January 13, 2023

The Honorable Bill Cassidy, M. D
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Thomas R. Carper
513 Hart Senate Office Building
Washington, DC 20510

The Honorable Tim Scott
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
703 Hart Senate Office Building
Washington, DC 20510

The Honorable John Cornyn
517 Hart Senate Office Building
Washington DC, 20510

The Honorable Robert Menendez
528 Hart Senate Office Building
Washington DC, 20510

Sent electronically to: dualeligibles@cassidy.senate.gov

Dear Sens. Cassidy, Carper, Scott, Warner, Cornyn, and Menendez:

Thank you for the opportunity to share our views on ways to improve the health care system and outcomes for individuals who are dually eligible for Medicare and Medicaid and for your work improving care for this population.

The mission of LeadingAge is to be the trusted voice for aging. We represent more than 5,000 nonprofit aging services providers and other mission-minded organizations that touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old.

Our comments reflect the perspective of providers of post-acute care, long-term services and supports (LTSS), and home and community-based services (HCBS). We also have providers who lead their own Medicare Advantage (MA) plans, Special Needs Plans (SNP), PACE programs, and other integrated models. Therefore, the focus of our remarks will be on the impacts of dually eligible older adults who our members serve in various residential and community-based settings.

LeadingAge published its own thought leadership on the topic of integrated services back in 2016. Our paper outlined key components of an integrated model but envision it for all of us as we age. As you deliberate on the best reforms to achieve true integrated care for dual eligibles, we encourage you to consider solutions that create an integrated option for both dual eligibles enrolled in managed care plans, as well as those who continue to receive their benefits via Medicare and Medicaid fee-for service

(FFS) including those assigned to various Center for Medicare and Medicaid Innovation models (e.g., Accountable Care Organizations, etc). Retaining this key tenet of beneficiary choice will help spur competition between plan-led and provider-led models of care and in turn, further innovation in pursuit of integration and better outcomes.

Let's start with what doesn't work. The fragmentation – both services and money -- within the current health care system is well documented. For a dual eligible, it is like going to a restaurant for dinner, but you have to order from multiple menus to get a full meal and then are expected to pay in different currencies and some of your selections can't be paid for with certain currencies. This is the situation dual eligibles often face trying to determine what services they can receive and who pays for them.

Not all Americans automatically become ill or develop cognitive or physical impairments at age 65. However, nearly 80% of adults who are 65 and older will develop a chronic condition sometime during their lifetime, and about half will eventually lose their ability to care for themselves because of physical impairments and/or cognitive decline.[1]

With frailty comes an array of needs for ongoing services and supports that address medical needs while supporting an individual's ability to carry out daily activities like bathing, dressing, and grooming, cooking, paying bills, and cleaning and maintaining the place they called home.

Older adults who experience frailty, typically, require an increasing number of visits to primary care physicians, specialists, and services from LTSS providers. These growing needs typically come at a time when older adults find themselves living with diminished financial resources, as they retire from full-time work and begin relying on accrued savings.

Today, families and older adults often are ill-prepared for this stage of life. They have no single or unbiased source of information to help them understand and evaluate the availability, quality, and cost of services. As a result, they have difficulty making proactive, informed, and meaningful choices that weigh the costs and benefits to meet the older adult's needs most effectively.

To make matters worse, our system rarely fosters communication and coordination among providers of services and supports. Nor does it encourage the development of an overarching aging service plan that follows the individual across settings. Without this coordination, care and services become fragmented. Resulting gaps can lead to personal hardship and unnecessary hospitalizations.

Some duals also face issues of cycling on and off Medicaid. None of this leads to integrated care or a holistic approach to care when coverage is not consistent nor clear. Further complicating the situation is myriad programs a dual may be enrolled in from Medicare FFS to a Medicare Advantage/Special Needs Plan to an Accountable Care Organization or Medical Home, and their Medicaid benefits may be provided by another managed care plan or through FFS.

Dual eligibles' needs are not neatly segmented into Medicare services and Medicaid services. Instead, we need to think of a dual eligible individual as a whole person. In this context, **integrated care** occurs where there is one pot of money to budget for the dual eligible's needs, one comprehensive care plan that identifies those needs and how to address them, one interdisciplinary service team (IDT) who

[1] Favreault, M. M., & Dey, J. (2016). Long-Term Services and Supports for Older Americans: Risks and Financing. Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/106211/ElderLTCrb-rev.pdf

coordinate and collaborate to address the needs of the whole person not a single diagnosis, and one service navigator who is a dual eligible's first point of contact to connect them to the right people and places to get their needs met.

