August 31, 2022

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–4203–NC
P.O. Box 8013
Baltimore, MD 21244–8013

The National PACE Association (NPA) is a national organization representing 147 operating Programs of All-Inclusive Care for the Elderly (PACE) organizations in 32 states. 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. The objective of PACE is to safely maintain the independence of older adults and people with disabilities in their homes and communities for as long as possible. POs currently serve over 61,000 patients, known as participants, nationwide. On behalf of our membership, NPA appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services request for information (RFI) in support of the Medicare Program; Request for Information on Medicare.

While the RFI specifically is soliciting comments for and from Medicare Advantage plans, NPA would like to take this opportunity to offer its comments to the statements and questions contained in the RFI related to service delivery to PACE Medicare eligible beneficiaries.

The PACE model of care has consistently demonstrated the ability to provide high quality, cost-effective care to older adults and those living with disabilities at home and in the community in lieu of a nursing home placement. Our members provide those requiring nursing facility level of care a true alternative to institutional placement through PACE enrollment.

POs stand ready to provide care to more people wishing to live at home, even as they face increasingly complex medical care and long-term service and support needs.

NPA appreciates your consideration of the following comments:

Section A: Advance Health Equity

CMS defines health equity as ''the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes'' (https:// www.cms.gov/pillar/health-equity). The CMS Framework for Health Equity (https://www.cms.gov/About-CMS/ Agency Information/OMH/equityinitiatives/framework-for-health-equity) lays out how CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive. We seek feedback regarding how we can enhance health equity for all enrollees through MA.

#1 What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following:

- *Enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life.*

PACE provides participants all the care and services covered by Medicare and Medicaid, including palliative and end of life care, as well as additional services not covered by Medicare and Medicaid as determined by each participant's care plan. Given the comprehensiveness of care available to the frail, older adults in PACE, all of whom are at a nursing home level of care, CMS should take further steps to highlight/promote PACE as an available option to Medicare and Medicaid eligible beneficiaries.

There are no limitations or conditions as to the amount, duration or scope of services made available to PACE participants that would otherwise apply under Medicare or Medicaid. The IDT assesses the participant's needs to develop a comprehensive care plan that meets those needs across all care settings on a 24-hour basis, each day of the year. Social and medical services are provided primarily in a PACE center with activities, therapies and primary care available on site. These services are supplemented by in-home care, transportation and contracted care with specialists, hospitals, and skilled nursing facilities.

The benefit package for all PACE participants includes Primary Care, Hospital Care, Medical Specialty Services, Prescription Drugs (including Medicare Part D drugs), Nursing Home Services, Nursing Services, Personal Care Services, Emergency Services, Home Care, Physical Therapy, Occupational Therapy, Adult Day Health Care, Recreational Therapy, Meals, Dental Care, Nutritional Counseling, Social Services, Laboratory/X-Ray, Social Work Counseling, End of Life Care and Transportation. Hospital, Nursing Home, Home Health, and other specialized services are generally furnished under contract. In most cases, the comprehensive service package permits participants to continue living at home rather than be institutionalized.

PACE services are financed by combined Medicare and Medicaid prospective capitation payments, and, in some instances, through private premiums. PACE organizations receive a monthly capitation payment for each eligible enrollee and combine these funds into a common pool from which providers pay health care expenses. This capitated financing allows PACE organizations to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. In exchange, PACE organizations assume full financial risk for all the health care services enrollees need. Unlike Medicare Advantage, PACE participants are not responsible for deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid.

PACE is an innovative model that provides a range of integrated preventative, acute care, and long-term care services to manage the often complex medical, functional, and social needs of the frail elderly.

PACE was created as a way to provide clients, family, caregivers and professional health care providers the flexibility to meet a person's health care needs while continuing to live safely in the community.

#2 What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

The National PACE Association (NPA) believes in the fundamental principles of equity, diversity and inclusion and that efforts to fully realize these principles create enormous opportunities to increase the satisfaction and

fulfillment of PACE staff, and the experience and quality of care for PACE participants. Recognizing that each PACE participant and staff person offers a unique set of ideas, beliefs and skills shaped by their heritage, background, and culture, NPA considers diversity and inclusivity critical to the success of PACE and essential to the empowerment, collaboration and innovation needed to maintain PACE as a leader in the healthcare industry.

In support of these fundamental principles, NPA launched an internal advisory group to assist in fostering an environment of diversity and inclusion within PACE, at all levels. This NPA staff driven advisory group subsequently evolved to become the NPA the Council on Diversity, Equity an Inclusion (Council), which held its inaugural meeting in March 2021. The Council is comprised of a diverse group of NPA staff, NPA member PACE organization representatives, and a NPA Board liaison. The Council's initial meetings served to find consensus on guiding values and to gain a deeper understanding of the NPA Board's perspective on the matter.

By establishing the Council, NPA acknowledges that a true commitment to the principles of equity, diversity and inclusion demands action. To that end, one of the primary objectives of the Council is to actively foster within NPA and its member organizations environments that recognize and value varying experiences and perspectives and the importance of such environments to achieving satisfaction and fulfillment among PACE staff, and the highest quality of care for PACE participants.

