



**American Hospital  
Association®**

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October 17, 2016

Martha Hennessy  
Deputy Director, Division of Medicare Advantage Operations  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: Proposed Rule: RIN 0938-AR60, Programs of All-Inclusive Care for the Elderly (PACE), (Vol. 81, No. 158, August 16, 2016)***

Dear Ms. Hennessy:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that would revise and update the requirements for the Programs of All-Inclusive Care for the Elderly (PACE).

The PACE program is a unique model of risk-based integrated delivery for frail, elderly individuals who are often dually eligible for both the Medicare and Medicaid programs. In recent years, PACE program evaluations have shown success in several outcome areas, such as health and functional status, quality of life, length of survival and service satisfaction. PACE beneficiaries also are found to be at no greater risk of readmissions than the overall Medicare population, despite their very complex health conditions.<sup>1</sup> In addition, some states, such as Virginia, have estimated that their cost for PACE program beneficiaries dually eligible for Medicare and Medicaid is, on average, \$4,200 less per year compared to a person receiving Medicaid services at home or in a nursing facility.<sup>2</sup> **The AHA strongly supports the innovations in care delivery and financing pioneered by the PACE program and generally supports CMS's efforts to update the program's regulatory requirements.**

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<sup>1</sup> American Hospital Association. 2011 Committee on Research, Teri Fontenot and Alfred G. Stubblefield, co-chairs. *Caring for Vulnerable Populations*. Chicago: American Hospital Association, 2011, p. 14

<sup>2</sup> Ibid.



CMS's proposals represent important steps for updating the PACE program with an eye toward improving care for beneficiaries and adding administrative flexibility for PACE organizations. Our comments focus on the following areas:

1. New interdisciplinary care team and patient assessments requirements;
2. Added beneficiary protections; and
3. Increased flexibility measures and Medicaid payment for PACE organizations.

### **INTERDISCIPLINARY TEAM**

The AHA has long supported the concept of patient-centered care through interdisciplinary care teams that coordinate health care and support services (i.e social services) with primary care practitioners at the core.<sup>3</sup> The concept of an interdisciplinary care team (IDT) is central to the PACE delivery model. We are pleased that CMS's proposed rule would ensure that primary care practitioners remain at the core of the IDT. The proposed rule would expand the definition of primary care practitioner to include non-physician care practitioners, such as nurse practitioners or physician assistants. These non-physician primary care practitioners would still be required to meet state licensure and practice only within the scope of his or her license. **The AHA supports this added flexibility and believes it would provide PACE organizations needed flexibility while ensuring that high quality care is delivered safely.**

### **PATIENT ASSESSMENT**

An essential component of care coordination is an effective care plan that is based on an initial comprehensive patient assessment, and periodically reassessed to reflect a patient's evolving needs.<sup>4</sup> The PACE program has, accordingly, long required the completion of a comprehensive initial assessment, with periodic updates. However, it also requires that all 11 members of the IDT be present for these assessments, including the primary care physician, registered nurse, dietician and occupational therapist, and social worker. CMS proposes to allow flexibility for which IDT member must be present for the initial assessment. Specifically, CMS would allow IDT members that are qualified to perform multiple clinical roles on the team be able to fulfill the IDT care domains while not requiring all IDT members be present. **The AHA supports CMS's proposal to allow IDT members to fulfill multiple roles and allow PACE organizations greater flexibility in terms of IDT staffing for initial patient assessments.** Such flexibility could be particularly beneficial to vulnerable communities, such as rural and inner city

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<sup>3</sup> American Hospital Association. 2013 Board of Trustees Report, Ensuring a Healthier Tomorrow: *Actions to Strengthen Our Health Care System and Our Nation's Finances* Chicago: American Hospital Association, 2013, p. 13

<sup>4</sup> Ibid.

urban communities where workforce shortages are extremely pronounced, and help allow them to utilize the innovations of the PACE care delivery model.<sup>5</sup>

### **BENEFICIARY PROTECTIONS**

CMS proposes additional beneficiary protections through enhanced employee screening. Specifically, CMS would require that PACE organizations increase safeguards for beneficiaries by ensuring that their hiring practices exclude individuals entered into a state nurse aide registry concerning abuse or neglect or found by a court of law to be guilty of mistreatment, abuse or neglect or convicted of specified crimes. **The AHA supports CMS's proposals to require that PACE organizations apply rigorous screening protocols similar to regulations governing long-term care facilities to ensure these frail elderly beneficiaries are safe from abuse, neglect or mistreatment.**

### **ADMINISTRATIVE FLEXIBILITY AND MEDICAID CAPITATION PAYMENT**

The PACE program has specific personnel requirements, including that personnel with direct patient contact have at least one year of experience working with frail elderly. CMS proposes modifications to this one-year experience criteria to allow PACE organizations some flexibility in hiring. Specifically, CMS would allow a potential candidate who meets all the competencies required of employees with direct patient care and complies with all immunization requirements to work for a PACE organization even with less than one year of experience working with the frail elderly. **The AHA believes that CMS's proposal would allow PACE organizations flexibility while maintaining patient safety.** Given the current health care worker shortage, this could help enable PACE organizations to better maintain a stable workforce.

In addition, the proposed rule would require that Medicaid capitation payments to PACE organizations be "sufficient and consistent with efficiency, economy and quality of care" to serve the enrolled population.<sup>6</sup> Given that PACE organizations are at risk for Medicaid-covered services such as nursing home care, the link to a payment standard is very important. **The AHA supports CMS's proposal to ensure that Medicaid capitation payments to PACE organizations are sufficient to cover the costs of efficient and quality care for the population and continues to urge CMS to ensure a transparent capitation rate-setting process as it applies to all managed care arrangements, but especially to capitation rates that apply to PACE organizations.**

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<sup>5</sup> Federal Register, Proposed Rule, Programs of All-Inclusive Care for the Elderly (PACE), (Vol. 81, No. 158, August 16, 2016), p. 54682

<sup>6</sup> Ibid, p. 54690

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Thank you for your consideration of our comments regarding updates and revisions to the requirements for PACE organizations. Please contact me if you have questions or feel free to have a member of your team contact Molly Collins Offner, director of policy, at [mcollins@aha.org](mailto:mcollins@aha.org) or (202) 626-2326.

Sincerely,

/s/

Ashley Thompson

Senior Vice President

Public Policy Analysis and Development