Care coordination is a strategy utilized both within integrated care models and other at-risk care models. Care Coordination often assigns a care coordinator or manager to an individual. Today, an individual may have more than one care manager assigned by different parts of the health care system. Ideally, care coordination would assign a single person/entity (e.g., navigator) to be a conduit between the individual and their service providers. Care coordination is successful when an individual's providers collaborate, communicate, and coordinate the care and services needed to address the individual's needs and think about the person holistically. To incentivize, the important collaboration, all providers must be eligible to be reimbursed for the time they dedicate to care coordination activities. This can be achieved by setting up an appropriate billing code, as has been done for physicians.

Aligned enrollment is a tool that ensures a dual eligible receives coordinated and integrated care through a single entity –plan or provider organization – that is financially and clinically required to cover services to address their identified needs. Within the context of managed care, enrollment is aligned when a dually eligible individual is enrolled in a single managed care plan owned and operated by one managed care organization and that plan provides coverage for both Medicare and Medicaid services.

The integrated service model that LeadingAge envisions begins with the needs of the older adult not from a medical or symptomatic perspective and requires both care coordination and aligned enrollment. It would deliver a holistic set of services and supports at the community level to all older adults, not just those with high needs and high costs. With this broader population focus, the ultimate goal is to prevent or slow the number of older adults with high costs and high needs, including slowing their need for Medicaid or other public financing.

The integrated service model would be implemented by an organized, community-based "hub" of providers working collaboratively to deliver services and supports to individuals. The hub could be directed by any group of providers not just a health plan, hospital, health system, or doctor but also a community based LTSS provider. Similar to Accountable Care Organizations (ACOs) that have individuals attributed to them based on where they receive the most services, a person could be assigned to a hub and a service navigator based upon where they receive the majority of services. For example, an individual who receives help with bathing, dressing, and grooming, medication management and meals from an assisted living or long-stay nursing home, could be assigned a service navigator from that site of service as it provides the bulk of the person's services on a daily basis since that site of service already coordinates with all of that person's other providers. Providers in the hub would be financially aligned to work together across services and settings and employ a person-centered approach to addressing each person's needs in a comprehensive way. We discuss possible vehicles for delivery of this vision below.

Models that Show Promise

The good news is there are many existing examples and programs from which to build an integrated model. We have identified those systems or programs that already encompass most or all of the vision we've outlined here. We summarize these programs below and include links to additional details about them and their outcomes.

- **TANDEM365:** Is an example of a multi-provider partnership that delivers integrated care for high-need, high-cost individuals enrolled in certain health plans. It provides evidence that these

models can be provider led and the funding integration can come through a managed care entity that then contracts with other providers in value-based arrangements.

TANDEM365 was established in 2009 by two LeadingAge members seeking to reduce hospital readmissions by closing service gaps for older adults who are age 55 and have complex care needs and high costs. Today, this in-home integrated care model is delivered by four LeadingAge members who are competitors, and a local ambulance company.

Like LeadingAge's proposed integrated service model, TANDEM365 takes a team approach to customizing care for the older adult. The model also provides a single point of contact—a nurse or social work navigator— who helps the older adult access needed services and supports so he or she can remain at home. Like the LeadingAge model, TANDEM 365 features an aging service plan (called a "life plan") that the interdisciplinary team develops in collaboration with the older adult.

TANDEM365 delivers non-traditional services that are not typically reimbursed by insurance plans. These include:

- Meals.
- Transportation.
- Telehealth.
- Personal emergency response systems.
- Personal care.
- Navigators who attend doctor visits or meet an older adult in the ED, when necessary.
- Round-the-clock rapid-response support from an emergency medical services team.

Commercial payers have acknowledged TANDEM365's three primary values: lower cost, satisfied members, and improved outcomes. One payer, PriorityHealth, initially helped pilot the program among plan members whose health care spending exceeded $25,000 per year. PriorityHealth paid $625 per month for every member participating in TANDEM365.

