



May 22, 2025

Honorable Abigail Slater  
Assistant Attorney General  
Antitrust Division  
U.S. Department of Justice  
950 Pennsylvania Avenue NW  
Washington, DC 20530

Honorable Robert F. Kennedy Jr.  
Secretary  
U.S. Department of Health and Human  
200 Independence Ave SW  
Washington, DC 2001

*Submitted electronically via Regulations.gov*

**RE: Recommendations to the Anticompetitive Regulations Task Force (Docket No. ATR-2025-0001)**

Dear Assistant Attorney General Slater and Secretary Kennedy:

On behalf of the 185 operating Programs of All-Inclusive Care for the Elderly (PACE) organizations in 33 states and the District of Columbia - and numerous additional entities pursuing PACE development and supportive of PACE - the National PACE Association (NPA) commends the Department of Justice (DOJ) on the launch of the Anticompetitive Regulations Task Force (Task Force). We look forward to partnering with the Task Force to identify potential revision or elimination of anticompetitive laws and regulations that undermine free market competition and potentially harm Medicare and Medicaid beneficiaries. It is in that spirit that NPA offers recommendations to the Task Force to address certain Medicare regulations that create an uneven regulatory playing field for PACE organizations (POs) and, consequently, limit beneficiaries' choice of long-term services and supports (LTSS).

PACE helps older adults live at home with a higher quality of life and at reduced cost by providing holistic and individualized care solutions. POs serve among the most vulnerable and expensive of Medicare and Medicaid populations - medically complex older adults over age 55 who are state certified as requiring a nursing home level of care. The objective of PACE is to maintain older adults' independence in their homes and communities for as long as possible. Fully integrated POs provide patients, known as participants, with all necessary medical, behavioral, and LTSS to maintain or improve their health. Over 83,000 participants receive care and services from POs

Identified as an evidence-based care model by the Department of Health and Human Services (HHS),<sup>1</sup> POs achieve high quality outcomes for their participants as well as for Medicare and Medicaid. The PACE model of care was highlighted as a consistently “high performer” in an analysis of integrated care models published by HHS. That study also found “that full-benefit dual eligible beneficiaries in PACE are significantly less likely to be hospitalized, to visit the ED, or be institutionalized,” in comparison to the control group.<sup>2</sup>

The hallmark of the PACE model is the interdisciplinary team (IDT) comprised of primary care providers, nurses, social workers, physical and occupational therapists, recreational therapists or activity coordinators, dietitians, PACE center managers, home care coordinators, drivers and personal care aides or their representatives. These individuals comprehensively assess participants’ care needs and develop and implement comprehensive, fully integrated care plans providing many services directly in the PACE center and participants’ homes. Additional services needed are provided through POs’ contracts with other providers.

Due to the extensive health care needs of PACE participants, POs interact with participants and their family caregivers on a regular and frequent basis, often daily. In addition to medical care, POs and their staff provide extensive LTSS, including adult day center services, in-home services, dementia care, palliative, end-of-life care and much more. PO staff are frequently in participants’ homes and involved in all aspects of their care due to the intensity of participants’ needs.

### ***Finalize Medicare Advantage Predatory Marketing Guardrails***

***(Proposed CY 2026 Provisions: Administration of Supplemental Benefits Coverage through Debit Cards: §§ 422.2, 422.102, 422.111, and 422.2263; Promoting Informed Choice in MA and Part D: §§ 422.2260 and 423.2260; and Expanded Agent and Broker Requirements Re: Medicare Savings Programs, Extra Help, and Medigap: §§ 422.2274 and 423.2274)***

NPA urges the Task Force to strongly recommend that the Centers for Medicare and Medicaid Services’ (CMS) expediently finalize Medicare Advantage (MA) guardrails delineated in the Contract Year (CY) 2026 MA, PACE and Part D Proposed Rule (CY 2026 Proposed Rule; CMS-4208-P).<sup>3</sup> The CY 2026 MA marketing guardrails, if effectuated, would go a long way toward

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<sup>1</sup> HHS, “Aging and Disability Evidence-Based Programs and Practices,” Last modified on January 31, 2018, <https://acl.gov/programs/strengthening-aging-and-disability-networks/aging-and-disability-evidence-based-programs>.

<sup>2</sup> Zhanlian Feng et al., “Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care: Final Report.” HHS, <https://aspe.hhs.gov/reports/comparing-outcomes-dual-eligibles>.