The Council serves as a catalyst for change and advocates for equity, diversity, and inclusion, with a specific focus on four overarching priorities:

- o Education and Awareness
- o Leadership Development
- o Workforce Development
- o Analyses and Evaluation

The Council has initiated activities in support of these priorities. The following are examples of those activities.

<u>Education and Awareness:</u>

- Developed Council on DEI welcome message to kick-off NPA annual conference;
- Facilitated roundtable and networking session during the annual conference to provide an opportunity for attendees to hear from a panel of PACE organizations efforts underway focused on DEI;
- Collaboration on NPA website redesign efforts to ensure inclusive web design, identification of strategies and solutions for inclusive and culturally sensitive interpretation
- Advancement of communication and language assistance efforts within PACE to improve the quality of services provided to all individuals

<u>Leadership Development:</u>

- Development of PACE leadership to gain support and ability for DEI to drive change throughout PACE and to promote a more diverse, inclusive, and equitable workplace

<u>Analyses and Evaluation:</u>

- Convene a DEI Learning Collaborative to deepen learnings and foster solidarity among those in PACE committed to promoting diversity, equity, and inclusion within their organizations.

  Throughout their history, PACE organizations have demonstrated their ability and fundamental commitment to serve medically complex older adults and those with disabilities in a culturally appropriate manner reflecting their communities. In1971 the first PACE program, On Lok in San

Francisco, was established because existing care models could not serve the older Asian and Pacific Islander American community well in their Chinatown North Beach neighborhood homes. Today, there are 144 PACE organizations located in rural areas, inner cities and the Cherokee Nation Reservation, among others, with some partnering with Federally Qualified Health Centers, empowering a diverse range of participants to remain independent for as long as possible while living in their homes and communities.

#6 For MA plans and providers that partner with local community-based organizations (for example, food banks, housing agencies, community action agencies, Area Agencies on Aging, Centers for Independent Living, other social service organizations) and/or support services workers (for example, community health workers or certified peer recovery specialists) to meet SDOH of their enrollees and/or patients, how have the compensation arrangements been structured? In the case of community-based organizations, do MA plans and providers tend to contract with individual organizations or networks of multiple organizations? Please provide examples of how MA plans and providers have leveraged particular MA supplemental benefits for or within such arrangements as well as any outcomes from these partnerships.

PACE addresses several social determinants of health (SDOH) as part of the care model, such as transportation, food security, social integration, support systems and access to high quality, linguistically and culturally appropriate health care services. In addition, POs commonly leverage partnerships with other community-based organization to ensure that SDOH above and beyond those offered through the care model, such as housing, are addressed.

Partners often include Area Agencies on Aging, Centers for Independent Living, Meals on Wheels, supportive housing organizations as well as other community partners and other offerings from parent organizations of POs. For example, St. Paul's PACE in San Diego is part pf a larger organization, St. Paul's Senior Services, which is a full-service, nonprofit retirement organization providing homes and care to generations of San Diego's seniors since 1960. Affordable, innovative and comprehensive programs are offered in a non-denominational environment with great value placed on optimal independence at all stages of life. St. Paul's Senior Services started with HUD housing and has incorporated that aspect into their Homeless Senior Housing initiative, where PACE provides all the medical and social care for those receiving housing services.*

(*Taken from Statement of Cheryl Wilson, RN, MA, LNHA, Chief Executive Officer, St. Paul's Senior Services, San Diego, California, On behalf of the National PACE Association, Before the Ways and Means Health Subcommittee, June 17, 2017, Care for Medicare Beneficiaries PACE at St. Paul's
https://nationalpaceassociation.sharepoint.com/:w:/g/EVYUZHx3sZBbqWTQwHXUls0B8w_k4PU887F3Olu71Z3k3A?e=XN7aUY)

Another example is the Amory Street Apartments and PACE Center, which was constructed through a partnership between Upham's Corner Health Center Elder Service Plan PACE and the Boston Housing Authority (MA). This collaboration resulted in the construction of a new PACE center for Upham's collocated with 12 apartments so that PACE participants could live close by and receive the services they need easily and at any time.

#9: How are MA SNPs, including Dual Eligible SNPs (D–SNPs), Chronic Condition SNPs (C–SNPSs), and Institutional SNPs (I–SNPs), tailoring care for enrollees? How can CMS support strengthen efforts by SNPs to provide targeted, coordinated care for enrollees?

Identified as an evidence-based care model by the Administration for Community Living, 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 a recently published analysis of integrated

care models by the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation Office of Behavioral Health, Disability, and Aging Policy 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.

We strongly believe that increasing access to the highly successful PACE model of care will "reduce program costs and improve quality and outcomes for Medicare and Medicaid beneficiaries"- stated goal of CMS' Innovation Center (IC). A recent policy brief from the Duke-Margolis Center for Health Policy recommended that the IC further explore PACE, given its value-based payment model, to help increase the availability of home care for older adults with complex biopsychosocial needs.

