



## **NPA Responses to CMS' Medicare Regulatory Relief RFI**

June 10, 2025

The following reflect the National PACE Association's (NPA) responses to the Centers for Medicare and Medicaid Services' (CMS) solicitation for public feedback titled, "Unleashing Prosperity Through Deregulation of the Medicare Program (Executive Order 14192) - Request for Information (RFI)."<sup>1</sup>

Submitted online via: <https://www.cms.gov/medicare-regulatory-relief-rfi>

### **Topic 1: Streamline Regulatory Requirements**

**1A. Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?**

As a provider and a health plan, the Program of All-Inclusive Care for the Elderly (PACE) is poised for growth. We know first-hand the promise and potential of PACE to serve older Americans with chronic needs who want and are safely able to receive care in the community. Yet, there are still an estimated two million individuals in this country eligible for PACE but without access to the program.

To ensure more PACE-eligible individuals have geographic access to PACE, especially in rural communities, we recommend CMS remove administrative barriers in the provider and participant PACE application processes. Specifically, we recommend that CMS:

#### ***PACE Participant Enrollment Recommendations***

- **Permit mid-month enrollment in PACE by revising or eliminating the outdated federal requirement at 42 CFR § 460.158 limiting the effective date of a participant's enrollment to the first day of the calendar month following the date the PACE organization (POs) receives the signed enrollment agreement.** Unlike any other Medicare or Medicaid provider, federal PACE regulations require a participant's PACE enrollment to begin on the first day of the calendar month following the date the PO receives the signed enrollment agreement. Under current federal PACE regulations, if for any reason an enrollment application is delayed, and the individual misses the cut off to begin receiving PACE services on the first of the month, they must wait another

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<sup>1</sup> <https://www.cms.gov/medicare-regulatory-relief-rfi>



full month. This can lead to a deterioration in their health or require them to find a different long-term care option. Simply put, it ought to be as easy to enroll in PACE as it is for an individual to enter a nursing home, if it is their choice to do so.

- **Allow POs to determine nursing home level of care (LOC) eligibility for enrollment in PACE.** Specify state review and audit requirements to ensure the accuracy of LOC determinations. Doing so would be consistent with the clinical expertise and responsibilities of the IDT to conduct the participant’s initial comprehensive assessment, periodic reassessments, and develop and execute the participant’s plan of care. Allowing the PO to determine nursing home eligibility for PACE enrollment would streamline the enrollment process, as state-based or third-party LOC determinations often delay a participant’s enrollment resulting in avoidable health deterioration, hospitalization or institutionalization.

### ***PACE Accessibility Recommendations***

- **Streamline CMS’ review of applications for new PACE programs and service area expansions (SAEs).** The current PACE application process, from a participant and provider perspective, is overly complex, restrictive, and misaligned with the operational realities of providers and the needs of older adults. Generally, it takes between 18-24 months to initiate a new PACE program<sup>2</sup>, with a medium cost to programs of approximately \$5.83 million (amount adjusted for inflation between 2003 and 2022).<sup>3</sup> The extensive time and cost it currently takes to start up a PACE program or expand an existing program unnecessarily delays or prevents beneficiaries from accessing PACE. NPA strongly encourages CMS to modernize and streamline the PACE application process to better support timely access to care, reduce administrative burden, and facilitate program growth.
  - **Allow POs to have multiple applications under concurrent CMS review, such that the PO with an application under review is not precluded from submitting another application.** The development of a PACE provider application can take over 180 days and involves close coordination with the applicant’s State Administering Agency (SAA). The current limitation of one application at a time unduly constrains a PO’s ability to scale, especially in states

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<sup>2</sup> Colin Higgins and Tom Stitt, PACE Growth Post COVID-19. Health Dimensions Group, August 24, 2023, <https://healthdimensionsgroup.com/insights/blog/pace-growth-post-covid-19/#:~:text=PACE%20PHILOSOPHY%20AND%20NEW%202023%20PROGRAMS&text=The%20number%20of%20new%20PACE,by%20time%20frame%20of%20opening.&text=Not%20including%20the%20first%20half,new%20programs%20has%20remained%20stable>.

