NATIONAL ASSOCIATION OF Community Health Centers

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October 16, 2016
Submitted electronically via http://www.regulations.gov

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-4168-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: RE: CMS-4168-P—Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE)

Dear Acting Administrator Slavitt:

The National Association of Community Health Centers, Inc. (NACHC) is pleased to submit the following comments in response to CMS' proposed rule on the Programs of All-Inclusive Care for the Elderly (PACE) published in the Federal Register on August 16, 2016. NACHC is the national membership organization for federally qualified health centers (FQHCs or "health centers"). With over 9,000 sites nationwide, FQHCs provide affordable, comprehensive primary care to over 24 million medically-underserved individuals. Our members include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Grantees, and Public Housing Primary Care Grantees, all of whom strive to meet the health care needs of the uninsured and underserved. For more general information on FQHCs, please see the attachment.

Health centers currently serve as the medical home for nearly two million Medicare beneficiaries, and that number is quickly growing. In fact, between 2005 and 2014, growth in patients nearing Medicare eligibility outpaced that of all other age groups, exceeding the rate of growth of total health center patients during that time period. Health center patients aged 65-74 represented the second fastest growing age group over the same period.

Nationwide, 40 percent of health centers' Medicare patients are dually eligible for both Medicare and Medicaid. Studies show those patients are significantly more likely to suffer from multiple chronic conditions, such as diabetes, chronic lung disease, and Alzheimer's disease. On average, Medicare patients make up roughly nine percent of a health center's patient mix, but for close to one in five health centers, this figure is over 20 percent. Health centers are proven to be highly effective providers of care, with a numerous studies demonstrating the quality and comprehensive care they provide to

their patients. Combined with their community-based care, in which every health center is geared to meet the needs of the community it serves, via services such as translation, health education, or transportation services, health centers are positioned to serve as valuable members of the PACE community.

There are several health centers that also operate PACE programs, however we believe that there is potential for more to get involved with this important program. However, under current law, many cite barriers to getting involved in the PACE program and we believe that the flexibility in the proposed rule will help to encourage more involvement in the program.

In general, we are supportive of CMS' efforts to update the PACE regulation and believe it is important to build upon the experience that CMS, States and PACE organizations have accumulated since the PACE regulation underwent its last significant revision in 2006. It is particularly important to provide PACE organizations greater operational flexibility in ways that will allow them to both be more efficient and expand without compromising the quality of care for which PACE is well known. In addition to reviewing the proposed PACE rule, we have had the opportunity to review the comments that the National PACE Association (NPA) will be submitting in response to CMS' proposed changes and requests for comment. We believe that NPA's recommendations improve further upon the changes that CMS has proposed and encourage CMS to consider them seriously in finalizing the PACE rule.

In particular, we would like to emphasize our support for NPA's recommendations related to the following:

- An expanded definition of primary care provider on the PACE interdisciplinary team (IDT) to include nurse practitioners, physician assistants and community-based physicians in addition to PACE physicians. This allows participants in the PACE program more options for how and from whom they can receive their primary care services while maintaining the integrity of the PACE program's interdisciplinary team which is central to its effectiveness. As providers in medically underserved areas, health centers rely on non-physician providers to help meet growing workforce needs. An expanded definition would help expand PACE programs to these medically underserved communities.
- Greater flexibility in PACE organizations' use of the PACE center and alternative care settings in response to participants' needs and preferences. This supports choice by PACE participants regarding how and where they would like to participate in activities and access PACE program services while allowing the PACE program to grow more efficiently and more nimbly and make the best of current resources.
- Greater flexibility with regard to how individual IDT members participate in assessments and care planning with the objective of varying the composition of the IDT for individual participants based on their care needs. This makes the most effective use of the IDT members' time, balancing the needs of assessing and care planning with the direct delivery of services to PACE participants.

- Allowing PACE organizations to open new PACE centers in approved service areas without having to submit expansion applications. This facilitates PACE programs' growth in response to increased enrollment and ability to offer additional settings of care within their service areas. Streamlining the administrative process removes a burden from both the PACE organizations and CMS in processing these applications.
- Supporting participant-directed home and community based settings options within the requirements of the PACE regulation, rather than the Home and Community Based Settings rule. This recognizes the PACE program's current home and community-based focus and assures participants' access to the PACE center as an option for primary care, rehabilitative care and activities.

If finalized, we believe the proposed rule as modified to reflect the concerns addressed in this comment will provide health centers and PACE organizations with much needed operational flexibilities resulting in more efficient operations, and new opportunities for program expansion that will expand access to the PACE program's high quality services for our country's seniors.

In closing, we appreciate the opportunity to submit comments on this proposed rule, and both our staff and our member health centers would be happy to provide any further information that would be helpful.

Sincerely,

Colleen P. Meiman, MPPA
Director, Regulatory Affairs
National Association of Community Health Centers
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Attachment A:

OVERVIEW OF FEDERALLY QUALIFIED HEALTH CENTERS

For 50 years, Health Centers have provided access to quality and affordable primary and preventive healthcare services to millions of uninsured and medically underserved people nationwide, regardless of their ability to pay. At present there are almost 1,300 health centers with more than 9,300 sites. Together, they serve ***over 24 million patients***, including nearly seven million children and more than 1 in 6 Medicaid beneficiaries.

Health centers provide care to all individuals, regardless of their ability to pay. All health centers provide a full range of primary and preventive services, as well as services that enable patients to access health care appropriately (e.g., translation, health education, transportation). A growing number of Health Centers also provide dental, behavioral health, pharmacy, and other important supplemental services.

To be approved by the Federal government as a Health Center, an organization must meet requirements outlined in § 330 of the Public Health Service Act. These requirements include, but are not limited to:

- ***Serve a federally-designated medically underserved area or a medically underserved population.*** Some Health Centers serve an entire community, while other target specific populations, such as persons experiencing homelessness or migrant farmworkers.
- Offer services to all persons, regardless of the person's ability to pay.
- Charge no more than a nominal fee to patients whose incomes are at or below the Federal Poverty Level (FPL).
- Charge persons whose incomes are between 101% and 200% FPL based on a sliding fee scale.
- Be ***governed by a board of directors, of whom a majority of members must be patients of the health center.***

Most §330 Health Centers receive Federal grants from the Bureau of Primary Health Care (BPHC) within HRSA. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing care to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients who are not indigent or who have insurance, whether public or private, are expected to pay for the services rendered. In 2014, on average, the insurance status of Health Center patients is as follows:

- 47% are Medicaid recipients
- 28% are uninsured
- 16% are privately insured
- 9% are Medicare recipients

No two health centers are identical, but they all share one common purpose: to provide primary health care services that are coordinated, culturally and linguistically competent, and community-directed, to uninsured and medically underserved people.