Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

October 17, 2016

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

RE: ***CMS–4168–P*- Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE) (81 FR 54666), August 16, 2016.**

Dear Acting Administrator Slavitt:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of the Catholic health ministry representing the largest group of not-for-profit providers of health care services in the nation, I would like to offer the following comments on the referenced proposal by the Centers for Medicare and Medicaid Services (CMS) to revise and update the requirements for the Programs of All-Inclusive Care for the Elderly (PACE) under the Medicare and Medicaid programs.

CHA strongly supports efforts to coordinate and integrate person-centered health care services along the continuum of care, in particular to address the needs of those who because of frailty or chronic conditions require continuing care, services and supports. As people in our communities live longer and the need for chronic care, services and supports grows, we must make sure we provide the elderly and persons with disabilities options to receive long-term care services and supports in the most appropriate care setting, whether at home, in the community or in a residential facility.

The PACE model has proven to be a successful method of providing integrated care for those who prefer to be cared for at home or in the community. CHA strongly supports efforts to make the program more accessible to more people and is pleased that the proposal in general provides the flexibility needed to make the program more widely available while maintaining high standards of care. We would like to offer the following specific comments:

- **Expansion and Relocation Application Process**

CMS proposes to require a PACE organization (PO) that wants to expand within its current service area to submit a complete application in order to do so. CHA is concerned that this is an unnecessary level of burden on existing and successful PACE organizations seeking to meet the needs of their participants within their service area. **Rather than requiring a complete new application, we urge CMS to consider allowing the PO to provide notice to CMS in advance of expansion within the service area, which would include relevant information (such as the location, the support of the State Administering Agency, indication of financial stability and, prior to opening, a state readiness review) without having to resubmit information previously provided to CMS.** A notification process in lieu of a new application would also be more appropriate for a PO that is relocating. We believe that allowing notification in these instances would be a streamlined and efficient way to ensure that CMS has the information it needs for effective oversight while expanding- access to new PACE center services.

- **PACE Organizational Structure**

CMS proposes to end the requirement that POs be not-for-profit entities. **While this change has the potential to increase access to PACE services to more beneficiaries, we urge CMS to monitor PACE expansion into this new sector to ensure there are no significant variations between for-profit and non-profit PACE providers with respect to service utilization, participant frailty and outcomes, costs and experience.** All PACE organizations should be held to the same quality performance and program requirement standards.

CHA is concerned with the definitional breadth of the proposal to require 60-day advance notice to CMS upon a change of ownership. **We urge CMS to clarify that a restructuring of the PO's parent entity would not require the 60-day notice and related requirements.**

- **Compliance Oversight Requirements**

CHA supports safeguards against fraud, waste and abuse and agrees in general with CMS' proposals to require POs to develop compliance oversight programs. CMS looked to the compliance requirements for Medicare Advantage plans and Part D plans in developing the PO requirement. As CMS noted in the preamble, POs are not just payers, they are health care providers. They are also different from MA/Part D plans with respect to program structure, size, staffing and access to resources. We urge CMS to keep these differences in mind when implementing and evaluating compliance with the new requirements. **In particular, we ask CMS to allow at least twelve months from the effective date of the final rule for POs to implement the compliance oversight requirements.**

- **Marketing**

CHA appreciates that CMS wants to ensure that potential PACE participants fully understand the program, including the rules, how to access services, and the ramifications of not accessing services through the PO. However, we disagree with the proposal to prohibit marketing by any individuals other than PACE organization employees. We are concerned this could be interpreted to disallow the use, for example, of advertising and media sources, experts communicating through social media, or partnerships with community organizations and state education efforts around long-term care services and supports. The PACE regulations set forth an intensive intake process which requires multiple interactions between PO staff and the potential participant, during which PACE staff must thoroughly explain how the program works. CHA believes the current rule prohibiting PACE organizations from contracting outreach efforts to individuals or organizations who are solely working with the elderly for enrollment purposes, together with the rigorous intake requirements, provide the right balance between protecting participants and giving POs the flexibility to disseminate program information in a way that facilitates participation and increased access to care. **We urge CMS not to finalize the proposed limitation on marketing.**

- **Service Delivery**

CMS has requested comments on potential changes to the PACE center requirements to inform future rule-making concerning how to allow greater flexibility with regard to the settings in which interdisciplinary team (IDT) members provide PACE services.

Our members with extensive experience providing PACE services indicate the need for additional flexibility on where IDT members provide PACE services, especially alternative care settings to better meet the needs of participants in an individualized manner that aims to improve care, outcomes and reduce costs. The current requirements that PACE participants attend a PACE center, and that they be assigned to IDTs attached to a PACE center, are too restrictive. For example, with appropriate processes for effective communication between IDTs and other provides, the IDT could be located elsewhere.

The philosophy of PACE is to offer care to participants in the settings of their choice. While many participants prefer to attend the PACE center, some prefer to receive services in their home or in alternative care settings such as adult day care centers, senior centers, etc. CHA urges CMS to consider allowing the use of such settings in PACE. This would give POs more flexibility in meeting the needs of participants and make PACE available to more people without the constraint of constructing new PACE centers.

- **Interdisciplinary (IDT) Team**

CHA is pleased to see added flexibility in the proposed rule regarding membership of the IDT. We agree with the underlying theme of the proposal to put an emphasis on the needs of individuals served rather than requiring the same IDT for every participant.

Definition of Primary Care Provider: **CHA strongly supports the proposal to allow nurse practitioners, physician assistants and community-based physicians to be primary care providers for PACE participants and to serve on the IDT in that capacity.** These changes will be especially welcome in rural areas, where there are serious shortages in primary care providers.

Dual roles: **CHA also supports the added flexibility of allowing one member of the IDT to fulfill two separate roles on the team**, if the individual is qualified for both roles. This proposal will also assist rural and smaller POs, as well as newly certified sites.

The "primarily serve" requirement: CMS proposes to exclude community-based physicians from the current requirement that IDT members primarily serve PACE participants. **CHA supports this change to the "primarily serve" rule and urges CMS to exclude other primary care providers in addition to community-based physicians, consistent with the proposal to expand the definition of "primary care provider."** We also ask CMS to consider eliminating the requirement entirely for all members of the IDT team. This would give the PO additional hiring and operational flexibility, for example to utilize part-time staff to meet participant needs.

- **Medicaid Payment**

CHA supports CMS' proposal to add a specific requirement that Medicaid payment be "sufficient and consistent with efficiency, economy and quality of care." This is an important balance to the existing requirement that the Medicaid PACE payment must be less than would be otherwise paid if the participant were not enrolled in PACE, essentially creating a ceiling but no floor to the payment amount. The proposed requirement will help ensure that payment will be reasonable and appropriate to enable the PO to provide the needed services to its frail elderly participants and adequate to meet PACE program requirements.

- **Additional Recommendation**

In addition to the above comments, CHA would like to make an additional recommendation for CMS' consideration. CHA asks that CMS consider amending the requirement that a PO must have a written contract with outside organizations, agencies or individuals that provide services. While POs should have written contracts with most outside providers, there are situation where

this requirement could be a barrier to providing the most appropriate care for a participant. For example, a participant may need care from a particular specialist not willing to contract with the PO. Additionally, requiring a PO to contract with its own parent entity for administrative or care-related services imposes an unnecessary administrative burden. Amending the regulations to accommodate these situations would help POs to more efficiently and effectively serve their participants.

In closing, thank you for the opportunity to share these comments on this proposed rule. We look forward to working with you on these and other issues that continue to strengthen the country's hospitals and health care system. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,

Michael Rodgers
Senior Vice President
Public Policy and Advocacy