NPA Responses to HHS RFI: Ensuring Lawful Regulation and Unleashing Innovation to Make American Healthy Again

July 14, 2025

The following reflect the National PACE Association's (NPA) responses to the Department of Health and Human Services' (HHS) solicitation for public feedback titled, "Request for Information (RFI): Ensuring Lawful Regulation and Unleashing Innovation to Make American Healthy Again)." [1]

Submitted online via: https://www.regulations.gov/document/AHRQ-2025-0001-0001

Questions

1. **What HHS regulations and/or guidance meet one or more of the following seven criteria identified in E.O. 14219[2]? Should they be modified or repealed? What would be the impact of this change, especially the costs and savings? *[Criteria include: Unconstitutional regulations and regulations that raise serious constitutional difficulties, such as exceeding the scope of the power vested in the Federal Government by the Constitution; Regulations that are based on unlawful delegations of legislative power; Regulations that are based on anything other than the best reading of the underlying statutory authority or prohibition; Regulations that implicate matters of social, political, or economic significance that are not authorized by clear statutory authority; Regulations that impose significant costs upon private parties that are not outweighed by public benefits; Regulations that harm the national interest by significantly and unjustifiably impeding technological innovation, infrastructure development, disaster response, inflation reduction, research and development, economic development, energy production, land use, and foreign policy objectives; or Regulations that impose undue burdens on small business and impede private enterprise and entrepreneurship].***

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.

[1] https://www.regulations.gov/document/AHRQ-2025-0001-0001
[2] https://www.federalregister.gov/documents/2025/02/25/2025-03138/ensuring-lawful-governance-and-implementing-the-presidents-department-of-government-efficiency

To ensure more PACE-eligible individuals have geographic access to PACE, especially in rural communities, we recommend HHS remove administrative barriers in the provider and participant PACE application processes. Specifically, the following federal PACE regulations and/or policies meet the criteria outlined in E.O. 14219 and should be modified or rescinded to reduce undue beneficiary and provider burden and enhance access to the innovative PACE care model.

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.** CFR § 460.158 stands as a prime example of a federal regulatory requirement that imposes burdens without clinical justification—adding layers of cost for taxpayers by unnecessarily delaying access to the value-based PACE care model without delivering corresponding value or improved outcomes. 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 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.

  This counterproductive regulatory limitation is not grounded in any statutory requirement and raises concerns under the E.O. criteria for rules that "impose significant costs not outweighed by public benefits" and "impede disaster response and healthcare access" by unduly limiting beneficiaries' access to the PACE care model. The PACE model is structured to support medically complex, frail older adults—many of whom face serious functional and cognitive challenges—in remaining safely at home. Compared to institutional care settings like nursing homes, PACE delivers significantly better outcomes at a fraction of the cost. Thus, there is no empirical medical or economic justification for a regulatory requirement that delays prospective participants from entering PACE. Modifying this rule to allow mid-month enrollment in PACE would lead to better patient outcomes and offer more timely care, with minimal administrative burden.

- **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.

  In sum, limitations on provider-determined LOC eligibility present a barrier to enrollment, especially for individuals in urgent need of community-based services. Allowing providers to determine LOC eligibility—consistent with the IDT's clinical authority—would reduce delays caused by inconsistent or duplicative state-based evaluations. This aligns with the E.O. criteria related to eliminating burdens that "impede private enterprise and entrepreneurship" and "harm the national interest by unjustifiably impeding access to care."

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[3], with a medium cost to programs of approximately $5.83 million (amount adjusted for inflation between 2003 and 2022).[4] 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. As such, we respectfully request that CMS:

[3] 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.

[4] 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.

- **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 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.

  Requiring a full SAE application in these cases results in costs and delays that are disproportionate to the regulatory benefit. This requirement meets the E.O. criteria for regulations that "impose significant costs upon private parties that are not outweighed by public benefits" and "unduly burden small businesses." NPA recommends 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 redundancies for applicants, and importantly, ensures participants' timely access to PACE.

- **Clarify in the CMS Readiness Review Tool,[5] used by SAAs to review non-operational PO applicants, that states may accept attestations from the PO that**

[5] CMS, State Readiness Review Tool, https://www.cms.gov/Medicare/Health-Plans/PACE/Downloads/Statereadinessreviewtool1103.pdf.

staff will be employed by the time the PACE center becomes operational. Doing so would ease the administrative and financial burden on 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 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.[6]

- **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.[7]

- **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.

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[6] 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.

[7] 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.

2. **What regulations should we reconsider as we look to achieve some of the policy objectives outlined in Executive Order 14212, "Establishing the President's Make America Healthy Again (MAHA) Commission," to focus on reversing chronic disease?**

To support the goals of E.O. 14212, particularly reversing chronic disease through prevention and person-centered care, NPA strongly recommends HHS reconsider several outdated regulations that create avoidable delays and limit access to the innovative PACE care model. Please refer to NPA's comprehensive response to Question 1 above. Collectively, these regulatory reforms would expand access, accelerate preventive interventions, and advance the MAHA Commission's goals by empowering older adults and individuals with disabilities to manage chronic conditions effectively in the community.