<sup>3</sup> Bipartisan Policy Center, Improving Access to and Enrollment in Programs of All Inclusive Care for the Elderly (PACE), October 2022, [https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/10/BPC\\_PACE\\_Report\\_Final.pdf](https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/10/BPC_PACE_Report_Final.pdf).



with multiple underserved areas where individuals would benefit from access to PACE. Our understanding is that this change does not require a change to federal PACE regulations and could be effectuated by CMS via clarifying guidance.

- **Permit established POs to add a new PACE center in an existing service area through a public notice process, foregoing the current service area expansion (SAE) application requirement (42 CFR §§ 460.10, 460.12).** The current requirement for an extensive SAE application—even when an organization is only adding a new PACE center within an existing CMS-approved service area—creates unnecessary delays and an administrative burden. These center-only expansions do not alter the geographic service area or the provider’s capacity to deliver care, yet they are subject to the same rigorous review as full SAEs. We recommend CMS create a streamlined, expedited pathway for center-only expansions that focuses on operational readiness rather than duplicative documentation.
- **Provide expedited and coordinated CMS and SAA concurrent review, rather than what is often a costly and protracted process of sequential agency review (42 CFR §§ 460.12, 460.18).** Doing so is consistent with, if not encouraged by, federal PACE regulations, given the coordinated review process required of CMS and SAAs. Further coordination of this process reduces administrative and financial burden to CMS and SAAs, reduces redundancy for applicants, and importantly, ensures participants’ timely access to PACE.
- **Clarify in the CMS Readiness Review Tool,<sup>4</sup> used by SAAs to review non-operational PO applicants, that states may accept attestations from the PO that staff will be employed by the time the PACE center becomes operational.** Doing so would ease the administrative and financial burden to POs. This is an administrative action that CMS could take, without necessitating rulemaking or a preceding statutory change, to effectuate, and one that would go a long way toward extending geographic access to PACE.
- **Increase the frequency at which CMS accepts applications for new and expanding POs from quarterly to monthly.** To eliminate the potential for delays in the development of new POs and the expansion of existing POs, we urge CMS to remove the current restriction limiting applicants’ ability to apply to just four days a year and allow applications to be submitted on a more continuous basis. Under current CMS application submission guidelines, if a PO

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<sup>4</sup> CMS, State Readiness Review Tool, <https://www.cms.gov/Medicare/Health-Plans/PACE/Downloads/Staterreadinessreviewtool1103.pdf>.



applicant misses the deadline to apply, the applicant must wait another three months to apply, posing significant delays in prospective participants' access to PACE. This change requires no statutory or regulatory change since CMS conveyed the limitation on applications through sub-regulatory guidance.<sup>5</sup>

- **To expand access to PACE in geographically underserved areas, including rural communities, we encourage CMS to partner with the Administration for a Healthy America (AHA) to reinstate the Rural PACE Planning and Development Grants, issued and subsequently withdrawn, by the Health Resources and Services Administration (HRSA) earlier this year.** PACE has a proven track record of improving care outcomes for older adults. These grants, once reissued, would provide the resources needed to reach populations in rural communities that can benefit from this model of care. Further, doing so is consistent with the Advisory Committee on Rural Health and Human Services' (NACRHHS) recommendations and considerations to expand PACE in rural America.<sup>6</sup>
- **Remove the anti-competitive and outdated federal regulatory limitation at 42 CFR § 460.24 that limits the total number of PACE programs that can be operational.** This arbitrary and outdated regulatory limitation serves to further exacerbate beneficiaries' barriers to accessing PACE, not to mention puts POs on an uneven playing field with Medicare Advantage (MA) plans, the latter of which are not subject to such anti-competitive requirements.

### **1B. Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?**

Below we note significant burden to POs stemming from Medicare administrative processes, quality monitoring and reporting requirements, and audit and evaluation standards, along with potential recommendations to mitigate this burden.

By adopting these strategies, POs can continue to uphold the highest standards of care and safety for participants while alleviating the administrative burdens that currently impede their operational effectiveness. NPA remains committed to working with CMS to develop solutions that support the quality of care and ensure the sustainability of the PACE model.

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<sup>5</sup> CMS, 2025 PACE Application Quarterly and Waiver Request Submission Dates," <https://www.cms.gov/files/document/2025-pace-application-quarterly-and-waiver-request-submission-dates.pdf>.

