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February 10, 2017

Patrick Conway, MD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-PACE Innovation Act Request for Information
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically at MMCOcapsmodel@cms.hhs.gov

Re: CMS-PACE Innovation Act Request for Information

Dear Acting Administrator Conway,

Trinity Health appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) Programs of All-Inclusive Care for the Elderly (PACE) Innovation Act Request for Information (RFI). Our comments and recommendations to CMS reflect a strong interest in advancing innovation and public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. Trinity Health includes 93 hospitals, as well as 120 continuing care locations that include PACE, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns almost $1 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with Graduate Medical Education (GME) programs providing training for 2,080 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 97,000 full-time employees, including more than 5,300 employed physicians, and have more than 15,000 physicians and advanced practice professionals committed to 19 Clinically Integrated Networks across the country.

Trinity Health PACE — a National Health Ministry of Trinity Health — is the largest sponsor of PACE organizations in the country. Trinity Health PACE operates 13 programs in nine states across five CMS regions, including Regions 1, 2, 3, 4 and 5. These Trinity Health PACE programs serve over 3,500 participants nationwide.

We thank CMS for the opportunity to comment on this RFI. If you have any questions on our comments that follow, please feel free to contact me at wellstk@trinity-health.org or 734-343-0824.

Sincerely,

Tonya K. Wells
Vice President, Public Policy & Federal Advocacy
Trinity Health

General Comments

The PACE Innovation Act of 2015 allows for the Center for Medicare and Medicaid Innovation (CMMI) to develop and oversee PACE-like models for new populations. As the largest sponsor of PACE organizations in the country, Trinity Health understands the role this program plays in helping frail, elderly individuals remain in the community by meeting their needs through individualized and comprehensive care. Expanding and adapting the PACE model to a broader range of populations could bring this same approach to other high-need individuals.

Trinity Health is a national leader in payment and delivery reform and innovation across Medicare, Medicaid, and commercial payers. Along with other members of the private sector group called the Health Care Transformation Task Force, we have committed to transitioning 75 percent of our business to value-based payment models by 2020. Trinity Health is currently participating in 16 Medicare Shared Savings Program (MSSP) ACOs and has five markets partnering as a Next Generation ACO. In addition, Trinity Health has 43 hospitals participating in the Model 2 Bundled Payments for Care Improvement (BPCI) initiative, 13 Skilled Nursing Facilities (SNFs) in Model 3 BPCI, and two hospitals in the Comprehensive Care for Joint Replacement (CJR) program. Our work extends beyond Medicare as illustrated by our participation in 98 non-CMS Alternative Payment Model (APM) contracts. We are firmly committed to transforming our delivery system into a People-Centered Health System. Our commitment to innovation extends to the PACE program – and we support CMS' efforts to test and expand PACE-like models that could benefit more individuals. We urge CMS to consider the learnings of the Financial Alignment Initiative and other CMMI initiatives including ACOs and BPCI when developing this model.

Providing a learning laboratory to test a wide variety of value-based care models is critical, but it also takes significant time and investment. Providers need a viable path to develop the capabilities needed to manage this risk and the assumption of such risk requires early success to maintain sustainability of continued participation. **All stakeholders – providers, CMS and states – need enough time for learning what payment mechanisms, including benchmarking methodologies, will best support the needed changes in care delivery. A capitated payment model is an important component of this opportunity for change, but providers need adequate support. This includes support for capital investments, inclusion of waivers, and limited or no down-side risk exposure.** We urge recognition of the significant investment of capital that is required to redesign care delivery to improve beneficiary health, and encourage CMS to provide up-front funding for organizations to adapt and make important infrastructure investments that would be needed to support PACE-like models. We also caution that expansion does not go too far outside of the PACE program's core strengths and competencies and that full waiver authority is included. Lastly, we urge that risk be phased-in and that down-side risk be limited.

Specifically, we ask that CMS:

1. **Design the P3C and other pilots to help PACE evolve and innovate, but ensure they are viable for a broad range of existing organizations to participate**, especially those that are non-profit and have limited capital, and that full waiver authority is included.
2. **Design P3C and other pilots with clear parameters, and consider a phased-in approach of certain components** (e.g. assumption of risk, expansion of PACE to less traditional populations or ages), which may allow for broader participation.

Our comments below provide more detailed suggestions in support of these recommendations.

Build on PACE Programs Core Strengths and Competencies in Initial Pilots

Trinity Health recommends that CMS better define the target populations in order to build on current PACE experience – and to successfully advance the model moving forward. Based on Trinity Health's long-established experience in PACE, we strongly urge that any PACE pilots be designed so that existing PACE organizations – especially non-profits with limited capital – are able to evolve the model and build on the current capabilities and strengths. We strongly support innovation and the testing of promising models, but also recommend that pilots be structured in a way that allows for a broad range of PACE organizations to participate and test the model and approach with new populations. For example, early PACE-like pilots could focus on populations with physical disabilities, or individuals with specific diagnoses such as a behavioral health condition, but allow for flexibilities depending on community need.

