National
MLTSS
Health Plan Association

October 17, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Programs of All-Inclusive Care for the Elderly (PACE) (CMS-4168-P)

Dear Administrator Slavitt:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS's) proposed rule to revise and update the requirements for the PACE program under Medicare and Medicaid.

The National MLTSS Health Plan Association is a new national organization comprised of the leading managed care organizations designed to deliver high-value, quality managed long-term services and supports (MLTSS) for state Medicaid programs and beneficiaries. Member organizations include: AmeriHealth Caritas, Anthem Inc., Centene Corporation, Commonwealth Care Alliance, Humana, L.A. Care Health Plan, Molina Health Care, Inc. and WellCare Health Plans, Inc.

As an industry, MLTSS health plans manage an array of specialized services and supports that enable individuals of all ages accessing LTSS to live in the most integrated setting. Organizations that sponsor MLTSS plans understand that the delivery of high-quality LTSS can have a significant positive impact on a person's independence, health, and quality of life. The National MLTSS Health Plan Association brings together the knowledge and experience of MLTSS health plans, the unique understanding of LTSS and of the variety of persons of all ages with disabilities and functional limitations who need these services, in order to pursue legislative and regulatory changes in Medicare and Medicaid that enable health plans to better serve members and help them achieve positive health outcomes.

The National MLTSS Health Plan Association supports CMS's efforts to improve upon and refine the success of the PACE program. As of 2016, there are 118 PACE programs that serve 38,000

beneficiaries and operate in 32 states[1]. PACE has successfully enabled individuals 55 years or older with nursing home-level of care needs to remain independent in their own homes through a unique program that employs an interdisciplinary team (IDT) to deliver services in a specific setting, such as an adult day health center.

CMS's proposed changes are intended to address requirements for the PACE program that have limited its capacity to grow and serve a larger population of seniors with disabilities. In particular, the rule proposes to change requirements that have been an essential part of the PACE model. The proposed rule:

- Revises the requirement that a PACE organization be a non-profit or public entity;
- Allows for the provision of services at alternative care settings outside the PACE center:
- Revises the requirement that members of the IDT primarily serve PACE participants at the PACE location, and allows community-based physicians to fill the role of primary care provider on the IDT while continuing to work in community settings.

The National MLTSS Health Plan Association commends the success of the PACE model and supports the objectives of the proposed rule to promote PACE, expand the model's capacity to serve seniors with disabilities, and generally build on what has made the model successful.

In modifying the PACE model, however, CMS is diminishing the highly-integrated, provider-centered care delivery features that have been integral to its success and warranted its unique payment and regulatory framework. CMS's proposed modifications to the PACE regulations will make PACE more like Medicare Advantage (MA) and Medicaid managed care plans, particularly those plans that serve populations with complex and/or chronic disabilities: MMP, DSNP, and MLTSS. PACE organizations providing services in the community and incorporating community-based physician practices will not be substantially different than MMPs or managed care plans that also integrate acute care and LTSS, manage members' care through intensive care management and an IDT, and accept full financial risk through capitated payments that pool funding from Medicare and Medicaid.

The regulatory environment for plans that are managing LTSS and integrating care has spawned a needlessly complex array of plan types. Differentiation between types of integrated plans has complicated choices for beneficiaries and created inconsistencies in treatment of beneficiaries. Rather than add yet another dimension of complexity, CMS should strive, as it promulgates new rules, toward a uniform regulatory framework for fully-integrated plans. There are features of PACE, particularly its pooling of funds and flexibility in providing services, that would be beneficial for all integrated plans serving beneficiaries with complex and/or chronic disabilities. By the same token, there are features of MA regulation, particularly providing important protections for beneficiaries, that should be applied to PACE organizations that will no longer have the restrictions that are imposed in current PACE rules.