<sup>6</sup> HHS, Programs of All-Inclusive Care for the Elderly in Rural America: Policy Brief and Recommendations to the Secretary, March 2023, <https://www.hrsa.gov/sites/default/files/hrsa/rural-health/resources/nac-policy-brief.pdf>.



### ***PACE Administrative Burden (Regulatory Compliance)***

- **Reassess onerous new (CY 2025) federal PACE regulatory requirements.** In the Contract Year (CY) 2025 MA, Part D and PACE Final Rule, CMS codified significant new federal regulatory requirements of POs that took effect January 1, 2025.<sup>7</sup> These provisions include new service delivery and care coordination timeframes in which the onus is placed not only on the PO but also the contracted long-term care provider or hospital to do its part for the PO to be deemed compliant (42 CFR §§ 460.98 and 460.102). CMS estimated that, in total, POs would incur a cost of \$2.1 million in CY 2025 to implement the PACE provisions in the final rule.

These provisions primarily address the *arrangement and scheduling* of IDT-approved services, not the actual *provision of* (furnishing or delivery) services. A more effective approach to evaluating participant protections and service delivery is through the review of documentation such as care plans, progress notes, and service logs to assess whether services were delivered promptly in accordance with participant’s unique health needs and ensure that services are provided in a manner that is responsive to the individual needs of participants, thereby upholding the person-centered philosophy of the PACE model.

- **Mitigate burden related to PACE personnel requirements for contracted entities providing staff that provide direct participant care.** NPA recognizes the critical importance of ensuring that all staff—whether employed directly or contracted—possess the necessary competencies to provide high-quality, safe care to participants. However, the current regulatory mandates under 42 CFR §§ 460.64(a)(3) and 460.71(a)(2) impose significant administrative burdens on POs by requiring them to directly oversee and validate the training and competency of contracted personnel. These provisions necessitate extensive documentation and monitoring efforts, diverting valuable resources from direct participant care and potentially hindering the agility of POs in responding to the dynamic needs of their participants. To balance the imperative of patient safety with the operational realities of POs, NPA respectfully suggests that CMS consider alternative approaches that maintain rigorous oversight without imposing

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<sup>7</sup> CMS, Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024-Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE), *89 Fed. Reg. No. 79*, April 23, 2024, <https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit>.



undue administrative strain. Recommended approaches for consideration include the following.

- **Leverage contractual accountability for training and competency.** POs already maintain detailed contracts with contracted entities and providers that include provisions requiring compliance with all applicable CMS and state requirements. These contracts can and should be the primary mechanism for ensuring that training and competency requirements are met, rather than imposing direct training and competency evaluation obligations on the PO itself. Further, imposing additional training requirements on contractors may discourage high-quality entities and providers from partnering with POs, particularly in underserved areas where provider networks are already limited.
- **Accept attestations as sufficient documentation.** Currently, while POs may accept attestations from contracted providers verifying that required personnel standards—such as background checks, Office of Inspector General (OIG) exclusion screenings, and medical clearances—are met, CMS audits still require POs to obtain and produce the underlying documentation. This creates a significant operational burden, leading to unnecessary duplication, as POs must again reach out to contracted entities to collect this documentation at the time of CMS audit.

To address this challenge, NPA recommends that CMS allow POs to rely on signed attestations from contracted providers to serve as both evidence of compliance and acceptable documentation during audits. This change would meaningfully reduce the administrative workload without compromising program integrity. To ensure continued accountability, CMS could establish a framework requiring POs to implement internal oversight protocols—such as periodic monitoring or sampling—to validate the accuracy and completeness of contractor attestations. Such a mechanism would strike a balance between reducing the burden on POs and maintaining program integrity.

- **Align federal PACE personnel requirements with state and industry standards.** NPA encourages CMS to ensure that federal PACE personnel requirements for contracted providers align with applicable industry and state standards. For example, where state licensure requirements for emergency medical technicians (EMTs) are in place, it would be reasonable to align federal PACE requirements accordingly, rather than layering duplicative or more restrictive requirements. This would help address concerns about burdensome and problematic additional requirements, especially when existing regulatory frameworks already ensure workforce competency and safety.



