MHPA Comments: PACE Proposed Rule

Summary of High-Level Response:

- MHPA believes that PACE Organizations (POs) and Medicaid MCOs play a key role in providing integrated acute and long-term services and supports (LTSS) to complex, vulnerable populations.
    - MHPA is concerned that many of the provisions included in this proposed rule permit flexibilities to PACE Organizations in providing integrated acute and LTSS that are not extended to Medicaid MCOs, MMPs and MA plans serving a similar population of beneficiaries.
    - MHPA believes that some provisions create an "unlevel" playing field between POs and MCOs, MMPs and MA plans that are providing similar services, though have more prescriptive requirements to which they must adhere.
- MHPA recommends that as CMS works to introduce flexibilities around the PACE program that it align standards and requirements for POs with those for Medicaid MCOs, MMPs and MA plans, where appropriate.

Proposed Provision (Issue Area)	MHPA Position	Proposed Modification
Medicaid Payment/Rate Setting (§460.182) CMS proposes that the monthly capitation amount included in PACE agreements be "sufficient and consistent with efficiency, economy, and quality of care." CMS is proposing to require that the PACE program agreement contain the state's Medicaid capitation rate OR the "methodology" for establishing the Medicaid capitation rates. Additionally, CMS is soliciting feedback on whether there is another rate setting methodology that could be used for POs that is more consistent/competitive with those used by similar programs (i.e., the Financial Alignment Demonstration).	MHPA believes that PACE rates should align with Medicaid rates, and that Medicare rates for POs should be consistent with Medicare Medicaid Plans (MMPs) or DSNPs. Consistency of rates across programs will help to ensure a level playing field when recruiting providers and care givers so that beneficiaries in both programs have sufficient access to needed care.	MHPA recommends that CMS modify language in the final rule to clarify that PO rates should be actuarially sound. MHPA also urges that, where appropriate, rate setting requirements for Medicaid MCOs be extended to POs. MHPA also strongly recommends that rates related to providing long-term services and supports (LTSS) be consistent across Medicaid and Pace and that Medicare rates for POs should be consistent with Medicare Medicaid Plans (MMPS) or DSNPs. MHPA recommends that CMS work to ensure this language is reflected in the final rule as it will create a more level playing field across the programs in terms of provider recruitment and beneficiary access.

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Contracted Services (§460.70) CMS is seeking input on whether services provided by a PO–or by an authorized contractor—should comply with Home and Community-Based Services (HCBS) rules (§441.301(c)(4)) when HCBS are provided (housing, services or both) to PACE participants.	MHPA believes that services provided by a PO—or by subcontractors authorized by the PO—should comply with HCBS rules. This is especially important given that CMS is proposing to allow POs the flexibility to provide services outside of the PACE Center, which diverges from current practice. MHPA believes that allowing POs to offer services outside of the PACE center allows for provision of service more similar to community-based settings by Medicaid MCOs. HCBS requirements should be applied consistently across programs in which these services are offered.	MHPA strongly recommends that any HCBS provider must be held to the same standards and requirements, regardless of whether provided by a PO or Medicaid MCO and that CMS should include this clarification in the final rule.
Interdisciplinary Care Teams (§460.102) CMS proposes to give POs greater flexibility related to their Interdisciplinary Care Teams (IDT). Specifically, CMS is proposing to: • Permit greater flexibility to involve non-physician practitioners in the IDT. Specifically allowing primary medical care to be furnished by a primary care physician, a community-based physician, a physician assistant, or a nurse practitioner. • Allow community-based primary care physicians that do not "primarily" serve PACE participants to be part of an IDT. • Allow individuals on an IDT to fulfill two roles (when applicable licensure requirements are met). CMS is also considering deleting IDT composition requirements.	MHPA understands CMS' rationale for proposing greater flexibilities to the IDT structure. Specifically, we understand the challenges of recruiting staff with the necessary licensure in certain geographic areas and understand the benefits of using trusted providers to provide more than one service or support, which can be especially important for vulnerable and hard to reach populations. Along with changes to the IDT, we suggest CMS work to apply consistent beneficiary protections and other requirements (e.g., rates, enrollment processes, marketing, etc.) across POs and MCOs—and other programs where appropriate—to ensure sufficient consumer protections and a level playing field.	MHPA strongly recommends that if CMS finalizes the proposed rule with the proposed flexibilities for the IDT configuration and settings of care, CMS should also institute network adequacy standards (e.g. time and distance standards), beneficiary protections and other requirements (e.g., rates, enrollment processes, marketing, etc.) for POs that are consistent with those in other programs, especially Medicaid. This will help ensure appropriate access to providers and needed care, as well as ensure a level playing field. MHPA also recommends that CMS estimate the impact its proposed changes to the IDT may have on recruitment of practitioners and access to care for beneficiaries across programs to ensure there will be no adverse effects before finalizing this proposal. Additionally, MHPA urges CMS to include clarifying language prohibiting providers and other IDT members from unfairly influencing members to enroll into a PO or MCO. Specifically, MHPA requests that CMS include language that prevents PO employees from using discriminatory practices to steer enrollees towards enrollment in a PO on the basis of health status.