NPA respectfully urges CMS and the IC to conduct PACE model tests, including ones for Medicare-only beneficiaries and for new populations, such as for those living with Alzheimer's under the age of 55, so that these options can be explored deliberately. Furthermore, initiating PACE-specific pilots would directly address the current gap in the IC's portfolio regarding accountable, integrated and community-based models serving individuals with serious, chronic illnesses. PACE enjoys significant alignment with the IC's five strategic goals as outlined below.

Drive Accountable Care

The PACE model of care embraces and embodies accountable care. PACE organizations bear full financial risk for all Medicare- and Medicaid-covered services, as well as any additional services required to implement an individual's care plan. PACE is accountable for these services across all settings, 24 hours a day, 365 days a year. The capitated and fully risk bearing payment methodology applied to PACE provides a strong incentive to avoid duplicative or unnecessary services while encouraging the use of high value care, including appropriate community-based alternatives to avoidable hospital and nursing home care.

PACE combines excellence in clinical care and care coordination from a dedicated staff of providers to achieve the highest standards of quality with efficiency. The scope of services provided spans all Medicare Parts A, B and D benefits, all Medicaid-covered benefits, and any other services or supports that are medically necessary to maintain or improve the health status of participants. Door to door transportation, home care, personal care, meals and adult day services, among others, are provided routinely to PACE patients, known as participants. Members of the IDT meet at the PACE center, and participants receive primary care, therapy, meals, recreation, socialization and personal care there, among other services. Care and services are also provided at home as needed.

Support Innovation

The direct provision of care along with the financial flexibility afforded by its capitated funding enabled PACE organizations to adapt their standard operating practices so they could continue caring for participants successfully during the COVID-19 pandemic. PACE participants, despite being at the nursing home level of care, have experienced case and mortality rates two-thirds of the rates in nursing homes during this public health emergency While PACE organizations always have provided care and services to participants in their homes in conjunction with those provided in centers, the COVID-19 pandemic forced most PACE centers to close. Facilitated by the autonomy and freedom granted by its payment methodology and all-inclusive nature, PACE organizations swiftly shifted to providing almost all care and services needed by participants in their homes. Vans normally used to bring participants to and from PACE centers were converted into mobile clinics; center-based staff were redeployed to deliver meals, groceries and prescriptions and provide medical care and LTSS as well as companionship in participants' homes.

As the COVID-19 pandemic continues, PACE organizations continue to evolve. NPA has been partnering with the Altarum Institute on an Agency for Healthcare Research and Quality R01 grant examining the wide variety of adaptations made by PACE organizations since the advent of the COVID-19 pandemic and evaluating which changes should be retained after the public health emergency concludes. We look forward to sharing the findings with you at the end of the year.

Address Affordability

PACE is a prime example of a successful value-based purchasing model made even more effective by being provider-based and all-inclusive. The capitated nature of PACE compels the interdisciplinary team to provide participants with high value care as often as necessary to address both chronic conditions and acute issues with the target of avoiding emergency department, hospital and/or skilled nursing facility care whenever possible. Several studies have reported PACE beneficiaries have lower hospitalization and nursing home admission rates in addition to fewer emergency department visits, in comparison to similar populations.

Given that a disproportionate amount of Medicare spending stems from care provided to beneficiaries in the last year of life, encouraging additional Medicare-only and dually eligible beneficiaries to enroll in PACE will help control costs for these populations since PACE expenditures are fixed and predictable. Particularly for Medicare-only beneficiaries, increased use of PACE would help reduce out-of-pocket expenditures and either slow or avert all together spending down to Medicaid.

On the Medicaid side, PACE programs provide care for a dual-eligible population age 65 and over at a cost that is on average 15 percent less per person per month than the costs the state Medicaid programs otherwise would incur to provide services to these individuals. Additionally, given PACE's capitated nature, cost growth can be better controlled. NPA research shows that the 5-year compound growth rates for PACE payments are significantly lower than those of Medicaid nursing home costs.

Partner to Achieve System Transformation

Considering our decades of experience in providing high quality, integrated, capitated, coordinated and culturally appropriate care to older adults and those living with disabilities where they want it- at home and in the community- PACE is eager to collaborate with the IC. It is in our nation's best interest for the IC to explore additional applications of the PACE model of care given the clear history of success and satisfaction.

Looking forward, NPA urges the IC to undertake PACE-specific pilots. a fully integrated, accountable and provider-based model that works for frail older adults. Testing the PACE model of care with new populations would encourage system transformation, increase accountable care, facilitate advances in health equity, support innovation and address affordability. Further, PACE is one of the best positioned models to address the gap in the current IC portfolio related to accountable care, provider-led solutions for medically complex, high need populations.

<u>Section B Expand Access: Coverage and Care</u>

CMS is committed to providing affordable quality health care for all people with Medicare. We seek feedback regarding how we can continue to strengthen beneficiary access to health services to support this goal in MA.