3. **For more general deregulatory consideration under E.O. 14192, are there additional HHS regulations and/or guidance that: Are confusing or unnecessarily complicated; Require an excessive number of reports or unreasonable record keeping, or information that is not needed or used effectively; Impose requirements on the wrong individual or group; Carry excessive penalties; Are conflicting (examples include but are not limited to conflicts between HHS and State regulations, public and private sectors); Impede access to or delivery of care or services; Impede efforts to innovate; Are obsolete; and/or Otherwise interfere with the public or private sector's ability to address chronic health conditions or otherwise promote the health and wellbeing of Americans? Should they be modified or repealed? What would be the impact of this change, especially the costs and savings?**

Certain federal PACE regulations and guidance present unnecessary complexity, impose burdensome documentation requirements, and ultimately impede PACE access to care for older adults with chronic health needs. These regulations and guidance should be reconsidered under E.O. 14192 for their administrative inefficiency and misalignment with the person-centered, integrated care philosophy PACE delivers. Specifically, we strongly recommend that HHS consider the following.

PACE Excessive 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.[8] These provisions

[8] 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.*

include new service delivery and care coordination timeframes in which the onus is placed not only on the PO but also the contracted provider – such as hospitals and care facilities – 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 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

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.

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[9] 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 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.

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

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.[10] 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. NPA urges 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.

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[10] 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.

4. **What alternative approaches could be taken to achieve or accomplish the same goal with a lesser burden? For example, are there less burdensome approaches that are used by other entities such as State governments or private companies that could be adopted by HHS to achieve its goal with less burdensome requirements? What would be the impact on costs and savings?**

Please refer to NPA's responses under Question 3 regarding opportunities to mitigate excessive administrative burden to POs stemming from federal regulatory requirements, such as opportunities related to PACE personnel requirements for contracted entities. We also call your attention to recommendations in response to Question 3 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, we recommend that CMS issue guidance recommending that states explicitly include PACE participants in their Medicaid paid caregiver programs. Currently, only a limited number of states allow PACE participants to access state Medicaid-paid caregiver programs. These programs compensate family members, friends, and neighbors who assist individuals with activities of daily living (ADLs) and other non-skilled services in their homes. Allowing PACE participants access to paid caregivers would advance aging-in-place strategies, reduce caregiver strain, and lower long-term healthcare costs by avoiding institutional care and preventable hospitalizations.

5. **Are there HHS regulations, guidance, or reporting requirements that are rooted in outdated technology? Can new technologies be leveraged to allow for rescinding or updating these policies? What are the cost implications?**

NPA offers the following recommendations for HHS' consideration as it seeks to better align Medicare requirements with current and new technologies to better serve our participants and achieve potential cost-savings.

- **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 HHS 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. Additionally, PACE is well-positioned to pilot and test the use of innovative technologies through CMS-supported model tests. Doing so would generate the real-world evidence needed to inform broader regulatory reforms and ensure that federal PACE rules keep up with evolving care delivery methods. By embracing a more tech-enabled, risk-adjusted approach,

rooted in participant needs and clinical judgment, HHS can achieve the same regulatory goals with lower burdens and better outcomes.

- **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.

  While in-person assessments are essential in many cases, regulations that broadly prohibit telehealth alternatives, even when medically appropriate and supported by participant's consent, are outdated. Allowing targeted, condition-specific use of telehealth assessments would increase flexibility, reduce avoidable disruptions in care, and maintain alignment with best practices already adopted by many state Medicaid programs and private-sector models.

- **Foster collaborative models between POs and contracted providers—predicated on reasonable Medicare and Medicaid reimbursement principles—to ensure participants have access to a robust PACE provider network.** Except for entities that provide emergency services pursuant to 42 CFR § 460.100[11], federal regulations at 42 CFR § 460.70(a)[12], require POs to have a written contract with each outside organization, agency, or individual that furnishes administrative or care-related services not furnished directly by the PO, including, at a minimum, the medical specialties stipulated in the regulation.

  However, unlike *non*-contract providers providing Medicare-covered services, CMS does not delineate the minimum amount POs must reimburse—and the provider must accept in full (as they would under traditional Medicare)—*contracted* providers for Medicare or Medicaid-covered services. Several of our PO members, particularly those in their initial trial period, report significant challenges securing contracts with providers, especially hospitals and specialty providers that charge rates above what Medicare would typically pay due to their market leverage or specialty demand/scarcity. To address these challenges, NPA respectfully requests CMS consider changes to federal regulations that would require a hospital within a PO's geographic service area to demonstrate good-faith contracting efforts, develop CMS-endorsed model contracts with templates that include fair reimbursement clauses, and/or potentially facilitate

[11] https://www.ecfr.gov/current/title-42/section-460.100
[12] https://www.ecfr.gov/current/title-42/part-460/section-460.70#p-460.70(a)

regional contracting pools. NPA would be happy to discuss with CMS these and other options to mitigate PACE contracting challenges.

With respect to Medicaid payments specifically, NPA appreciates that the 2025 PACE Medicaid Capitation Rate Setting Guide provides more specificity on how the Amount Would Otherwise be Paid (AWOP) and rates should be established. We are hopeful that the additional detail and documentation provided by CMS to states will lead to a more transparent PACE rate-setting process. We strongly recommend that states acknowledge the administrative and support costs associated with the direct provision of care, by POs and their contracted entities, in developing payment rates.