-Chair
Rural and Underserved Communities Task Force
Committee on Ways and Means
U.S. House of Representatives

Dear Chairman Neal, Ranking Member Brady, and Co-Chairs Davis, Sewell, Arrington and Wenstrup:

On behalf of the National PACE Association (NPA), please accept this letter in response to the Committee on Ways and Means Rural and Underserved Communities Health Task Force Request for Information (RFI).

NPA is a national organization representing 113 operating Programs of All-Inclusive Care for the Elderly (PACE) organizations in 28 states, and numerous additional entities pursuing PACE development and supportive of PACE. PACE organizations (POs) serve among the most vulnerable of Medicare and Medicaid populations—medically complex older adults over age 55 who are State certified as requiring a nursing home level of care. The objective of PACE is to maintain the independence of program participants in their homes and communities for as long as possible. POs currently serve over 51,000 participants nationwide.

Fully integrated, POs provide program participants with all needed medical and supportive services, including the entire continuum of Medicare- and Medicaid-covered items and services. In exchange for monthly capitated payments, POs assume full financial risk for the full range of community-based and, as needed, institutional services they are responsible for providing, either directly or through contracts with other community-based providers, hospitals, nursing homes, etc.

The hallmarks of this unique model of care are: the broad scope of services, the interdisciplinary team (IDT) and the PACE center. The person-centered PACE care model combines excellence in clinical care and care coordination from a dedicated staff of providers with the focus on quality and efficiency. The scope of services provided spans all Medicare Parts A, B and D benefits, all Medicaid-covered benefits, and any other services or supports that are medically necessary to maintain or improve the health status of participants. Door to door transportation, home care, personal care, meals and adult day services, among others, are provided routinely to

participants. Members of the IDT practice at the PACE center, and participants receive primary care, therapy, meals, recreation, socialization and personal care there, among other services. Care and services also are provided at home as appropriate. Under PACE, typically fragmented health care financing and delivery systems come together to serve the complex biopsychosocial and medical needs of these frail, elderly and disabled patient populations.

For example, many PACE participants live with dementia, diabetes, congestive heart failure, and vascular disease among other chronic conditions; on average PACE participants have six chronic conditions. While PACE staff do their utmost to provide care in the PACE center and at home, at times a participant's condition may warrant admission to hospital or skilled nursing facility, the cost of which is covered by the PO. During these stays, PACE staff remains involved, actively planning for and managing the discharge transition and follow up care. IDT members ensure transportation home is arranged, as well as for any follow up care needed at the PACE center or elsewhere—which is critical for residents of rural and underserved areas where availability and costs of transportation may be significant challenges. The IDT also plans for and makes sure any other post-discharge needs are addressed, such as medication, home care, durable medical equipment, meals and the like. The substantial, hands on care rendered by PACE staff results in better outcomes as well as decreased anxiety for participants and their families over care expenses and access.

Identified as an evidence-based care model by the Administration for Community Living, PACE programs achieve high quality outcomes for the participants as well as for Medicare and Medicaid. Despite being at the nursing home level of care, participants enrolled in PACE experience a low risk of long-term nursing home admission; in fact, 95 percent of participants live in the community. Furthermore, lower rates of hospitalization, readmission and potentially avoidable hospitalization were found among PACE enrollees than in similar populations. The hospitalization rate was 24 percent lower than that for dually eligible beneficiaries receiving Medicaid nursing home services. For readmissions, the rate for PACE participants was 16 percent less than the national rate of 22.9 percent for dual eligibles 65 years of age and older. For potentially avoidable hospitalizations, the rate for PACE participants was 44 percent lower than that for dually eligible Medicaid nursing home residents. And for emergency department visits, the incidence rate is lower than one visit per participant, per year.

As our nation ages, Congress and the Administration should foster increased interest in high quality, cost-effective and evidence-based models of care. A recent WebMD/John A. Hartford study found that the number of Americans 65 years of age and older is expected to comprise close to 25 percent of our nation's population by 2060, up from 16 percent today (52 million). In rural counties, older Americans make up 18 percent of the population in contrast to 15 percent of suburban counties and 13 percent of urban counties reports the Pew Research Center. The sheer magnitude of the baby boomers could have a significant effect on rural areas over time according to the U.S. Census Bureau. There is a clear preference among rural adults to remain at home as they age – 73 percent per a 2018 AARP study. However, rural elders as compared to their urban peers face notable challenges- lower income levels, more chronic diseases and increased use of long-term care services and supports. PACE is a proven method of surmounting these challenges for high need older Americans and those living with disabilities both in rural and urban settings. Please find below our responses to several of the specific information requests contained in the RFI.