[1] http://www.npaonline.org/policy-advocacy/value-pace#history

In this light, we raise the following concerns with the proposed rules:

- *Implications of Incorporation of Community PCPs for Beneficiary Access*

  CMS states in the proposed rule that the types of providers in the (IDT) should change along with "evolving medical practices and technologies". Thus, CMS has proposed to allow primary medical care to be administered by a primary care physician, a community-based physician, a physician assistant, or a nurse practitioner. In addition, CMS is proposing to remove the requirement that members of the IDT must primarily serve PACE participants—this would make PACE providers resemble more of a network than a staff model of care, especially if those providers are in settings outside the PACE center.

  We support these efforts to expand beneficiary choice and increase the ability of PACE organizations (POs) to address increasing shortages of primary care providers, but also note that this could move PACE away from the characteristics of the IDT that helps make PACE a unique model.

  As PACE begins to resemble a network rather than IDT model of care, maintaining beneficiary access to quality providers becomes a concern. There is no sound reason to apply a different standard for network adequacy to a network of community providers in a PACE than to a network in an MMP, DNSP, or MLTSS plan. Beneficiary access to quality care should be a consistently-defined feature across all types of integrated plans using a network model.

- *Application of the Home and Community-based Settings (HCBS) Rule to PACE*

  The proposed rule asks for comments about the appropriateness of requiring contracted services authorized by the PO or services operated directly by the PO to be subject to HCBS regulations. As CMS explains, the purpose of the HCBS regulations are "to ensure that individuals receiving long-term services and supports through home and community based) HCBS programs…have full access to the benefits of community living and the opportunity to receive services in the most integrated setting appropriate." PO beneficiaries should be afforded the same level of protection to encourage self-direction, community integration, and participation.

  However, this topic raises substantial questions about how all adult day programs will be treated under this rule. As MLTSS health plans, we are aware of the administrative challenges associated with complying with the requirements put forth by the HCBS settings rule and we are concerned with the impact this might have on the PACE program. To the extent that beneficiaries benefit from PACE's adult day program being excluded from the settings rule, we would suggest that beneficiaries of the same age in other programs (e.g., MMP, MLTSS) could benefit from the same adult day exclusion. Regardless, all other HCBS settings for which PACE provides services should be subject to the rule.

As the PACE program evolves under this proposed rule to provide substantially more services outside of the center, the distinction between PACE and other programs that might justify a difference in the application of the rule disappear. Challenges that the HCBS rules might pose to a modified PACE program should be addressed in the context of all managed care plans that must comply with these rules.

- *Clarification of Marketing provisions*

  CMS proposes to prohibit "contracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with the elder to solicit enrollment." Instead, the responsibility of marketing program would be given to POs through their own employees. CMS notes that the low enrollment rates of PACE and the significance of enrolling in the program as its primary concern for giving responsibility to the POs rather than entities that may lack the specialized knowledge about the program. We are supportive of this proposal insofar as POs are subject to appropriate restrictions and compliance mechanisms. POs should be subject to other marketing requirements applied to MA, MMPs, and MLTSS programs outlined in the April 2016 Medicaid/CHIP Managed Care final rule including producing provider directories, use of independent enrollment brokers, and restrictions on inappropriate counseling by community providers.

  Furthermore, we ask CMS for additional clarification on the term "employee" as it applies to the marketing requirements. For example, are providers primarily based in the community that begin to provide services to PACE organizations considered to be employees? There is concern that a referral relationship could develop in this situation that may not be in the interest of the beneficiary. We would also ask CMS to make a distinction between marketing and enrollment activities. In Medicaid for example, plans are able to market, but enrollment is often handled by a neutral third-party that serves as an additional beneficiary protection.

We commend you on this effort to further develop and refine the PACE program and we appreciate the opportunity to comment on these changes. We welcome any opportunity to meet with members of CMS to discuss how to ensure PACE reaches its full potential and how to implement the program in such a way that beneficiaries continue to receive the high quality care they are used to and deserve.

Sincerely,

G. Lawrence Atkins
Executive Director