October 17, 2016

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4168-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Sir/Madam:

The Home Care Association of New York State (HCA) appreciates the opportunity to provide comments on the proposed rule that would revise the requirements for the Programs of All-Inclusive Care for the Elderly (PACE).

HCA is a statewide association representing nearly 400 health care providers, organizations and individuals involved in the delivery of home care services to over 300,000 Medicare and Medicaid patients in New York State. HCA's members include Certified Home Health Agencies (CHHAs), Long Term Home Health Care Program (LTHHCP) providers, Licensed Home Care Services Agencies (LHCSAs), providers of various waiver programs, Managed Long Term Care plans, hospices and others. HCA's home care providers are sponsored by hospitals, nursing homes and free-standing nonprofit, public and proprietary agencies.

We offer a unique perspective because we represent the full gamut of the long term care system, including plans that offer PACE programs.

For many years, PACE has proven successful in keeping frail, older individuals in the community. Through its comprehensive services, interdisciplinary approach, and focus on utilization of the PACE center, PACE has kept its members out of institutional settings.

However, if PACE is to continue to exist, increase its membership, and meet changes in the health delivery system, PACE needs to be reformed. We believe that many of the proposed changes outlined below will allow PACE to grow and adapt to changes in the marketplace.

Personnel Qualifications (§460.64)

HCA supports CMS's proposed change that would allow PACE staff to engage in direct participant contact in cases where they don't have one year of experience working with frail or elderly population but they meet all other requirements and receive appropriate training from the organization on working with this population.

This change will allow PACE organizations greater flexibility to hire staff who have both the necessary skills and other important attributes (such as language and cultural competencies), but who lack specific experience with the PACE population. PACE organizations will be able to address this lack of experience with training, and we expect this change will expand PACE organizations' access to qualified drivers, aides, activity staff and others.

Service Delivery (§460.98)

HCA recognizes the PACE center's role as a vital delivery setting for PACE participants, but we believe the current regulation – with regard to the assignment of participants to Interdisciplinary Teams (IDTs) that are attached to the PACE center – is too restrictive.

Currently, the PACE center houses the PACE IDT, but this does not have to be the case. We believe the PACE IDT can be located in other settings as long as processes are in place to assure effective communication among PACE IDT members and additional care providers.

IDT (§460.102)

Composition of IDT

HCA strongly supports CMS's proposed changes to §460.102(b)(1) and §460.102(c) allowing for nurse practitioners, physician assistants, and community-based physicians, in addition to PACE physicians, to be primary care providers (PCPs) on the PACE IDT.

Currently, more than half of all PACE organizations use nurse practitioners as PCPs on the PACE IDT under waiver authority. Nurse practitioners have been very effective partners in this role. Although physician assistants have not been able to assume the role of primary care provider on the PACE IDT, there are a number of physician assistants practicing in PACE organizations. We believe that physician assistants will also be valuable members of the IDT.

Regarding the proposed expansion to community physicians, such a change, already allowed under waivers for about 20 PACE organizations, will allow for greater flexibility in delivering primary care. This will address the challenges PACE organizations face in hiring enough PCPs, allowing for program growth, and enhancing efficiency without compromising quality. The use of community-based physicians has allowed PACE participants an expanded choice of primary care providers beyond PACE staff, and sometimes has allowed them to retain an existing primary care physician when enrolling in PACE.

To facilitate the use of community-based PCPs (physicians, nurse practitioners, and physician assistants), we recommend that CMS allows for flexibility in how they participate in PACE IDT discussions to develop participants' care plans and carry out other IDT responsibilities. Currently, PACE organizations with waivers to use community-based physicians as primary care providers on the PACE IDT utilize different approaches in how these physicians participate in team discussions, including directly and through a liaison. Such alternative approaches to direct participation of the community-based PCP should be encouraged in the care planning process.

Allowing Individuals to Serve Two Roles on IDT (§460.102(b))

HCA supports CMS's proposal to allow one individual to fulfill a maximum of two separate roles on an IDT when the individual meets applicable state licensure requirements and is qualified to fill each role and able to provide appropriate care to meet the participant's need. This flexibility will be useful for new and small PACE organizations, including those in rural communities.

Elimination of "primarily serve" requirement (§460.102(d)(3))

HCA supports the provision to exclude those community-based physicians who are proposed to be on the IDT from the requirement that they service primarily PACE participants, and we also favor that this be extended to other members of the IDT. PACE organizations face many operational challenges, including the need to hire part-time staff consistent with staffing needs as program census increases and to utilize qualified staff who may not choose to work full-time for the PACE organization. Rather than regulating the amount of time that PACE IDT members serve PACE, we believe the focus should be on ensuring that their responsibilities on the IDT are fulfilled.

Participant Assessment (§460.104)

We partially agree with CMS's proposal to require that initial comprehensive assessments be conducted in time to allow the IDT to complete the plan of care within 30 days of enrollment. However, we believe that there are circumstances when this deadline cannot be met; for instance, when a participant is out of the service area, hospitalized or refuses to complete the assessment and care planning process within 30 days of enrollment.

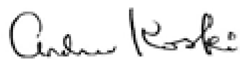
In such and other related cases, we request that CMS allow for the PACE organization to document the reasons that the care plan was not completed within 30 days without being determined to be out of compliance.

In addition, we agree with CMS's proposal to require assessments be consolidated into a plan of care through "team discussions" rather than the current "discussions in team meetings." This recognizes other methods of IDT communications, including conference call and video conferencing, and is particularly important with other proposed changes to allow community-based primary care physicians to be members of the IDT.

Lastly, while we agree with CMS that initial comprehensive assessments and reassessments be conducted in-person, we request that CMS allow for alternative ways to meet this requirement, such as video conferencing or other technology. This would be particularly helpful in rural areas, where distances and travel times may be long and costly.

Thanks for considering our comments. I am available at 518-810-0662 if you have any questions or need more information.

Sincerely,



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