The initial pilot showed these results for the program's high-touch, in-home services:

- Inpatient hospital stays reduced by 38%.
- ED visits reduced by 52%.
- Overall total cost of care lowered by 35%.[2]

Following the successful pilot, PriorityHealth penned a three-year contract to continue its partnership with TANDEM365 through a new, risk-sharing arrangement. TANDEM365 was also asked to pilot its program with Blue Care Network of Michigan.

[2] This data is pulled from a 2014 Plante Moran report on the program.

As the program has grown, it continues to show promising results. In 2018, TANDEM365 interventions resulted in participants experiencing:

- Lower Emergency Room use -- 4.4% for TANDEM365 participants compared to 11.88% for average Michigan Home Health participants

- Fewer hospitalizations -- 4.43% vs. 14.98%

- **Financially Integrated Dual Eligible Special Needs Plans** – While there are a variety of Special Needs Plans (SNPs) that a dual eligible may choose, we believe that Financially-Integrated Dual Eligible Special Needs Plans show the greatest opportunity to ensure an integration approach to addressing their needs. This is because to achieve integration via a SNP the following conditions are necessary to overcome the systemic fragmentation duals experience: the SNP must serve duals, must have a contract with the state Medicaid agency to provide Medicaid services, and those Medicaid services must be comprehensive including long-term services and supports and behavioral health. In addition, it requires a single managed care entity to cover all Medicare and Medicaid services and integrate a capitated Medicare and Medicaid payment. True integration requires financial, administrative, and clinical integration. It can only be achieved through a single pot of money, single set of rules and a single at-risk entity.

- **Program for All-Inclusive Care for the Elderly (PACE):** The fully integrated, comprehensive care model—available to qualifying Medicare and Medicaid beneficiaries and private payment individuals currently serves more than 60,000 individuals in 32 states and is a provider-led model. This model has been highly successful in delivering a fully- integrated experience for dual eligibles in the community, however, as the Bipartisan Policy Center report notes it is plagued with barriers that prevent its more widespread adoption. The challenges include: "reducing administrative barriers to the submission and review of applications for new PACE programs and service area expansions (SAEs); high Part D premiums that make PACE unaffordable for Medicare beneficiaries who are ineligible for Medicaid; limits on eligibility that make PACE unavailable to certain high-need, high-cost (HNHC) populations who are likely to benefit from the model; strict federal rules around marketing PACE programs; lack of clear, easily accessible consumer information on PACE; quality and encounter data that do not adequately capture the full range of services delivered by PACE models and the value of PACE; and inadequate resources at the state and federal levels to support the appropriate growth of PACE." Further refinements of this program could make it an ideal program for achieving integration for more duals. Mr. Carper and Mr. Cassidy's bill, the PACE Part D Choice Act, would allow greater access to PACE for Medicare only beneficiaries which would greatly expand the number of currently clinically eligible beneficiaries that are prevented by accessing PACE for financial reasons. Mr. Scott co-led legislation, the PACE Expanded Act, that would alleviate some of these issues and we encourage consideration of how the barriers addressed in that legislation and the BPC report could be included in the proposal that results from this RFI.

  Also, of note, unscrupulous marketing and enrollment activities by some Medicare Advantage plans has led to some current PACE enrollees from being disenrolled from the PACE program and enrolled into and MA or Special Needs Plan product that does not meet the individuals' needs.

- **SASH -** The Supports and Services at Home (SASH) program was created by LeadingAge member Cathedral Square Corporation in collaboration with multiple health and aging services provider organizations. Launched in 2011, SASH is an affordable, housing-based care coordination program that serves as an extender to community health teams (CHT) supporting Vermont's statewide medical home model.

  Teams composed of housing-based care coordinators and wellness nurses work with dedicated representatives of community-based service agencies (Area Agencies on Aging, Visiting Nurse Associations, and mental health agencies) to support participating residents in one or more affordable housing communities. The teams may also serve Medicare recipients living in the communities surrounding the housing properties.

  SASH teams:

  - Conduct comprehensive assessments of residents to identify any health- and wellness-related needs.
  - Help those residents access and arrange services to address identified needs.
  - Provide onsite wellness and prevention programs.
  - Coordinate with the CHTs to assist individuals who have complex needs and monitor those individuals in the community.
  - Work with local hospitals to help support and monitor transitions home after a hospital stay.