PACE organizations have been extended several temporary enforcement discretions (see CMS FAQ document, April 9, 2020) during the pandemic. As part of this, CMS exercised its enforcement discretion to adopt a temporary policy of relaxed enforcement in connection with the signature requirements at 42 CFR 460.152(a)(2), 42 CFR 460.154, 42 CFR 460.156, 42 CFR 460.158 and 42 CFR 460.210(b)(12) to allow for the

PACE organization to instead obtain a "verbal signature" or verbal concurrence from the participant and/or their designated representative. In doing so, CMS recommended that the PACE organization receive concurrence from its state administering agency, maintain a record of the verbal signature or concurrence that clearly documents who took part in the verbal agreement, both at the PACE organization and the participant side. Further, CMS stated that the participant should actually sign all required documents including the enrollment agreement in-person as soon as this becomes possible.

This enforcement discretion has been and will continue to be essential during the PHE to reduce the need for non-essential in-person contact and to prevent delays in participants' access to PACE services. In addition, NPA believes continued flexibility allowing PACE organizations to obtain a "verbal signature" or verbal concurrence in place of an "actual" signature for requirements in 460.152(a)(2) (release allowing PACE organization to obtain potential participant's medical and financial information and eligibility status for Medicare and Medicaid), 460.154, 460.156,460.158 (enrollment agreement), and 460.210(b)(12) (release permitting disclosure of personal information) would be beneficial and should continue even after the expiration of the PHE in an effort to make the enrollment process more efficient and enhance beneficiaries' timely access to PACE services.

The PACE enrollment process is a complicated one involving the potential participant and the PACE organization, as well as the State Administering Agency which must assess potential participants to certify they meet nursing home level of care requirements, if this has not already been established. This process also may involve a determination of a potential participant's financial eligibility for Medicaid. All aspects of the enrollment process must be completed by the end of a given month, or even earlier if the state has additional deadlines to effectuate an enrollment on the first of the following month. Efforts to limit time lost in obtaining actual signatures should be pursued with the goal of preventing delays in beneficiaries' access to PACE services. It is not unusual for a potential participant to be referred to a PACE organization mid-month or later leaving little time for the PACE organization and State to complete the steps needed to effectuate an enrollment. Eliminating any loss of time resulting from the need to obtain actual signatures could prevent a situation in which the process is not completed in time for the potential participant to enroll the first of the following month and access needed services.

Allowing for a "verbal signature" or verbal concurrence to meet the signature requirements until an actual signature is obtained would address situations in which there is insufficient time to schedule appointments to obtain signatures, likely at the PACE center or the potential participant's home, or in some other way have the participant sign all required documents. In some cases, avoiding the loss of even a day or two that results from having to obtain actual signatures may prevent a month-long delay in access to PACE services. We are not aware of any detrimental consequences of this enforcement discretion.

#1 What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?

Individuals in need of long-term services and supports (LTSS) often face a complicated patchwork of service options and need assistance exploring the public and private programs available to them, navigating eligibility and enrollment requirements, and weighing other factors that affect their ability to live independently. The need for assistance in understanding their LTSS options may exist when individuals first apply for Medicaid or among Medicaid beneficiaries whose care needs change. To help these individuals, the National PACE Association believes it is important for states to offer effective options counseling that educates individuals

about the range of LTSS available and to assist them in selecting the option that best meets their needs. Given the unique needs of each individual, there is no single correct approach to options counseling. However, individuals need access to options counseling that meets the following criteria:

- Comprehensive: Individuals need to be aware of the full range of health and LTSS options available to them and be able to develop and access person-centered, tailored plans of care.
- Competent: Care plans should be provided by experienced, knowledgeable staff that is fully versed in the complete range of available services.
- Conflict-Free: This will ensure that options counselors, enrollment brokers or their sponsoring organizations do not inappropriately influence individuals' choices for their own financial benefit.
- Continuous and Timely: While it may be expedited when necessary, options counseling should be offered to all individuals prior to their enrollment in a plan. The process should allow sufficient time for clinical and financial eligibility determinations and for individuals to consider and weigh all options. Counseling should be revisited as individual needs or circumstances change.

In addition, states should be encouraged to make options counseling available to all individuals who meet one of the following criteria:

- request or indicate an interest in receiving information or advice concerning LTSS;
- are required to enroll in an insurance plan as part of a state-managed LTSS program or financial alignment demonstration initiative;
- are referred by a hospital, nursing home, assisted living home or other long-term residential setting; home-and community-based waiver services provider; or another agency;
- have had a recent change in health status, resulting in a greater need for LTSS;
- need assistance coordinating their LTSS and health care needs across many services and systems;
- have LTSS needs but are unsure about the process of accessing services or what services will best meet their preferences or needs;
- lack awareness of existing community resources and supports and could benefit from decision support and education around their options;
- have cognitive impairment and could benefit from support about early intervention, caregiver support, or LTSS related to dementia;
- have behavioral health needs and would like support regarding options related to their specific needs or situation; or
- disenroll from their current managed care or LTSS plan.

Whenever possible, options counseling services should not have any financial, organizational, or other relationship with LTSS providers, health plans and sponsors. However, if an organization offers both counseling services and LTSS, the state should develop and enforce policies and procedures to separate those functions or contracted relationships from the options counseling function.