- **Permit chart reviews in lieu of conducting in-person reassessments in response to service determination request (SDR) denials under specified conditions.** Federal PACE regulations at §§ 460.104(d)(2), 460.121(h)(1), and 460.104(d)(2) require the appropriate members of the PO’s interdisciplinary team (IDT) to conduct an in-person reassessment before making a final decision in the event of the IDT’s anticipated denial or partial denial of a SDR. As such, POs must often conduct a full reassessment in response to an SDR, even when the participant’s condition has not changed and their relevant clinical information is documented. The current approach is inefficient and burdensome, consuming unnecessary clinical resources, diverting staff from their primary responsibility of providing direct participant care. Further, the current approach delays timely decision-making, especially when the requested service is non-urgent or already under consideration, not to mention contributing to participant fatigue, particularly for those with cognitive or functional impairments who may find repeated assessments burdensome.

NPA recommends that CMS provide greater discretion to POs to respond to SDRs, particularly when the request pertains to services already addressed in the participant’s care plan or recently evaluated by the IDT. Specifically, we respectfully request that CMS permit POs to, in certain circumstances, conduct a targeted chart review—rather than a full reassessment—when the participant has been recently assessed (e.g., within 30 days); the requested service is already addressed in the care plan or under active review; and no significant change in condition has occurred. This could occur with a virtual assessment. The revised approach preserves clinical integrity and participant safety; reduces administrative burden; and supports more timely and efficient responses to participant needs. POs would continue to document the rationale for the decision and ensure that the IDT reviews the request in accordance with regulatory standards.

### ***PACE Quality Monitoring and Reporting Burden***

One of the most significant administrative challenges faced by POs stems from duplicative and inconsistent quality reporting requirements outlined at §§460.130(d), 460.200(b)(1), 460.200(c), and 460.202. Currently, POs are required to submit both aggregate and individual PACE Quality Data<sup>8</sup> to CMS through the PACE Quality Monitoring Module in the Health Plan Management System (HPMS).

In addition to these federal requirements, region-specific mandates add unnecessary redundancy. For example, CMS Regional Office (RO) Account Managers often require POs to

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<sup>8</sup> CMS, PACE Quality Data Monitoring & Reporting Guidance, January 2024, <https://www.cms.gov/files/document/pace-quality-monitoring-and-reporting-guidancejanuary-2024.pdf>.



submit the same data in a separate spreadsheet—sometimes monthly—despite it already being included in the quarterly HPMS submission. Further duplication occurs at the state level, where several SAAs require the same data in different formats, duplicating information already provided to CMS.

As a result, POs must report the same data through multiple channels, increasing administrative burden without improving the quality or utility of the data. This inefficiency not only diverts critical provider resources but also creates confusion and inconsistencies in reporting expectations between CMS and state agencies.

We strongly advocate for a centralized and streamlined reporting process, using a standardized format that allows CMS Central Office, ROs, SAAs, and POs to access consistent data through a single unified platform. Reducing duplicative reporting requirements is essential to alleviating provider burden and enabling more effective, consistent, and meaningful quality oversight.

### ***PACE Audit Burden***

NPA remains deeply concerned about the continued retrofitting of MA and Part D audit processes for use in the PACE program. The current audit framework fails to reflect PACE's integrated provider-based care model, by imposing data collection and reporting demands that are disproportionately complex and misaligned with how POs deliver and document care. Many of the data elements required during CMS audits presume automated, plan-level retrieval capacities that simply do not exist in PACE's provider-centric infrastructure. As a result, burden estimates cited by CMS significantly understate the time, staffing, and administrative resources required by POs to manually extract and prepare clinical documentation for audit review and divert critical staff time away from direct care and participant engagement.

The proposed 2026 PACE Audit Protocol introduces new templates, cover sheets, and impact analysis requirements that, while aiming to standardize data submissions, continue to impose an excessive burden on POs.<sup>9</sup> In particular, the demand for highly specific clinical data and participant-level medical records involve time-intensive manual reviews by clinical and interdisciplinary staff.