2. What successful models show a demonstrable, positive impact on health outcomes within rural and underserved communities?

PACE is a proven approach to addressing the comprehensive needs of older adults, inclusive of medical care, functional support and social determinants of health for high cost, high need older Americans and those living with disabilities. Congress recognized the potential of PACE to serve rural areas by providing start-up funds for PACE organizations in rural communities. HHS reported to Congress on this effort that "PACE programs benefit rural areas in a multitude of ways, affecting not only the beneficiaries, but also their families and local communities." Today 11 organizations that received those funds are joined by an additional 9 organizations serving rural communities. These POs and 111 others nationwide examine the needs of their participants holistically via IDTs, which then devise and execute comprehensive, person-centered plans of care. All medical and social needs of participants 24 hours a day, seven days a week, 365 days a year are met through care and services delivered both in the PACE center and at home. The capitated funding methodology used by PACE allows for unprecedented flexibility for POs in meeting medical and other needs in creative ways. Providers drive care and coverage decisions, and thus are empowered to nimbly combine preventive, acute and long-term care services/supports to best meet the needs of each participant. These efforts result in positive outcomes. When compared to nursing home patients and home and community-based service recipients, PACE participants experienced lower mortality rates and were less likely to be in a nursing facility according to a HHS report.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

Numerous communities have worked with local health and social service entities to establish PACE. This comprehensive, integrated and coordinated model of care ensures all appropriate care is received daily by participants. Having a participant come in to the PACE center facilitates socialization and interaction, decreases isolation, and improves nutrition. Capitated financing enables POs to focus on the provision of high-quality care. All-inclusive, person-centered care plans constructed and executed by the high-touch PACE IDT prevent lapses in care provision, regardless of setting or provider. By integrating Medicare and Medicaid coverage, POs provide all preventive, acute, or long-term care or supports needed by a participant to achieve their highest level of functioning. These interventions often result in either the reduction or elimination of hospital and nursing home admissions. But when there is such an admission, PACE staff actively manage the transition home so that the participant's care is seamless. "[T]he rural PACE program preserves, enhances, and, in many cases, restores the independence, health and well-being of its participants [,]" HHS stated to Congress. "PACE also reduces burden among family care-givers . . . . PACE both creates full time jobs and also fortifies local small businesses to stimulate the economy of rural America. This report finds overall favorable experience by beneficiaries, communities and the rural PACE pilot sites[.]" Furthermore, participants shared with HHS that "they had been depressed and lonely before coming to PACE; they felt that PACE saved their lives and helped them feel like life was worth living again."

NPA Recommendations for Improving Care Delivery and Health Outcomes in Rural and Underserved Communities

1. CMS Should Implement PACE-Specific Pilots

Now there are roughly 20 rural PACE programs across the nation, and many urban POs endeavor to reach underserved older Americans and those living with disabilities. But to fully explore the applicability of the PACE model of care to new populations residing in rural and underserved areas, NPA recommends that Congress urge CMS to initiate additional PACE pilots. Current eligibility requirements restrict PACE access to individuals who are age 55 or over and require a nursing home level of care. The PACE Innovation Act of 2015 (P.L. 114-85) authorized CMS to test the PACE model with new populations, such as younger people with disabilities, individuals at risk for needing nursing home care and others. CMS released Requests for Information (RFIs) in December 2016 and July 2017 regarding the initiation of PACE-specific pilot for people living with mobility deficits across the lifespan. However, since then the agency has not taken any further action on other PACE- specific pilots. NPA understands that the Center for Medicare and Medicaid Innovation (CMMI) at present is not undertaking any efforts towards the initiation of PACE-specific pilots. NPA is gravely concerned that in the absence of pilots based on the PACE care model to test PACE innovations, opportunities to help serve new medically-complex populations particularly in rural and underserved areas will be missed.