In addition, states should be urged to develop evaluation tools and assessments to ensure that options counselors are not engaging in self-referral or referrals to organizations with which they have a contracted interest. These evaluations will measure self-referral and contractually related organization referral rates, explore patterns and trends in enrollment, and evaluate the effectiveness of the organization in separating functions and minimizing opportunities for abuse. To ensure options counselors are knowledgeable and experienced, the state should evaluate the entire system to assess whether individuals' needs are being met.

The state should review enrollment processes, “no wrong door” policies, options counseling, consumer satisfaction and ombudsman processes.

NPA believes that the current PACE application process restricts growth and expanded access to PACE services. While NPA appreciates that CMS has undertaken efforts to streamline the PACE application process, we believe that important opportunities remain to enhance the efficiency and effectiveness of the PACE application process, particularly as it relates to expansion applications.

CMS should allow for a PO to have more than one New PACE Center or Service Area Expansion application under CMS review at a time. NPA appreciates that CMS provides POs the opportunity to submit Service Area Expansion applications, including both applications to expand a PO’s service area and applications to add a new PACE center within an existing service area, on a quarterly basis. However, this frequency remains insufficient to address the needs POs face as providers of care to expand their service capacity and serve Medicare and/or Medicaid beneficiaries in new service areas. In many cases, it is exceedingly difficult for a PO to coordinate the submission of an application involving a new PACE center and completion of that PACE center in a way that minimizes the length of the application process. Often the reasons for this are outside the PO’s control, e.g., delays in construction, delays in state licensing/certification processes, etc.

Hence, if there is a need for a new PACE center within an existing service area or a new opportunity to expand its service area while an existing application is pending CMS review, a PO may not be able to act for an extended time period. Depending on the circumstance, during this period, 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. For this reason, NPA recommends Congress direct CMS to reconsider its current policy of limiting POs to one application pending CMS review at a time and allow for multiple pending applications of all types.

#2 What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?

Medicare Plan Finder does not offer PACE as a selection, leading Medicare beneficiaries to believe the only two options available to them are original Medicare or Medicare Advantage (MA). NPA believes that the solution is to offer PACE as an option for those at nursing home (NH) level of care (LOC). Also, since PACE is all-inclusive, unlike MA, no changes need to be made – PACE is the model everyone else, including SNPs and MA, seek to emulate, why not encourage the target model?

Allow Medicare-Only PACE Participants to Enroll in Marketplace Part D Plans. Since PACE is required to provide all Medicare and Medicaid benefits to a participant, each PO establishes and manages a Part D plan. Unlike dually eligible beneficiaries, Medicare-only beneficiaries must pay a monthly premium to POs for their Part D coverage. As such, Medicare-only beneficiaries should have the freedom to select the Part D plan of their choice. In our experience, unaffordable Part D premiums in PACE force many otherwise eligible Medicare-only beneficiaries to forego PACE as an option. Given that 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, 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 $43.00 for stand-alone Part D plans.

In 2022, less than 1 percent of the more than 60,000 PACE participants are Medicare-only beneficiaries; the remainder are either Medicaid-only or dual-eligible beneficiaries for whom Part D premiums are subsidized. Addressing the high cost of Part D premiums for Medicare-only beneficiaries seeking to enroll in PACE by allowing participation in marketplace prescription drug plans in lieu of PO-operated Part D plans, would increase access to this innovative model of care. Looking forward, if Congress imposes a $2,000 cap on the out-of-pocket expenses stemming from deductibles and/or coinsurance for Medicare Part D beneficiaries, PACE Medicare-only enrollees will be the sole group of Medicare beneficiaries unable to be helped by this cost reduction since the financial burden stems from their premiums alone.

#5 What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?

During the COVID-19 public health emergency (PHE), the Centers for Medicare and Medicaid Services (CMS) has permitted PACE organizations (POs) the flexibility to use remote technology for scheduled and unscheduled participant assessments, care planning, monitoring, communication, and other related activities that normally would occur on an in-person basis. This flexibility has enabled POs to successfully use remote technology to conduct one or more interdisciplinary team (IDT) member assessments. This has been beneficial both from the perspective of the participant as well as the PO/IDT. Given this success, POs – and some states – have expressed strong interest in utilizing this flexibility to continue to have enhanced access to participants once the PHE comes to an end. Some POs, with their states' concurrence, have already submitted request to CMS for BIPA 903 waivers to continue this flexibility. However, it is the National PACE Association's (NPA) understanding that CMS has chosen not to evaluate the waiver requests since the PHE and related flexibilities are still in effect.

NPA would like to urge CMS to provide clarification that POs will be able to conduct remote assessments, without interruption, following the PHE. For this to be possible, unless CMS is considering other opportunities for continuing the PHE flexibilities, it will be necessary for CMS to evaluate waiver requests from interested POs prior to the expiration of the PHE since waiver requests are generally accepted only once a quarter and POs cannot anticipate with certainty when the PHE will end. For example, the current PHE has been extended through mid-July, to avoid a gap in a PO's ability to conduct remote assessments, it would have needed to submit a waiver request on June 24th Allowing for a 90-day review period, if approved, the waiver might not take effect until as late as September 22, 2022, more than two months after the PHE has expired.