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Service Delivery (§460.98) CMS proposes to allow greater flexibility with regard to alternative care settings in which IDT members provide PACE services.	Currently, POs must provide services at home, in inpatient settings and at PACE centers at a minimum.	MHPA strongly recommends that if CMS finalizes its proposed flexibilities with relation to the IDT configuration and settings of care that it should also institute network adequacy standards (e.g. time and distance standards), beneficiary protections and other requirements (e.g., rates, enrollment processes, marketing, etc.) for POs that are consistent with those in other programs, especially Medicaid. This will help ensure appropriate access to providers and needed care, as well as ensure a level playing field.
Marketing (§460.82) CMS proposes to prohibit non-employed agents/brokers, including contracted entities, to market PACE programs. Additionally, CMS proposes to prohibiting unsolicited marketing—defined as "direct contact, including calling or emailing a potential or current participant without the individual initiating contact". CMS proposes to define the "principal languages of the community" requirement consistent with Medicare Advantage at a 5 percent language threshold for marketing materials.	MHPA believes that POs should be subject to the same marketing requirements that MCOs—and MMPs, MA plans, and plans providing MLTSS—are subject to. This includes being required to make the same marketing information available to beneficiaries (e.g. provider directors) and providing these materials in accessible formats as outlined in the Medicaid MCO final rule and other pertinent regulations.	While MHPA believes that POs should be strictly required to adhere to certain marketing requirements we understand that POs may be uniquely situated to explain their benefits packages to their beneficiaries. CMS proposes to require that POs ensure that their employees/contractors "do not engage in any practice that would reasonably be expected to have the effect of steering or encouraging disenrollment of PACE participants due to a change in health status." While this language protects against discriminatory behavior impacting disenrollment, MHPA urges CMS to include language that prevents employees/contractors from discriminatorily steering enrollees towards enrollment in a PO on the basis of health status.
Quality Assessment and Performance Improvement (§460.132) CMS is proposing to require POs to create Quality Improvement (QI) plans to be collaborative and interdisciplinary.	MHPA supports CMS' intent that QI plans be collaborative and interdisciplinary, but does not believe that the proposals included in the rule are sufficient given that CMS is also proposing to allow members of the IDT to provide services in alternative settings outside of the PO's center.	MHPA urges CMS to put additional protections in place to ensure that QIs are comprehensive and account for care provided across the care continuum and in various settings.
Voluntary disenrollment (§460.162) **Involuntary disenrollment** (§460.164) **Enrollment agreement** (§460.154)	MHPA strongly recommends that CMS align beneficiary protections within PACE with protections extended to beneficiaries	MHPA believes that the proposed timeline and protections for involuntary disenrollment are not sufficient and urges CMS to align protections and processes for PACE with regulations that

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CMS proposes to permit participants to dis-enroll from the PACE program at any time. Disenrollment would be effective the first day of the month after which the PO receives the notice. CMS is proposing to permit involuntary disenrollment effective the first day of the month following 30 days from when a notice was sent by the PO to the participant. Reasons for involuntary dis-enrollment have also been expanded to include failure to pay (or to make satisfactory arrangements to pay any cost-sharing) due to the PO after a 30-day grace period. Involuntary disenrollment would also be permitted if the beneficiary fails to pay or make satisfactory arrangements to pay any applicable Medicaid spenddown liability or any amount due under the post-eligibility processes after a 30-day grace period. CMS proposes that if a Medicaid-only (or private pay PACE participant) becomes eligible for Medicare they will be disenrolled from PACE if they enroll in Medicare coverage other than through the PACE organization.	enrolled in Medicaid MCOs, and other programs where appropriate.	govern involuntary disenrollment for Medicaid MCO beneficiaries. Specifically, we recommend CMS consider the grievance and appeals processes available to Medicaid MCO beneficiaries.
Compliance Oversight Requirements (§460.63) CMS proposes to require each PO to have a compliance oversight program, which would be responsible for monitoring and auditing compliance. CMS reviewed Medicare Part C and D compliance requirements, but decided to waive all Part D requirements except for two: monitoring and auditing.	MHPA believes that POs should be held to all compliance standards required in Part D, and where possible, align with requirements for Medicaid MCOs.	MHPA recommends that in the final rule, CMS work to align compliance standards for POs with compliance standards required in Part D and, where possible, with Medicaid MCO requirements.

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PACE Organizational Structure (§460.60) CMS proposes to codify allowing for-profit entities to be PACE organizations. Currently the regulation says only non-for-profit or public entities are allowed to serve as a PO; but as of 2015, eligible for-profits have been permitted to serve as POs.	This proposal updates regulation to reflect current practice.	MHPA believes that some provisions in the rule create an "unlevel" playing field between POs and MCO, MMPs and MA plans, which provide similar services but are held to more prescriptive requirements.