NPA's Web-based Responses to Targeted Questions in "Make Your Voice Heard RFI: Promoting Efficiency and Equity within CMS Programs"[1]

Submitted via Web-based Portal on November 3, 2022

Topic 1A: Accessing Healthcare and Related Challenges

CMS wants to empower all individuals to efficiently navigate the healthcare system and access comprehensive healthcare. We are interested in receiving public comment on personal perspectives and experiences, including narrative anecdotes, describing challenges individuals currently face in understanding, choosing, accessing, paying for, or utilizing healthcare services (including medication) across CMS programs.

Examples may include, but are not limited to:

- Challenges accessing comprehensive and timely healthcare services and medication, including primary care, long-term care, home and community-based services, mental health and substance use disorder services;
- Challenges in accessing care in underserved areas, including rural areas;
- Receiving culturally and linguistically appropriate care (e.g., tailoring services to an individual's culture and language preferences);
- Challenges with health plan enrollment;
- Challenges of accessing reproductive health services;
- Challenges of accessing maternal health services;
- Challenges of accessing oral health services and the impact on overall health;
- Understanding coverage options, and/or technology to support access to coverage; and,
- Perspectives on how CMS can better communicate quality standards and accessibility information to individuals, particularly those with social risk factors.

NPA Response 1A:

As CMS notes in its overarching comments to the RFI, many populations – including individuals dully eligible for Medicare and Medicaid, which are the vast majority (nearly 90 percent) of participants served by PACE – disproportionately face challenges to accessing healthcare and other challenges. The Program of All-Inclusive Care for the Elderly (PACE) offers an important opportunity to effectively serve Medicare, Medicaid, and dually eligible beneficiaries through its innovative combination of the broadest scope of care and services at the highest level of integration.

The PACE Model of Care is centered on the belief that it is better for frail individuals and their families to be served in the community whenever possible. PACE organizations (POs) serve among the most vulnerable of Medicare and Medicaid populations – medically complex older adults over age 55 who are State certified as requiring a nursing home level of care. For these individuals – and for many other potentially eligible but unenrolled individuals – PACE provides a critical home- and community-based alternative to nursing home-level care. Although all PACE participants are eligible for nursing home care, 95 percent continue to live safely at home.

PACE is unique in that it is both a health provider and a health plan. This allows PACE to combine the intensity and personalized care of a provider with the coordination and efficiency of a health plan. POs provide the entire continuum of medical care and long-term services and supports (LTSS) required by frail older adults, including services – such as those

[1] https://www.cms.gov/newsroom/press-releases/make-your-voice-heard-request-information-seeks-public-comment-promote-efficiency-reduce-burden-and

focused on addressing social determinants of health (SDOHs) (e.g., transportation, food security, and social integration) that typically fall outside of traditional Medicare and/or Medicaid. In addition, POs commonly leverage partnerships with other community-based organizations to ensure that SDOHs beyond those offered through the care model (e.g., housing) are addressed.

Identified as an evidence-based care model by the Administration for Community Living (ACL)[2], PACE programs achieve high quality outcomes for their participants as well as for Medicare and Medicaid. In fact, the PACE model of care was highlighted as a consistently "high performer" in an analysis of integrated care models published by the Assistant Secretary for Planning and Evaluation (ASPE). 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.[3]

Of note, a recent Bipartisan Policy Commission (BPC) report on expanding access to PACE cites a study highlighting "PACE's potential to reduce health disparities between white and racial and ethnic minority adults with long-term care needs."[4] An excerpt from the BPC report follows:

> *There has been a disproportionate increase of racial and ethnic minorities utilizing nursing home care, and research shows that racial and ethnic minorities have poorer health outcomes than their white counterparts in nursing homes. The study found that PACE aligned with the needs of elderly racial and ethnic minorities with chronic conditions partially because PACE organizations have increased flexibility to provide culturally competent care.*

Enhancing access to PACE is not only critical to accelerating optimal health outcomes and care efficiencies in Medicare and Medicaid but is key to advancing the administration's health equity agenda. Providing equitable alternatives to institutional care – especially among racial and ethnic minority adults with disproportionately increased nursing home enrollment and poorer health outcomes – ensures that all individuals have a "fair and just opportunity to attain their optimal health."[5]

Topic 1B: Recommendations for how CMS can address these challenges through our policies and programs.