NPA would very much appreciate communication from CMS to POs, States and NPA on the potential to extend PHE flexibilities after the PHE ends, whether CMS will consider waiver requests related to flexibilities allowed under the PHE, and when such waiver requests will be accepted for evaluation. We ask that whatever action CMS takes will allow for flexibilities to continue uninterrupted.

In addition, NPA urges CMS to allow for the continuation of regulatory flexibilities that would facilitate beneficiaries' timely enrollment and access to PACE services by allowing for PACE staff visits to a participant's place of residence and a potential participant's visits to the PACE center to be done using remote technology. We fully recognize this will not be possible in all cases, e.g., when a potential participant does not have access to necessary technology or is unable to use it effectively, or the PO is not confident that it can explain the program effectively to a potential participant or accurately assess the potential participant's ability to be cared for appropriately in a community setting via remote technology. In cases when these barriers do not exist,

however, we believe alternatives to multiple in-person visits should be available to POs and potential participants. Such alternatives could expedite the enrollment process and, in some cases, may be responsive to potential participants' preferences. We advocate for a continuation of this regulatory flexibility after the PHE expires with respect to requirements in 460.152(a) for in-person visits when the PACE organization has determined the requirements of the intake process in 460.152(a)(1)-(4) can be met and use of remote technology is agreed to be the potential participant or his/her representative.

Based on PACE organizations' experience during the PHE, we do not believe this approach, used appropriately, will compromise the intake and enrollment process.

Section C Drive Innovation to Promote Person-Centered Care

We strive to deliver better, more affordable care and improved health outcomes. Key to this mission are care innovations that empower the beneficiary to engage with their health care and other service providers. We seek feedback regarding how to promote innovation in payment and care delivery, and accountable, coordinated care responsive to the specific needs of each person enrolled in MA.

PACE organizations stand ready to provide care to more people wishing to live at home, even as they face increasingly complex medical care and long-term service and support needs. However, a number of access and affordability policy barriers, both legislative and regulatory, stand in the way of PACE meeting these needs. As a means to overcome this NPA encourages CMS to implement the provisions of the PACE Expanded Act (S. 3626) and the PACE Plus Act (S. 2166/H.R. 6770).

Sponsored by Sens. Bob Casey (D-PA) & Tim Scott (R-SC) the PACE Expanded Act (S. 3626) would expand access to PACE by Medicare and/or Medicaid beneficiaries by:

- Permitting any time enrollment
- Establishing flexible rate setting for Medicare-only beneficiaries
- Eliminating quarterly submission of new provider and SAE applications
- Deeming applications approved within 45 days unless denied or additional information requested
- Clarify that the Federal Coordinated Health Care Office as a point of contact for State Medicaid Agencies for implementing and operating PACE programs

Sponsored by Sen. Bob Casey (D-PA) in the Senate & Reps. Earl Blumenauer (D-OR3) and Debbie Dingell (D-MI12) in the House, the PACE Plus Act (S. 2166/H.R. 6770) would expand access to PACE for Medicare and/or Medicaid beneficiaries by:

- Establishing two-way PACE agreements
- Permitting any time enrollment
- Establishing flexible rate setting for Medicare-only beneficiaries
- Eliminating quarterly submission windows for new provider and SAE applications
- Deem applications approved within 45 days unless denied or additional information requested
- Incentivize State Medicaid Agencies to expand eligibility for PACE with 90% FMAP for those new populations
- Clarify that the Federal Coordinated Health Care Office as a point of contact for State Medicaid Agencies for implementing and operating PACE programs

#3 What steps within CMS's statutory or administrative authority could CMS take to support more value-based contracting in the MA market? How should CMS support more MA accountable care arrangements in rural areas?

The Program of All-Inclusive Care for the Elderly (PACE) can play a significant role in supporting the goals of state and federal policy-makers to meet beneficiaries' needs as whole persons and to serve individuals with

LTSS needs in fully-integrated care models. PACE offers consumers a provider-based alternative to larger, insurer-based managed care plans while helping policy-makers achieve their goals for more effective and efficient care. Given that PACE was created to provide participants, family members, and caregivers flexibility to meet the health care needs that keeps people living in their homes and communities, PACE focuses on the whole person and care coordination. However, enrollment in a PACE organization (PO) is limited to those who reside within its defined service area. The service area is established in the PACE program agreement with the state and the Centers for Medicare and Medicaid Services (CMS).

Since PACE can only serve those who live in the defined service area, it is a limited state option. The National PACE Association believes CMS could extend its long-term commitment to PACE and encourage states without PACE to pursue it as an option and encourage states with PACE to expand the program. CMS could encourage states to assess the projected growth of persons 55 years of age and older that meet nursing home level of care and initiate and/or expand PACE through new programs or expanding the areas served under existing program agreements.

In addition, we recommend that CMS implement two changes to the application process for PACE to encourage development of new PACE organizations and expansion of existing programs:

1) Remove quarterly restriction on submission of initial and 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 ask CMS to 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.

2) Allow for a PO to have more than one Service Area Expansion (SAE) application under CMS review at a time. We appreciate that CMS provides POs the opportunity to submit SAE applications, inclusive of applications that actually expand the PO's service area as well as applications that only add a new PACE center to an existing service area on a quarterly, rather than annual, basis.