  Initially, the SASH care coordinator and wellness nurse were primarily supported through Medicare's Multi- Payer Advanced Primary Care Practice demonstration.[21] The care coordinator/wellness nurse team currently continues to receive Medicare support through the states Vermont All-Payer ACO Model.

  The SASH program is another example of how integrated service models are most successful when they start with the needs of individuals where they live and connect and surround those individuals with needed services through an accountable group of providers. SASH has served more than 10,000 participants since its inception and currently, serves approximately 5,000 individuals living in more than 140 housing properties and in the surrounding communities. An ongoing evaluation has found that SASH is slowing the growth of total annual Medicare expenditures for participants in early launching housing properties by an estimated $1,227 per beneficiary per year, compared to non-participating individuals. Subsequent evaluations show savings for both Medicare and Medicaid, and improved outcomes such as reduced ER visits and increases in primary care.

Required Elements for Integrated Care

We have observed that these programs and other successful integrated care models have the following features in common that we believe form a list of essential elements to be included in any future integrated model of care for dual eligible and/or other populations:

- *Pooled funding and risk sharing:* At its core integration demands the ability of a single entity – group of providers or plan -- to pool all sources of funding, and the freedom from the existing FFS structure (e.g., capitation). Working together, the responsible entity offers a full range of coordinated services and supports designed to help an individual maintain health and achieve personal goals. The entity assumes a portion of the risk for outcomes and total cost of care.

  This element can be found today in models like ACO REACH (and its predecessor Direct Contracting), which provides examples of how to structure capitated reimbursement structures and subcapitated arrangements. Pooled funding and full-risk are important components of FIDE-SNPs and PACE programs, which offer two options for delivering financial and clinical integration -- one is plan-led and the other a provider-led model respectively. Under FIDE-SNPs and PACE programs a single entity integrates the payments –Medicare and Medicaid – and is responsible for coordinating and integrating the necessary care. True integration requires both financial and clinical integration, which is lacking in most models today. Full financial risk affords flexibility to the responsible entity to address an individual's needs instead of being limited by the list of Medicare and/or Medicaid covered services.

- *Single point of contact:* A single "service navigator" that works with the older adult, their family and the individual's interdisciplinary service team (IDT) to answer questions, and identify and coordinate needed services, supports and resources across settings. The navigator serves as a liaison between the individual, their family, and their IDT.

  According to a study by Accenture, 52% of Americans have what they call "low healthcare system literacy" and 26% of US Consumers have low healthcare system literacy and a high need for intervention. We can assume that a portion of these low literacy individuals are dual eligibles. Accenture estimates that we could save $3.4 billion a year in administrative costs if all consumers had high healthcare system literacy. A service navigator could play an important role in improving healthcare literacy for the dual eligible population as well as the broader population.

  A single navigator or coordinator is a key element in the TANDEM 365, SASH, and PACE models.

  As part of the HCBS settings rule, beneficiaries must receive conflict free case management. We want to be sure that dual eligible are not overly burdened by case managers. As part of your instructions to HHS on the creation of a single point of contact, CMS should be instructed to integrate the idea of a single point of contact concept into the definition of conflict-free case management. The evidence from the models we described shows that a single point of contact for navigation is best, and we would want to make sure this best practice is in compliance with current regulations.

- *Assessment and single service plan:* The interdisciplinary service team (IDT) conducts a comprehensive assessment of each older adult and uses its findings to develop a universal aging

service plan in collaboration with the older adult, his or her family, and all identified care and service providers. The service plan provides a comprehensive picture of all the older adult's needs for services and supports and any social risk factors (SRFs) the person may have, not just medical needs. The responsible entity then must identify the best ways to optimize the person's health and/or function within the available funding. It would also identify the individual's:

- Functional and cognitive capabilities.
- Health-related social needs, including housing, transportation, and nutrition.
- Current living and support environment.
- Existing providers engaged in addressing the older adult's needs.

We see this element in PACE, TANDEM 365, SASH and will be in FIDE-SNPs as social determinant of health questions are incorporated into health risk assessments beginning in CY2024.

- *Omni-service coordination:* Comprehensive service coordination is also a key strategy for improving outcomes for the older adult and the effectiveness of the responsible entity. To facilitate this coordination, the IDT, the service navigator, older adults, and families would have real-time access to the individual's health information and aging service plan. Technology tools would be used to share information, improve access to services and supports, enhance wellness and independence, and facilitate predictive modeling to improve outcomes and identify best practices.