While CMS has taken some steps to reduce duplicative reporting, such as eliminating certain monitoring and corrective action plan implementation requirements, the audit protocol still demands an uncommon level of per-participant information not typically expected of other Medicare or Medicaid provider types. As discussed in response to Question 2C, NPA urges

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<sup>9</sup> CMS, Agency Information Collection Activities: Proposed Collection; Comment Request: CMS-10630 The PACE Organization (PO) Monitoring and Audit Process, *89 Fed. Reg. No. 246*, December 23, 2024, <https://www.federalregister.gov/documents/2024/12/23/2024-30620/agency-information-collection-activities-proposed-collection-comment-request>.



CMS to revisit its burden assumptions and recommends piloting audit elements to develop a more appropriate, provider-informed oversight model tailored specifically to PACE's unique structure and care delivery model.

**1C. Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and other providers?**

Please see NPA's responses to Question 1B regarding opportunities to mitigate significant burden attributed to Medicare administrative processes, quality, or data reporting requirements.

Notably, NPA is in the initial stages of engaging the PACE community and other key stakeholders to support and promote the adoption of standardized data and a core set of quality measures tailored to the PACE model. These efforts aim to drive continuous quality improvement, strengthen accountability, and simplify oversight through consistent performance evaluation. As this initiative moves forward, we welcome the opportunity to meet with CMS to share progress and explore collaboration. Demonstrating the effectiveness of the PACE model through consistent, reliable metrics is essential to fostering greater accountability for the quality of care and health outcomes delivered, while supporting its growth and ensuring long-term sustainability.

**Topic 2: Opportunities to Reduce Burden of Reporting and Documentation**

**2A. What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?**

Please see NPA's responses to Question 1B regarding opportunities to mitigate significant burden, yet not undermine Medicare program integrity, to POs stemming from Medicare administrative processes, quality, or data reporting requirements.

**2B. Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?**

Please see the above responses under 1B regarding opportunities to reduce the complexity of the more onerous and time-intensive data retrieval aspects of the PACE audit process, as well as opportunities to significantly streamline PACE quality data monitoring and reporting.

Further, NPA supports CMS' continued transition of POs to submit all risk adjustment data to the encounter data system (EDS), rather than the Risk Adjustment Processing System (RAPS), to streamline data submissions and improve payment accuracy for POs. NPA believes that the



methodical approach CMS has taken in the past has worked well for POs, therefore NPA continues to strongly encourage CMS to be cautiously optimistic as POs progress through the entire proposed four-year transition period to EDS.

**2C. Are there documentation or reporting requirements within the Medicare program that are overly complex or redundant? If so, which ones? Please provide the specific Office of Management and Budget (OMB) Control Number or CMS form number. (Note: The OMB Control Number consists of two groups of four digits joined by a hyphen and it generally appears on the top right of the first page of a Medicare form and the CMS form number generally appears on the bottom left of the page of a Medicare form.)**

***PACE Audit Protocol (CMS-10630; OMB Control Number: 0938-1327)***

The PACE Audit Protocol, as currently implemented and as proposed for 2026, requires an excessive amount of time from providers, diverting them from their primary responsibility of patient care. Specifically, CMS' approach to auditing the provider aspects of PO operations is predicated on the assumption that POs can easily extract large volumes of information from participant medical records. However, since clinical documentation is typically narrative in nature, this data is not easily retrievable.

Consequently, the significant data demands built into the 2023 audit and the proposed 2026 audit must largely be met through manual reviews of PACE participants' medical records. While POs' data systems are improving, electronic medical records are mainly designed to capture clinical data needed for documenting and coordinating assessments and treatments. The extensive data requests during the audit process place a significant burden on clinical staff, diverting them from their primary role of providing participant care to manually reviewing medical records. We are unaware of any other instance where such detailed information is required on a per-enrollee basis to monitor MA plans or other Medicare or Medicaid provider types.

The burden estimates of 780 hours, at approximately \$70/hour equating to \$54,600 provided by CMS for the PACE 2026 Audit Protocol, are too low and fall short of reflecting the time and resources required of POs being audited, especially for medium and large size programs. NPA's estimates of burden, based on input from many POs, are substantially higher than these figures. In large part, this is due to requirements for information that often is only accessible by undertaking in-depth medical record reviews involving significant numbers of providers. It is extremely important that CMS continue to take steps to reduce the burden on the audit process which, as proposed, is excessive and will harm POs' ability to provide care for the participants they serve. There is a scaled impact of the protocol related to program size; the burden of data collection/documentation requirements is very directly related to volume - in this case driven by program census. This places an undue hardship on any program of substantial size or complexity.