However, this frequency remains insufficient to address the needs POs face as providers of care to expand their service capacity and serve Medicare and/or Medicaid beneficiaries in new service areas. In many cases, it is very difficult for a PO to coordinate the submission of an application involving a new PACE center and completion of that PACE center in a way that minimizes the length of the application process. Often the reasons for this are outside the PO's control, e.g., delays in construction, delays in state licensing/certification processes, etc. Hence, if there is a need for a new PACE center within an existing service area or a new opportunity to expand its service area while an application is pending CMS review, a PO may not be able to act for an extended time period. Depending on the circumstance, during this period, 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.

For this reason, we ask CMS to reconsider its current policy of limiting POs to having just one service area expansion application pending CMS review at a time. While we understand that CMS systems challenges must be overcome to allow POs to have multiple applications under review concurrently, we are hopeful that CMS would be willing to address these in favor of supporting beneficiaries' access to PACE services.

Similarly, we are confident that other challenges that CMS has identified with respect to multiple pending applications also can be addressed, e.g., any challenges or confusion resulting from reviewing multiple applications concurrently or identifying the most recent information needed to amend the PO's program agreement and would appreciate the opportunity to address these with agency staff.

#9 What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and nonmedical needs of enrollees with serious illness through the full spectrum of the care continuum?

Implementing PACE-Specific Model Tests Through the Innovation Center Is Critically Important. Current eligibility requirements restrict PACE access to individuals who are age 55 or over and require a nursing home level of care. The PACE Innovation Act of 2015 (P.L. 114-85) authorized CMS to test the PACE model with new populations, such as younger people with disabilities, individuals at risk for needing nursing home care and others. While CMS took action in 2016 and 2017 toward implementing PACE-specific pilots, progress has stalled. During the Biden-Harris Administration, NPA has had several meetings with Innovation Center (IC) Director Liz Fowler and her staff on the prospect of PACE pilots, but no definitive step has been forward. NPA is gravely concerned that pilots not based on the PACE care model are inappropriate to test PACE innovations, which could help serve new medically complex populations in their homes and communities rather than in institutional settings.

The Innovation Center Should Implement PACE-specific Model Tests Swiftly. NPA respectfully urges CMS and the IC to move forward swiftly and implement PACE-specific model tests, for which they have the authority. Such an effort will build on and adapt the PACE model to serve new populations, offering beneficiaries an opportunity to experience an effective, integrated, community-based care option that supports their independence and quality of life. Many community providers who serve these new populations are ready to move forward but cannot under the currently proposed approach. Exploring new alternatives for the delivery and financing of community-based LTSS is an important task in planning for our nation's care needs. PACE-specific model tests will provide valuable opportunities to understand how this proven model of care can be adapted to serve new populations living with complex care needs.

Section D Support Affordability and Sustainability

We are committed to ensuring that Medicare beneficiaries have access to affordable, high value options. We request feedback on how we can improve the MA market and support effective competition.

PACE organizations stand ready to provide care to more people wishing to live at home, even as they face increasingly complex medical care and long-term service and support needs. However, a number of access and affordability policy barriers, both legislative and regulatory, stand in the way of PACE meeting these needs. As a means to overcome this NPA encourages CMS to implement the provisions of the PACE Part D Choice Act (H.R. 4941).

Introduced by Reps. Earl Blumenauer (D-OR3), Jackie Walorski (R-IN2), Debbie Dingell (D-MI12) and Christopher Smith (R-NJ4) the PACE Part D Choice Act (H.R. 4941) would:

- Expand access to PACE by Medicare-only beneficiaries
- Facilitate increased scale of PACE programs
- Permit a Medicare-only PACE participant to opt out of the PACE Part D plan
- Enable that participant to purchase a standalone Part D plan

- For many Medicare-only participants, the total yearly out of pocket cost of a standalone Part D plan, even with the premium, a deductible and cost-sharing, is less than the yearly premium cost for their PACE Part D plan

#1 What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?

Unlike insurer-based health plans, which rely primarily on contracted provider networks, PACE organizations (POs) represent a provider-based model with an interdisciplinary team of health professionals who have a direct care relationship with the enrollee. POs also differ from most insurer-based managed long-term services and supports (MLTSS) health plans in bearing full financial risk, without a capitation rate adjustment, for enrollees who require a long-term nursing facility placement.

PACE enrolls only the frailest beneficiaries, specifically those who meet their state eligibility criteria for nursing home level of care and require comprehensive, ongoing and intensive services to meet their chronic health and long-term care needs.

To ensure beneficiaries have access to services that is as similar as possible across long-term care programs and options, the Centers for Medicare and Medicaid Services (CMS) should encourage states to establish adequate payment PACE rates that support the growth of existing POs and the development of new POs. Federal law requires states to make a prospective monthly capitation payment to a PO for a Medicaid participant that is less than what would otherwise have been paid under the state plan if not enrolled in PACE, considers the comparative frailty of participants, and is a fixed amount regardless of changes in a participant's health status.