  This element is a key aspect of TANDEM 365, SASH, and PACE. However, to achieve this goal to support integrated models there must be further national investments in technology and interoperability to ensure all providers across the continuum can meaningfully participate in health information exchange and associated technology with other providers.

- *Quality assurance:* An integrated service framework should define measures of quality that gauge the satisfaction of the older adult and his or her caregivers. Quality measures would also be tied to achievement of the individual's goals, as identified in the aging service plan. More globally, we should expect CMS to collect quality data and measure performance across all programs that serve dual eligible and Medicare beneficiaries to ensure these beneficiaries receive the same quality across programs across managed care, CMMI models, and FFS, and to ensure taxpayer dollars are funding effective programs.

Actions Congress can Take to Further Integration for Dual Eligibles.

Laws and regulations can provide a framework for the integrated service model that LeadingAge envisions as long as it does not stifle creativity by being overly prescriptive.

We acknowledge that a few providers, including some LeadingAge members, have found ways to work within existing regulatory and funding confines to create an integrated service model in their communities. We applaud their efforts, which represent laudable examples of what is possible.

However, there remains a strong need to reform our entire delivery system so that these promising examples become far more widespread and can optimize their full potential. We must work together to

ensure that *all* older adults have access to the full breadth of medical, social, and long-term services and supports needed to live a healthy and independent life.

Therefore, we have outlined below a menu of steps that policy makers could take to move our delivery system toward integration and incentivize providers to adopt a more holistic approach to the work they do.

Building a Foundation for Holistic Service Delivery

- Require every dual eligible to have a service navigator. This person's role is to be:
    - A *resource* who identifies and explains available care and service options to help older adults and their families proactively address the older person's needs and understand the associated costs.
    - A *coach* who engages older adults as active participants in their health. Older adults and their families have firsthand knowledge about the older adult's needs, changes in condition, preferences, and resources. Better health outcomes and compliance with the aging service plan are more likely to occur when older adults and their families are engaged in self-managing their chronic conditions and achieving the goals of their aging service plan.[3]
    - A *translator* who serves as a liaison among providers and between the individual and the interdisciplinary care team. The navigator obtains answers, clears up confusion and ensures optimal outcomes.
    - A *navigator* who helps older adults and their families navigate health care and support systems by setting up appointments or arranging for selected services to ensure needs are met in a timely manner.
- Require every dual eligible to have a comprehensive risk assessment or re-assessment at least once per year that includes social risk factor items such as stable housing, transportation, and access to nutrition.
- Expand the existing Medicare wellness visit benefit to include a comprehensive assessment that evaluates an older adult's need for services and supports, and social risk factors-- such as stable housing transportation and access to nutrition-- to foster independence and manage health and wellness. The American Geriatrics Society supports this concept.
- *Expand the list of reimbursable services:* Permit Medicare and Medicaid reimbursement for any services that optimize the health or function of an older adult as long as he or she is part of an integrated service model, has received a comprehensive risk assessment, and has a corresponding care and service plan.

[3] https://report.nih.gov/nihfactsheets/Pdfs/Self-management(NINR).pdf

Facilitating Coordination Among Providers

- Incentivize health information exchange: Technology plays a key role in the ability of providers to share information across settings. This investment can lead to better outcomes, less duplication and more informed decision making. Therefore, Congress should provide funding for incentives for all providers to invest in needed technology to allow interoperability and sharing of real-time patient data across all settings. To date, meaningful use dollars were only made available to physicians and hospitals for this important work. However, these are not the only providers with which dual eligibles engage. If our goal is to truly keep folks out of the hospital and healthier longer, then we must recognize the critical role providers who support an individual's activities of daily living are (e.g., LTSS providers, home and community-based services, personal care attendants, etc.) and ensure they, too, can collaborate and benefit from the information in an individual's electronic health record.

- *Foster health information sharing:* Reexamine the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to identify actual barriers to health information sharing among health and service providers. Once these barriers to integration are identified, seek appropriate legislative or regulatory changes, and educate providers about the types of sharing that HIPAA allows.