***PACE Quality Monitoring and Reporting Guidance (CMS-10525; OMB Control Number: 0938-1264)***

One of the most significant administrative challenges faced by POs stems from duplicative and inconsistent quality reporting requirements outlined at §§460.130(d), 460.200(b)(1), 460.200(c), and 460.202. Currently, POs are required to submit both aggregate and individual PACE Quality Data<sup>10</sup> to CMS through the PACE Quality Monitoring Module in the Health Plan Management System (HPMS).

In addition to these federal requirements, region-specific mandates add unnecessary redundancy. For example, CMS RO Account Managers often require POs to submit the same data in a separate spreadsheet—sometimes monthly—despite it already being included in the quarterly HPMS submission. Further duplication occurs at the state level, where many SAAs require the same data in different formats, duplicating information already provided to CMS.

As a result, POs must report the same data through multiple channels, increasing administrative burden without improving the quality or utility of the data. This inefficiency not only diverts critical provider resources but also creates confusion and inconsistencies in reporting expectations between CMS and state agencies.

We strongly advocate for a centralized and streamlined reporting process, using a standardized format that allows CMS Central Office, ROs, SAAs, and POs to access consistent data through a single unified platform. Reducing duplicative reporting requirements is essential to alleviating provider burden and enabling more effective, consistent, and meaningful quality oversight.

**Topic 3: Identification of Duplicative Requirements**

**3A. Which specific Medicare requirements or processes do you consider duplicative, either within the program itself, or with other healthcare programs (including Medicaid, private insurance, and state or local requirements)?**

Within the Medicare program—particularly in models like PACE—there are several areas where federal and state oversight processes create duplication, leading to inefficiencies and administrative burden without improving care quality or outcomes. These duplicative requirements often stem from a lack of coordination across regulatory bodies, inconsistent

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<sup>10</sup> CMS, PACE Quality Data Monitoring & Reporting Guidance, January 2024, <https://www.cms.gov/files/document/pace-quality-monitoring-and-reporting-guidancejanuary-2024.pdf>.



interpretations of standards, and fragmented data systems. To address these challenges, a more integrated and collaborative approach is essential. Key areas of duplication include:

- **Audit and Oversight Activities:** POs frequently undergo both federal and state audits, which often examine similar areas of compliance using different criteria, timelines, and documentation formats. This redundancy not only strains staff capacity but also detracts from time and resources that could otherwise be devoted to participant care.
- **Reporting Requirements:** Medicare and Medicaid programs, along with various state entities, often require similar but non-aligned data submissions. Differences in formatting, timelines, and metrics lead to duplicative efforts in data preparation and submission. For example, NPA has identified significant redundancies in PACE quality reporting requirements, evaluation standards, and oversight initiatives. As discussed in response to Question 1B, federal regulations, such as those outlined at §§460.130(d), 460.200(b)(1), 460.200(c), and 460.202, impose substantial quality reporting obligations and additional inconsistent demands of POs from CMS ROs and SAAs. This often results in the same data reported multiple times by a PO in different formats, increasing the administrative burden to POs without enhancing data quality or oversight. Additionally, the lack of a uniform set of PACE evaluation standards can and does often lead to duplicative PO reporting and increased burden to POs.
- **Interpretation of Regulations:** Inconsistent application and interpretation of CMS guidance at the state level can lead to conflicting compliance expectations, particularly around care planning, staffing ratios, and participant rights. These inconsistencies create confusion and increase the risk of inadvertent noncompliance.

As CMS seeks to streamline Medicare requirements and processes of providers, including POs, NPA encourages CMS to consider the following overarching recommendations:

- **Harmonization of Standards:** CMS and state agencies should jointly establish uniform audit protocols, performance measures, and reporting formats for PACE. A standardized approach would reduce unnecessary variation and streamline compliance efforts.
- **Joint Oversight Initiatives:** Coordinated federal-state oversight—such as joint audits and shared monitoring schedules—can significantly minimize duplicative reviews. This would enhance consistency, improve communication between agencies, and ensure more coherent findings.
- **Data and Information Sharing:** Investment in interoperable IT systems that allow secure, real-time data access for both federal and state regulators would eliminate repeated data requests and enable more efficient program monitoring.