NPA Response 1B:

Key administrative barriers to meaningfully accessing home and community-based services through PACE follow, along with NPA's proposed recommendations to CMS:

- Barriers to Accessibility and Affordability for Medicare-only PACE Participants – Despite being a benefit under both Medicare and Medicaid, most PACE participants (nearly 90 percent) are dually eligible for Medicare and Medicaid, while less than 0.5 percent are eligible only for Medicare. Barriers currently exist that prevent Medicare-only beneficiaries from affordably and readily accessing PACE. This lack of access is a critical equity issue with respect to Medicare-only beneficiaries who now are disadvantaged with respect to PACE access. Given that the need for care will continue to increase along with the rapidly rising numbers of older Americans, eliminating these impediments is prudent public policy.

  Because PACE Part D plans must establish monthly premiums inclusive of deductible and cost-sharing amounts that are based on notably higher drug and administrative expenditures and significantly smaller covered lives pools, PACE Part D premiums differ greatly from those for marketplace Part D plans. In 2022, the national average monthly premium for PACE Part D plans is $1,1015.03, in contrast to the national average premium of $32.08 for

[2] ACL, "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.
[3] Zhanlian Feng et al. "Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care: Final Report." ASPE. Accessed October 26, 2022, https://aspe.hhs.gov/reports/comparing-outcomes-dual-eligibles.
[4] BPC, October 5, 20222, https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/10/BPC_PACE_Report_Final.pdf.
[5] CMS Innovation Center, Key Concepts: Health Equity, https://innovation.cms.gov/key-concepts/health-equity.

stand-alone Part D plans.[6] This discrepancy is only likely to widen with the recently enacted $2,000 out-of-pocket Part D expense cap, pursuant to the Inflation Reduction Act (IRA), that does not apply to Medicare-only PACE participants. This unintended consequence of the IRA will further decrease the affordability of PACE for Medicare-only adults who wish to improve their quality of care and life in a community-based alternative to a nursing home.

While NPA continues to work with our congressional champions to address this oversight, we call on CMS to, via the Innovation Center, test an important change to the PACE model that would eliminate the financial disincentives to enroll in PACE faced by Medicare-only beneficiaries. Under NPA's proposed PACE Part D Plan Choice Model, PACE participants could choose between their PO's Part D Plan and a stand-alone marketplace Part D plan. NPA research has found that standalone Part D plans will be more affordable overall for most Medicare-only PACE participants, inclusive of premiums, deductibles, and coinsurance, than the Part D prescription drug offered by their PO.

- Application Barriers Restrict Access to Home-and Community-based Services via PACE – While we appreciate the efforts CMS has undertaken to streamline the PACE application process, we believe that important opportunities remain to simply and minimize the burden of the process. Specifically, NPA recommends that CMS:

    - Remove the Quarterly Restriction on Submission of Initial and Service Area Expansion (SAE) Applications – The development of a PACE provider application is complicated and involves close coordination with the applicant's State administering agency. To eliminate the potential for delays in the development of both new POs and growth among existing POs, we respectfully request that CMS reconsider the current restriction limiting applicants' ability to submit an application to just four days a year and allow applications to be submitted on a continuous basis; and

    - Allow POs to Have Concurrent SAE Applications Under CMS Review – Under current CMS guidelines, POs may not have more than one SAE or new PACE center application pending CMS review at a given time. This administrative burden unnecessarily poses additional barriers to PACE participant access by delaying POs' ability to establish a new PACE center within an existing service area or a new opportunity to expand its service area during the CMS review period. Depending on the circumstance, the PO may have less than optimal PACE center capacity in an existing, approved service area or miss out on an opportunity to provide beneficiaries in a new service area access to its services. We urge CMS to reconsider its current policy of limiting POs to one application pending CMS review at a time and allow multiple pending applications of all types.

