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Mr. Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

RE: File code CMS-4168-P

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) notice of proposed rulemaking: **Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE)**. The proposed rule would revise and update the requirements for PACE plans. We appreciate your staff's ongoing efforts to administer and improve the PACE program, particularly considering the competing demands on the agency.

The comments of the Commission do not pertain to the specifics of the regulation, but to the potential for expansion of the PACE program resulting from a number of factors, including

- The proposed rule, aspects of which aim to streamline the operations of PACE plans and reduce the administrative burden on plans (provisions to which we do not object);
- The effectuation of the provisions of sections 1894(a)(3)(B)(ii) and 1934(a)(3)(B)(ii) of the Social Security Act, which allow for-profit PACE plans, based on a Congressionally mandated study that concluded that there were no material differences between for-profit and not-for-profit PACE plans; and
- The expanded demonstration authority provided for in the PACE Innovation Act of 2015, which allows the Center for Medicare and Medicaid Innovation to test innovations in the PACE program.

With respect to the possible types of PACE demonstrations, one potentially large expansion would be the extension of PACE to beneficiaries under the age of 55. CMS, in its 2013 and 2014 reports to the Congress by the Medicare-Medicaid Coordination Office, noted that it had proposed legislation to lower the age of PACE eligibility to 21, but in its 2015 report the agency noted that a

legislative change was not being recommended because the agency was assessing “opportunities to test PACE-like models, including for younger adults with disabilities,” through the new demonstration authority.¹

As outlined in the Commission’s 2012 report to the Congress,² the Commission supports the PACE program as a means of providing coordinated care to a vulnerable population that might otherwise reside in institutions. The PACE program has shown good results, and because the program enrollment has been relatively small and more beneficiaries could be expected to benefit by enrollment in PACE, the Commission recommended ways to increase PACE enrollment—for example, by lowering the age of eligibility for PACE. However, the recommendations for expansion were conditioned on implementation of the first recommendation that the Commission made with respect to PACE, which was to reform the PACE payment system.

The PACE payment system is different from the payment system for Medicare Advantage (MA) plans. PACE plans were specifically excluded from MA payment reforms in the Patient Protection and Affordable Care Act of 2010 (PPACA), and PACE plans were not included in the MA quality bonus program. Medicare continues to pay PACE plans using pre-PPACA benchmarks, with the double payment for indirect medical education continuing to be incorporated in the PACE payments. Our analysis indicates that, with the current county distribution of PACE enrollment, PACE benchmarks are at approximately 120 percent of county fee-for-service (FFS) expenditure levels. If PACE enrollees were in MA plans, or if PACE benchmarks were the same as those applicable to MA, the benchmarks would be at approximately 102 percent of FFS. If an expanded PACE program continued these enrollment patterns, Medicare would incur higher program expenditures for each new PACE enrollee. The Commission recommended that the PPACA MA payment reforms be applied to PACE, and that PACE plans should be eligible for quality bonus payments (which could raise the PPACA benchmarks for PACE enrollees to 107 percent of FFS from 102 percent).

In our 2012 report to the Congress, the Commission estimated PACE benchmarks at that time to be 17 percent higher than FFS on average. The report also noted that the 17 percent figure would be affected by the degree of accuracy of the risk adjustment system applied to PACE payments, and that in the risk adjustment system expenditures for some categories of beneficiaries were under-predicted and some were over-predicted. In September 2013 the Commission reported that the accuracy of the risk adjustment for MA plans would be improved by having separate adjustment factors for dually eligible Medicare-Medicaid beneficiaries based on the nature of Medicaid eligibility.³ That is, there should be separate adjustments for those with full dual eligibility status (with full Medicaid coverage) and those with partial dual status (assistance with Medicare premiums or cost sharing only). CMS has implemented this change to the risk adjustment system for MA plans, but PACE plans remain under the prior system. The prior system uses a single

¹ Department of Health & Human Services, Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office. *Fiscal year 2013 report to Congress* (and idem for 2014 and 2015).

² Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

³ <http://medpac.gov/docs/default-source/meeting-materials/september-2013-meeting-presentation-issues-for-risk-adjustment-in-medicare-advantage.pdf?sfvrsn=0>

Medicaid risk adjustment factor for all types of Medicaid beneficiaries. It is likely that this system results in an under-adjustment of payment rates for PACE enrollees, because virtually all PACE enrollees are fully dually eligible (98 percent in 2014), and because fully dual-eligible enrollees are higher-risk enrollees than those with partial dual status. In the MA payment rate announcement for 2017, CMS stated that at a future date it would examine whether to change the PACE risk adjustment system based on dual eligible status. Addressing the issue may also obviate the need for a frailty adjuster for Medicare's PACE payments. If the current high benchmarks for PACE plans are considered an implicit means of compensating for possible under-prediction in the risk adjustment system, we believe that the preferred way to address this issue is through refinements to the risk adjustment system, rather than maintaining an across-the-board higher level of benchmarks.

While the changes that the Commission recommended for PACE payment in our 2012 report to the Congress would require legislation, such changes could be tested through a demonstration. As reiterated in the Senate report to accompany the PACE Innovation Act of 2015, demonstration authority under section 1115A of the Social Security Act is used to test "innovative payment and delivery models to reduce program expenditures."⁴ We would encourage CMS to consider using a payment model that is different from the current PACE payment model and which would not result in additional program expenditures for enrollees of PACE demonstration plans.

Conclusion

The Commission appreciates the opportunity to comment on the proposed rule and to call attention to the recommendations the Commission has made with a view towards expanding the PACE program. We also value the ongoing cooperation and collaboration between CMS and Commission staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of these comments, please feel free to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,



Francis J. Crosson, M.D.
Chairman

⁴ S. Rept. 114-108—A bill to amend Title XI of the Social Security Act to clarify waiver authority regarding programs of all-inclusive care for the elderly (PACE programs). July 30, 2015.