Accurate and fair Medicaid rate setting is central to the financial sustainability of POs as well as responsible stewardship of state financial resources. CMS and states should work to ensure PACE rates meet the following principles:

• Comprehensive – PACE rates should reflect the range of services PACE offers. This should include an assessment risk for institutional care. Rates should also be comparable with similar populations as it relates to member acuity of the population served. Given that all PACE participants meet nursing home level of care, there should be a reasonable blend of those who live in nursing homes and those who live in the community. States should share the blend with POs.

• Timely and prospective – CMS should work with states to ensure that PACE rates are updated regularly. NPA agrees with CMS' 2015 recommendation that rates be adjusted annually and not later than every three years. This would improve rate setting accuracy for PACE in states that have gone beyond three years in making any adjustments. In addition, some states share rates after the fiscal year has already begun, which can create difficulties for POs especially if there is a rate decrease. Therefore, final rates should be provided to POs prior to the date they go into effect.

• Transparent – Given that rate setting should be a partnership between the state and POs, states should be forthcoming with data used to set rates so POs can fully understand what encompasses the rates. This information should include the nursing home versus home and community-based services mix as well as the acuity of the population served and the comparable population. States should be encouraged to share how they factor in the financial risk for institutional placement into the rates. And

finally, states should provide a forum for POs to provide questions and feedback. In response, states should outline how they have addressed questions and concerns raised by POs.

• Predictable – CMS should also encourage states to make rates as predictable as possible. Given that PACE is a fully at-risk model, rates should be stable, so POs can plan and grow with some certainty that their rates won't be significantly cut in any given year.

• Sufficient and Appropriate – CMS should also urge state to establish rates that are sufficient and appropriate for the anticipated service utilization of the populations and services covered under the contract and provide appropriate compensation to the PACE organizations for reasonable non-benefit costs.

• Actuarial rate certification – Along with proposed capitation rates, states should be encouraged to provide sufficient detail, documentation, and transparency of the rate setting components to enable another actuary to assess the reasonableness of the methodology and the assumptions supporting the development of the final capitation rate.

#2 What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?

A more accurate approach to PACE risk adjustment would include dementia HCCs in the PACE CMS-HCC payment model.

Given the high prevalence of dementia in the PACE population and associated Alzheimer's disease, NPA strongly recommends the application of the 2020 CMS-HCC model v24 which does contain dementia HCCs to PACE. Notably, this HCC model is currently applied to Medicare Advantage (MA) plans which serve a population that has a significantly lower prevalence of dementia than PACE, and therefore a significantly lower risk of the costs associated with caring for people with this condition.

Inclusion of dementia in the HCC model applied to PACE meets all of CMS' criteria for HCC risk adjustment conditions. Specifically for the PACE population dementia is 1) clinically meaningful 2) predictive of medical expenditures, and 3) minimally subject to clinical discretion and indicative of significant disease burden.

In addition to dementia, several key condition categories of high importance to accurately assessing the risk of PACE participants meet these criteria; however, they continue to be excluded in the 2017 CMS-HCC risk adjustment payment model: pressure ulcer (HCC 159), moderate chronic kidney disease (HCC 138) and several mental health and substance use disorder condition categories.

E. Engage Partners

The goals of Medicare can only be achieved through partnerships and an ongoing dialogue between the program and enrollees and other key stakeholders. We request feedback regarding how we can better engage our valued partners and other stakeholders to continuously improve MA.

#2 How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers?

PACE organizations stand ready to provide care to more people wishing to live at home, even as they face increasingly complex medical care and long-term service and support needs. However, a number of access and affordability policy barriers, both legislative and regulatory, stand in the way of PACE meeting these needs. As a means to overcome this NPA encourages CMS to implement the provisions of the Elizabeth Dole Home Care Act (S. 3854/H.R. 6823).

Introduced by Sens. Jerry Moran (R-KS), Maggie Hassan (D-NH) and Jon Tester (D-MT) the Elizabeth Dole Home Care Act (S. 3854/H.R. 6823) would expand access to HCBS for Veterans and increase caregiver support and would also facilitate the increased scale of PACE programs.

Additionally, the Act would:

- Expand access for all VA Medical Centers to all VA HCBS programs in Two Years.
- Require every VA Medical Center located within the geographic service area of a PACE organization to establish a partnership with them
- Mandate coordination between PCAFC and VA's HCBS. If a veteran is denied or discharged from the PCAFC the veteran will be assessed for participation in all other HCBS programs
- Establish a "one stop shop" webpage to centralize information for families and veterans on all programs and includes an informational eligibility assessment tool
- Establish a three-year pilot program to address shortages of home health aides. VA will directly hire or repurpose current nursing assistants to be home health aides for veterans
- Require VA make the Veteran Directed Care and Homemaker Home Health Aide programs available in the territories and to Native veterans using IHS, tribal, or urban Indian health organizations
- Expand access to respite care for family caregivers of veterans enrolled in home care programs

#3 What steps could CMS take to enhance the voice of MA enrollees to inform policy development?

NPA believes CMS could accomplish this by meeting with NPA and its member organizations at least annually for the opportunity to provide CMS with feedback and additional input in matters related to policy and regulatory development.