- **Stakeholder Engagement:** Regular, structured engagement between CMS, state agencies, and PACE providers through advisory panels or working groups can surface areas of duplication and drive consensus on practical, system-level solutions.
- **Regulatory Flexibility:** Where duplicative oversight requirements do not yield additional value for participant care, CMS and state agencies should consider offering targeted waivers or conditional flexibilities to reduce the administrative burden while maintaining program integrity.
- **Policy Clarification and Guidance:** Issuing joint federal-state guidance documents on key regulatory areas can reduce ambiguity and ensure that POs receive consistent and actionable direction.

### **3B. How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring?**

Enhancing cross-agency collaboration between CMS and SAAs is essential to reduce duplicative efforts in auditing, reporting, and compliance monitoring for PACE. Drawing from established best practices in federal-state coordination, NPA recommends the following strategies.

- **Implement coordinated audit scheduling and sample sharing.** To minimize redundant audits, CMS and SAAs should synchronize their audit schedules and share audit samples. This approach would prevent multiple agencies from reviewing the same records, thereby reducing the administrative burden on POs. By aligning audit timelines and sample selections, both entities can ensure comprehensive oversight without unnecessary duplication.
- **Leverage existing assessments and attestations.** CMS and SAAs can accept and cross-reference each other's assessments and attestations. For instance, if an SAA conducts a comprehensive review of SDRs, CMS could utilize the findings from this review to inform its own evaluations. This approach would prevent both agencies from independently assessing the same records, thereby conserving resources and reducing the administrative burden on POs.
- **Utilize technology for data sharing and monitoring.** Implementing secure data-sharing platforms can enable real-time information exchange between CMS and SAAs. Such platforms would allow for efficient tracking of compliance metrics, audit outcomes, and corrective actions, ensuring that both agencies are informed and can act promptly when necessary.



### **3C. How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?**

NPA offers the following recommendations for CMS' consideration as it seeks to better align Medicare requirements with best practices and industry standards.

- **Leverage PACE model tests to further the reach of PACE to additional high-cost, high-need individuals and geographic areas.** There is considerable upside for CMS to leverage PACE, a proven, risk-adjusted care model, as an innovative incubator. These model tests could provide important data to inform PACE scaling and policy refinements, leading to expanded access to the program. NPA would be interested in hearing more about CMS' plans to support innovation and facilitate broader access to integrated care models. We have ideas we would be happy to discuss, including model tests that would expand access to PACE in rural areas and improve the affordability of Part D for PACE participants.
- **Permit targeted telehealth flexibilities.** POs provide comprehensive, person-centered care for older adults with chronic conditions in the PACE center and in participants' homes. Thus, telehealth is an important tool for POs, to ensure uninterrupted access to essential services, especially for individuals living in rural communities. However, current federal regulations (42 CFR § 460.104) significantly limit POs' ability to leverage telehealth to conduct participant assessments. To better align with best practices and industry standards without adding regulatory burden, Medicare should expand targeted telehealth flexibilities that support PACE and integrated, person-centered care. While in-person participant assessments are an integral part of the care model and drive the delivery and coordination of comprehensive care and services to PACE participants, there may be select circumstances under which, when medically necessary and with participant consent, conducting a remote assessment may be in the participant's best interest (e.g., when a participant is sick and wishes not to come into the PACE center for an unscheduled assessment). We recommend CMS extend enforcement discretion to POs in limited circumstances and with appropriate documentation and participant consent.



#### **Topic 4: Additional Recommendations**

**4A. We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.**

To further reduce the administrative burden on POs, CMS should incentivize PACE workforce development and pipeline programs to strengthen long-term provider capacity. In regions facing acute workforce shortages, temporary or waiver-based regulatory flexibilities should be permitted to defer non-critical hiring or contracting requirements, ensuring continued access to care while reducing administrative strain.