Operationally, there are also many issues that each PACE program must address to participate in a pilot. For instance, changes in staffing requirements are likely to be needed for new populations with different clinical needs relative to the geriatric populations PACE programs serve today. Also, changes will need to be made to Interdisciplinary Teams (IDTs), as well as local community partnerships in order for current PACE programs to be able to participate in the pilot programs considered in the RFI.

Trinity Health recommends that CMS consider stratifying pilots based on program participant characteristics, including age, in order to address the unique clinical and socio-demographic needs of various populations. Those below 55 years of age will have different needs – requiring tailored IDTs, services, and supports. We also ask that CMS ensure that P3C and other pilots allow for – and promote – beneficiaries gaining independence. A pilot, for example, to better serve populations with behavioral health needs would greatly benefit from the PACE core concepts and person-centered approach; however, these populations have unique recovery needs and a pilot should incentivize care providers to successfully recover participants and discharge them from the program. Strategies to foster and build independence for populations participating in PACE programs may require that the target population be clearly, and narrowly defined – at least initially to ensure that appropriate program design features are included to address the clinical needs of potentially discrete population groups.

Additionally, we believe that organizations should have the flexibility to modify care delivery, as necessary, to ensure the pilot's continued success. **A capitated payment model is an important component of this opportunity for change, but providers need adequate support. This includes support for capital investments, inclusion of waivers, and limited or no down-side risk exposure.** We recommend that waiver authority be maintained, and not limited to the application process and Program Agreement, as it would be difficult to fully anticipate future needs during the application cycle. We also request that in addition to the program waivers identified in the RFI, that CMS expand the list of waivers including those for Habilitation Support. We suggest that CMS consider how this additional program waiver, and others, could further support implementation of the proposed P3C model.

Design Parameters for PACE Pilots Should Be Clearly Defined

In general, Trinity Health asks that CMS set appropriate, clearly defined parameters that allow programs to successfully expand and adapt the PACE model. We believe that clear design parameters will help programs both accurately determine their capacity to participate and also identify the functions that need to be developed to care for beneficiaries. Again, CMS could begin by more narrowly defining the target populations as the pilot begins to ensure programs feasibly address population-specific needs and that programs clearly measure beneficiary impacts and outcomes. CMS should also set clear expectations and requirements for the level of social support services (e.g. transportation, other non-medical supports) P3C participants receive relative to those that are residing in the community. Because PACE centers are configured differently from community-based programs, PACE programs would have to assess the level of change needed to meet the social support services required for a population with physical disabilities. Trinity Health also asks that CMS provide clarity on any community integration requirements in a pilot given the coordination, payment, and other issues that will emerge if PACE organizations must make non-medical supports available to the broader community.

We also ask CMS to consider allowing programs flexibility in the populations they enroll, including limiting or phasing in populations, to ensure pilot participants can adequately address the medical and social support needs of new populations. This approach would ensure that programs would be serving beneficiaries for whom the program could establish the appropriate supports and services. While these types of approaches could make evaluation more challenging, it could also boost participation and ensure beneficiaries' needs are appropriately addressed. Clearly defining target populations will help programs assess the changes in capacity, skill-set and financial resources needed in order to participate in the pilot program.

CMS should also select populations based on gaps in the current community-based care continuum to ensure that PACE-like pilots or models do not duplicate – but instead allow for closer collaboration with – the work of existing service and payment systems, such as community-based mental health centers (CMHCs). Lastly, clearly delineating populations is also important to ensure appropriate eligibility determinations and enrollment in pilots versus the traditional PACE program. Allowing for flexibility in determining the unique needs and populations across communities, through any CMS pilot solicitation, would be recommended.

Trinity Health also recommends that CMS ensure that any evaluation of PACE pilots be based on appropriate metrics for the program and population. Evaluation methods should include patient-reported outcome measures (PROMs) and incorporate improvement and health status measures, especially for specific populations for whom improvements in condition may be a goal. We have found that measurement, data sharing, and performance feedback are essential to successful innovation.

Lastly, we ask that CMS limit or phase-in risk to those programs participating in pilots, especially given that the majority of PACE organizations have limited resources, and will have upfront costs related to redesigning IDTs, structures, and addressing staffing and care needs for new populations and conditions. Specifically, we strongly recommend that CMS maintain any risk stabilization programs, such as stop-loss and risk corridors, for the duration of the pilot. This is especially critical as pilot participants begin to care for new populations where costs from untreated conditions or needs that have not been addressed may be difficult to predict. We believe these are critical design components to increase the ability of not-for-profit organizations to participate and ultimately the ability to realize better health, better care and lower costs.