Topic 2A: Understanding Provider Experiences

CMS wants to better understand the factors impacting provider well-being and learn more about the distribution of the healthcare workforce. We are particularly interested in understanding the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, documentation and reporting requirements, operations, or communications on provider well-being and retention.

Examples may include, but are not limited to:

- Key factors that impact provider well-being and experiences of strained healthcare workers (e.g., compassion fatigue, retention, maldistribution);
- The increasing use of digital health technology on provider well-being and attrition;

[6] CMS, "CMS Releases 2023 Projected Medicare Basic Part D Average Premium," Accessed November 1, 2022, https://www.cms.gov/newsroom/news-alert/cms-releases-2023-projected-medicare-basic-part-d-average-premium#:~:text=The%20Centers%20for%20Medicare%20%26%20Medicaid,1.8%25%20from%20%2432.08%20in%202022

- Feedback regarding compliance with payment policies and quality programs, such as provider enrollment requirements on healthcare worker participation in underserved populations, and what improvements can be made;
- Impact of CMS policies on patient panel selection, and on providers' ability to serve various populations; and
- Factors that influence providers' willingness or ability to serve certain populations, particularly those that are underserved and individuals dually eligible for Medicare and Medicaid.

Topic 2B: Recommendations for CMS policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations.

NPA Response 2B:

Overall, rural counties have a higher proportion of seniors than urban counties. However, seniors in rural areas are less likely to have access to community-based services and more often have no choice but to enter a nursing home when they have long-term care needs. Interest in leveraging the PACE model to serve older adults in rural areas continues and was noted during the recent meeting of the National Advisory Committee on Rural Health & Human Services in which NPA participated.[7]

Additionally, last month, the Bipartisan Policy Center (BPC) issued a report delineating recommendations to expand PACE, including through the development of new POs in areas with low PACE penetration rates and/or disparate access to PACE, such as rural areas. As the report notes, "PACE has grown more slowing in rural areas due to barriers, including provider shortages, low population density, and longer travel distances to the adult care centers."[8]

NPA believes that enhanced access to PACE – including through CMS' pursuit of PACE-specific pilots, such as the PACE Part D Plan Choice Model for Medicare-only beneficiaries – will go a long way toward ensuring more equitable geographic access to PACE in rural communities.

Topic 3A: Advancing Health Equity

CMS wants to further advance health equity across our programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities. We want to better understand individual and community-level burdens, health-related social needs (such as food insecurity and inadequate or unstable housing), and recommended strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

Examples may include, but are not limited to:

- Identifying CMS policies that can be used to advance health equity:
    - Recommendations for CMS focus areas to address health disparities and advance health equity, particularly policy and program requirements that may impose challenges to the individuals CMS serves and those who assist with delivering healthcare services;
    - Recommendations on how CMS can better promote and support accommodations, including those from providers and health plans, for people with disabilities and/or language needs or preferences;
    - Input on how CMS might encourage mitigating potential bias in technologies or clinical tools that rely on algorithms, and how to determine that the necessary steps have been taken to mitigate bias. For example, input on how we might mitigate potential bias with clinical tools that have included race and ethnicity,

[7] HRSA, National Advisory Committee on Rural Health & Human Services, Accessed November 1, 2022, https://www.hrsa.gov/advisory-committees/rural-health

[8] BPC, "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

sex/gender, or other relevant factors. Further, input on potential policies to prevent and/or mitigate potential bias in technology, treatments or clinical tools that rely on clinical algorithms.
- Input on how CMS coverage and payment policies impact providers, suppliers, and patients, especially in the treatment of chronic conditions and the delivery of substance use disorder and mental healthcare, including individuals who are dually eligible for Medicare and Medicaid; and
- Feedback on enrollment and eligibility processes, including experiences with enrollment and opportunities to communicate with eligible but unenrolled populations.