- Instruct HHS to establish appropriate reimbursement codes, like the Medicare Chronic Care Management Current Procedural Terminology code available to physicians, for all providers (e.g., LTSS, HCBS, nursing homes, etc.) to bill for their time collaborating and coordinating care and services with other providers for Medicare beneficiaries and dual eligibles. We would also recommend instructing HHS to look at what codes already exist that are not activated in Medicare that could be used to improve care for dual eligibles and working to make them available for all relevant providers to bill. Examples include Medicaid Medical Homes, adult day services in the VA, and palliative care bundled payment. If we want coordination, it must be paid for and available to be billed by all providers who can and do deliver these services.

- Encourage HHS/CMS/CMMI to develop value-based arrangement templates that plans, and other integrated model entities can use to contract with service providers in a way that aligns all these providers to deliver value to the dual eligible not just get paid a reduced FFS amount.

- Encourage the Secretary of Health and Human Services to ensure that all provider disciplines' curricula include skill development and instruction on collaboration across providers, working in teams, communication skills, etc.

Expanding the Pool of Providers Who Can Lead Integrated Models

If we are serious about transforming service delivery and lowering cost, we must pursue models that originate in the community and engage with individuals before a hospitalization occurs. Achieving this goal requires the participation of a variety of providers.

- *Demonstration programs:* Amend existing ACO and other CMMI demonstration language to:

- Expand the definition of providers that can lead these integrated service models. Include LTSS, post-acute, hospice and palliative care providers, and other community-based organizations and providers in this definition.

- Allow these LTSS and other community-based providers to qualify for the Advanced Investment Payments in the Medicare Shared Savings Program ACO model so they can obtain an "advance" on their projected shared savings. Providers can use that advance to make the upfront infrastructure investments needed to pursue such integrated service models.

- Instruct CMMI to test a track of ACOs that targets dual eligibles and integrates Medicaid funding with Medicare ACOs including requirements for a single care navigator and comprehensive care planning and include requirements that incentivize LTSS and other community providers to lead these models.

- CMMI should also launch a demonstration to test a voluntary, national, fully integrated service model like the one described in the LeadingAge paper that is based in a residential care setting such as a long-stay nursing home, assisted living, or affordable housing. The model, led by post-acute and/or LTSS providers, would allow Medicare funds to be pooled with Medicaid and/or private funds. It would also leverage technologies that have been demonstrated to effectively support integrated service models in addressing older adults' needs.

Creating a Flexible Framework

- *Build on other models:* Create and test a regulatory framework for the new integrated services model that builds on PACE and FIDE SNP. At a minimum, the framework should require a community-based hub of providers to conduct a comprehensive risk assessment, develop an aging service plan, coordinate services through a single service facilitator, and consolidate and integrate funding for older adults. Provider payment options might look like those available under the ACO REACH model.

- *Deliver services in the right place:* Eliminate the requirement that service provision be limited to a certain site of service or source of payment. Instead, allow for service provision to be governed by provider scope of practice and qualifications so services can be provided in homes, congregate housing communities, assisted living communities, or another location, as long as that care can be provided safely. This change would help address workforce shortage issues, ensure that older adults receive timely access to care where and when they need it, and potentially reduce unnecessary ED visits and health care utilization.

- *Allow consumer choice:* Permit older adults to choose the group of providers that receives and utilizes all available public and private funding to provide them with cross-continuum coordination of services. This "integrator" could be a health plan, ACO, integrated service hub, medical home, or health care home. The integrator would only be chosen by a third party if an individual did not select.

We understand that this RFI is focused on the dually eligible population and for all the reasons outlined in our response, we applaud and support your efforts. We want to note that our members serve a lot of near duals. Integrated services could also reduce costs and improve outcomes for those older adults who still are impacted by lack of stable housing, transportation, nutrition, and access to health care but are not eligible for even the fragmented duals system we have today. We encourage considering whether any of these proposals could expand eligibility to beneficiaries who qualify for Medicare Savings Programs or the Part D Low Income Subsidy. Another option would be to allow for a sliding scale "buy in" option. Massachusetts allows for all older adults to be assessed for their Home Services program that is part of their Frail Elderly Waiver, and they determine cost share based on income. The Part D Choice Act is an example of how PACE could be made more accessible to Medicare only beneficiaries and other changes to the program could be made to make buying in more feasible.

We hope the information and models we've shared and highlighted prove helpful in your deliberations. We look forward to an opportunity to discuss these ideas and others with you in the future.

Sincerely,

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