<sup>3</sup> Medicare and Medicaid Programs; Contract Year 2026 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 (CMS-4208-P), 89 Fed. Reg. 99340 (proposed December 10, 2024) (proposed to be codified at 42 CFR Parts 417, 422, 423, and 460. <https://www.federalregister.gov/documents/2024/12/10/2024-27939/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare>

curbing anti-competitive and predatory MA marketing practices that prevent Medicare and Medicaid beneficiaries from exercising fully informed choice in the marketplace, particularly when choosing among integrated care plan options.

Notably, the CY 2026 Proposed Rule included commonsense safeguards to protect Medicare and Medicaid beneficiaries, including PACE participants, from MA predatory marketing practices pertaining to MA plans' misuse of debit, over the counter (OTC), or flex cards. The need for these beneficiary safeguards has never been stronger given the proliferation of MA plans' use of debit cards as an enrollment inducement or incentive.

NPA has heard firsthand from our members how MA plans, through aggressive (and, in some cases, deceptive) marketing, have lured PACE participants to leave PACE and enroll in sub-optimal MA coverage (i.e., a far less integrated and comprehensive plan), often foregoing care until their PACE enrollment is able to be reinstated. These examples are unfortunately not unique to PACE, as CMS has made repeated reference to the voluminous MA marketing complaints it has received in recent years. As such, NPA strongly supports CMS' CY 2026 proposal that would prohibit MA plans from marketing the dollar value of a supplemental benefit or the method by which a supplemental benefit is administered, such as use of a debit card by the enrollee to provide the plan's payment to the provider for the covered services.

Finally, NPA recommends that CMS take further measures to curtail MA plans from using debit cards as an enrollment incentive. Doing so would help ensure that informed beneficiary choice remains at the forefront in a competitive marketplace. Although PACE offers the same non-medical benefits included in a Dual Eligible Special Needs Plan (D-SNP) flex spending card (e.g., meals, utility payment assistance), federal PACE regulations at 42 CFR §460.82(e)<sup>6</sup> prohibit POs from participating in activities that could mislead or confuse potential participants and are not to use gifts or payments to induce enrollment. Therefore, POs are unable to promote debit cards as an incentive for enrollment, an activity in which MA plans are widely and openly engaged despite the Medicare Managed Care Manual (Chapter 4, Section 40) stipulating otherwise.<sup>7</sup>

MA plans ought to be held accountable for promoting covered Medicaid and Medicare benefits, as required by CMS, not debit cards. Focusing strictly on the provisions of care aligns with federal MA marketing regulations and promotes equity in member choice.

### ***Eliminate Anticompetitive PACE Marketing Restrictions (42 CFR § 460.82)***

NPA requests the elimination of the federal regulatory stipulation at 42 CFR § 460.82, underscored in CMS' PACE Marketing Guidelines (updated in 2018), that precludes POs' ability to begin marketing to prospective participants until the PO is operational. NPA also recommends the elimination of 42 CFR § 460.82(e)(5) that limits POs' ability to engage in direct marketing.

The current regulatory restriction places both POs and individuals dually eligible for Medicaid and Medicare at a disadvantage when evaluating Medicare plan options. Unlike MA and Special Needs Plans (SNPs), POs are not listed on CMS' Medicare Plan Finder, and Medicare plan brokers often lack sufficient knowledge about how PACE compares to MA-only or SNPs. As a result, beneficiaries who could benefit from PACE are not fully informed of all their options, since POs are restricted from direct marketing. Furthermore, the regulatory prohibition is overly stringent considering CMS' rigorous and thorough approval of all PO marketing materials to ensure compliance with federal regulations and prevent deceptive or misleading practices.

***Eliminate the National Cap on Number of PACE Programs (42 CFR § 460.24)***

NPA strongly urges the Task Force to eliminate the anti-competitive and outdated federal regulation at 42 CFR § 460.24 limiting the total number of PACE programs that can be operational. Unlike MA plans, or any other Medicare or Medicaid provider, this federal regulation arbitrarily limits the total number of PACE programs that can be operational to a date set more than 25 years ago following the conclusion of the PACE demonstrations and the statutory authorization of PACE as a permanent Medicare program. NPA contends that this provision is outdated, anticompetitive and can be struck without effect.

In closing, we appreciate your consideration of NPA's comments. For questions or additional information, please do not hesitate to reach out to me at [katiep@npaonline.org](mailto:katiep@npaonline.org).

Sincerely,



Katie Pahner  
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