NPA Response 3A:

NPA strongly urges CMS to reconsider policies and practices that unintentionally disadvantage beneficiaries' access to information about the full spectrum of their care options – including home- and community-based alternatives, such as PACE – that are critical to enabling beneficiaries to make informed care choices. We believe that beneficiaries benefit when given information about PACE that is on par with the information typically communicated about their other plan options. For example, Medicare Plan Finder does not offer PACE as a selection, potentially leading Medicare beneficiaries to believe the only two options available to them are original Medicare or Medicare Advantage.[9]

Further, while PACE marketing guidelines at §460.82[10] provide fundamental guardrails to ensure full transparency and participant protections, general marketing restrictions may unintentionally inhibit POs' ability to reach underserved and underrepresented populations, such as individuals dually eligible for Medicare and Medicaid. We would welcome an opportunity to address these issues with CMS to improve beneficiaries' access to PACE services.

Topic 3B: Understanding the effects on underserved and underrepresented populations when community providers leave the community or are removed from participation with CMS programs.

Topic 3C: Recommendations for how CMS can promote efficiency and advance health equity through our policies and programs.

NPA Response 3C:

Removing systemic (administrative and legislative) barriers to accessing PACE – as discussed above – is not only critical to accelerating optimal health outcomes and care efficiencies in Medicare and Medicaid but is key to advancing the Biden Administration's health equity agenda. Providing equitable alternatives to institutional care – especially among racial and ethnic minority adults with disproportionately increased nursing home enrollment and poorer health outcomes[11] – ensures that all individuals have a "fair and just opportunity to attain their optimal health."[12] As detailed above, NPA respectfully urges CMS, via the Innovation Center, to conduct PACE model tests, including one for Medicare-only beneficiaries, to remove barriers to integrated, community-based models like PACE.

Topic 4A: Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE, such as eligibility and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.

Examples may include, but are not limited to:

[9] https://www.medicare.gov/plan-compare/#/?year=2023&lang=en
[10] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-E/part-460
[11] BPC, October 5, 20222, https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/10/BPC_PACE_Report_Final.pdf.
[12] CMS Innovation Center, Key Concepts: Health Equity, https://innovation.cms.gov/key-concepts/health-equity.

Impact of COVID-19 PHE waivers and flexibilities and preparation for future health emergencies (e.g., unintended consequences, disparities) on providers, suppliers, patients, and other stakeholders.

Topic 4B: Recommendations for CMS policy and program focus areas to address health disparities, including requested waivers/flexibilities to make permanent; any unintended consequences of CMS actions during the PHE; and opportunities for CMS to reduce any health disparities that may have been exacerbated by the PHE.

NPA Response 4B:

NPA appreciates the critical steps CMS has taken to assist POs in meeting the needs of their participants during the ongoing COVID-19 public health emergency (PHE) period. These actions have been essential to PACE programs' ability to protect the health and safety of more than 60,000 medically complex, frail older Americans and persons with disabilities enrolled in PACE. Although 95 percent of participants continue to live in the community with the support of their POs, all are eligible for nursing home care.

Specifically, CMS' use of enforcement discretion to extend regulatory flexibility to POs has been essential to their ability to protect the health and safety of PACE participants and staff. Enforcement discretion has allowed POs to limit unnecessary in-person contact with prospective program participants during the intake and enrollment process, and for PACE IDT members to conduct participant assessments and reassessments remotely when appropriate.

While we understand the PHE has been extended through mid-January 2023, we continue to urge CMS to consider options for extending these critical regulatory flexibilities for POs beyond the PHE. This flexibility is needed to continue to protect the health and safety of POs' exclusively nursing home-eligible participants, at times addressing their individual preferences to be seen remotely rather than in-person. Further, these flexibilities have assisted POs in addressing other challenges resulting, at least in part, from the pandemic that will continue well beyond the PHE. As is the case for virtually all health care providers, POs are facing workforce challenges, and the regulatory flexibilities extended during the PHE have provided POs necessary flexibility in how they utilize their workforce. Workforce challenges will not disappear once the PHE is over, and POs and their participants would benefit from opportunities to exercise continued flexibility, as appropriate, fully considering the needs of individual participants.

NPA respectfully requests CMS consider ways to mitigate anticipated (and significant) gaps in POs' ability to perform assessments remotely following the end of the PHE absent an extension of these critical flexibilities. We continue to urge CMS to consider waiver requests of POs in advance of the expiration of the PHE to ensure that POs can continue remote assessments without interruption following the PHE period.