NPA has assembled a series of videos entitled, "Before I Found PACE." One of the videos features the experience of rural elders Terri Ann and Leon Dirteater with Cherokee Elder Care PACE in Tahlequah, OK; to view the video click here. NPA, in conjunction with The John A. Hartford Foundation and West Health, has launched an initiative entitled PACE 2.0 to facilitate the spread and scale of PACE. The project seeks to identify underserved subpopulations currently eligible to enroll in PACE, as well as new unserved populations that could benefit from the PACE model. To meet the needs of these individuals, the project will support the development of strategies to scale PACE operations and spread the model to more communities. The goal is to achieve a five-fold increase in those served by PACE and promote implementation of the strategies developed.

2. Direct the Health Resources and Services Administration to Clearly Include PACE Programs as Eligible Entities for Grant Programs and Other Initiatives

One strategy NPA recommends to improve care delivery and outcomes in rural and underserved areas is for Congress to direct the Health Resources and Services Administration (HRSA) to clearly include PACE programs as eligible entities for their grant programs and other initiatives. These efforts would empower HRSA to implement in rural and underserved areas promising practices and evidence-based approaches to address health disparities and enhance population health—such as PACE. Examples include:

- Ensure the Federal Office of Rural Health Policy considers PACE programs to be eligible to participate in the Rural Health Network Development Planning Program, the Rural Health Network Development Program and the Rural Health Care Services Outreach Grant Program, among others. Partnerships between PACE organizations, Critical Access Hospitals, Federally Qualified Health Centers and other provider entities should be encouraged.
- Instruct the Bureau of Health Workforce to include PACE programs operating in health professions shortage areas as auto-approved National Health Service Corps (NHSC) sites. Then POs designated as such sites may employ health professionals receiving NHSC loan repayment and scholarship assistance.
- Encourage the Office for the Advancement Telehealth to include PACE programs as eligible providers for Telehealth Network Grant Program, among other initiatives.

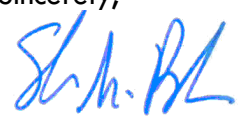
3. Increase Access to and Affordability of PACE for Medicare-only Beneficiaries
Another strategy NPA recommends to improve care delivery and outcomes in rural and underserved areas is to increase the affordability and accessibility of PACE for Medicare-only participants.

- ***Allow Medicare-Only Beneficiaries Who Enroll in PACE to Choose a Distinct Part D Plan Rather Than Requiring Them to Enroll in the Part D Plan of the PACE Organization***
  PACE is required to provide all Medicare and Medicaid benefits to a participant. Therefore, a Medicare-only beneficiary is limited to the Part D plan offered by the PACE program for prescription drug coverage. Unlike dually-eligible beneficiaries, Medicare-only beneficiaries must pay a monthly premium for Part D coverage. As such, they should have the freedom to select the Part D plan of their choice. Greater selection and flexibility are critical so that Medicare beneficiaries may receive the Part D coverage best suited to their medical and financial needs.
- ***Allow PACE Organizations More Flexibility in Determining the Premiums Charged to Medicare-Only Beneficiaries***
  Existing regulations limit the ability of PACE organizations to establish the premiums charged to Medicare-only beneficiaries since the amounts must be set in accordance with the Medicaid rates paid for dual-eligible beneficiaries. This requirement unduly limits the ability of PACE organizations to establish rates reflecting consumers' interest in differentiated rates based on the range of care needs within the nursing home level of care population. With few exceptions, PACE Medicaid rates for dually-eligible individuals are not adjusted for risk or need.
- ***Authorize PACE Organizations in States Without PACE to Move Forward Under a Contract with Medicare***
  Currently, PACE organizations can operate only in states that have added the PACE program to their Medicaid plans and agree to enter into three-way PACE program agreements with PACE organizations and the Centers for Medicare & Medicaid Services (CMS). To date, 18 states have not elected PACE as a state option, so Medicare beneficiaries do not have access to the program in those states.

In closing, NPA looks forward to working with Chairman Neal, Ranking Member Brady as well as Task Force Co-Chairs Davis, Sewell, Arrington and Wenstrup in improving the access and affordability of care for older Americans and those living with disabilities in rural and medically underserved areas of our nation. We cordially invite you and your staff to tour a PACE program and experience this unique and innovative model of care firsthand.

NPA appreciates the consideration of our comments; should you need additional information, please contact Francesca Fierro O'Reilly, Vice President, Advocacy, at either FrancescaO@npaonline.org or 703-535-1537.

Sincerely,



Shawn M. Bloom
President and CEO