August 18, 2015

Andrew M. Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-2390-P

Re: Comments on Proposed Medicaid/CHIP Managed Care Rule (CMS-2390-P)

Dear Administrator Slavitt:

On behalf of the North Carolina PACE Association and the approximately 1400 frail, elderly individuals served in North Carolina, we write to offer our comments regarding the Center for Medicare & Medicaid Services (CMS) Notice of Proposed Rulemaking (NPRM) on *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability [CMS-2390-P].*

The North Carolina PACE Association was formed in 2011. It represents the 11 PACE organizations that serve residents of 37 of North Carolina's 100 counties in 12 centers. North Carolina's first PACE program opened in 2008; our 11th, in March 2015. Sponsoring organizations include hospitals, home care agencies, continuing care retirement communities, and federally qualified health centers. The Association is committed to expanding PACE to serve all 100 counties, reaching all who need and desire this unique service.

PACE organizations are authorized under Sections 1894 and 1934 of the Social Security Act and regulated under 42 CFR Part 460, and therefore ***not*** subject to the sections of the code modified in the NPRM. Nonetheless, as PACE organizations function alongside, compete with, and serve many of the same populations as the managed care organizations (MCOs) subject to this rule, PACE organizations are directly and indirectly affected by these changes.

States often look to federal regulations formulated for related programs such as home and community based waivers or Medicaid managed care to help guide their administration and oversight of the PACE program. In light of both PACE's shared characteristics with these programs and its distinct differences, properly considered rules and regulations for Medicaid managed care and home and community based waiver programs can be helpful. Conversely, in the absence of an understanding of PACE's specific statutory requirements, delivery system design and care model, extending rules from other programs to PACE can result in missed opportunities for alignment, inappropriate policies, and unintended confusion.

We believe it is important for the NPRM to support the alignment of Medicaid managed care plans with PACE. With this goal in mind, we offer comments and recommendations on the following issues (and related sections of the NPRM) that most directly impact PACE and our ability to serve frail, vulnerable populations:

- **Actuarial Soundness, Rate Setting & Medical Loss Ratio**
  - §438.4 – Actuarial Soundness
  - §438.5 – Rate Development Standards
  - §438.7 – Rate Certification Submission
  - §438.8 – Medical Loss Ratio Standard
- **Options Counseling, Enrollment and Disenrollment**
  - §438.56 – Disenrollment Standards and Limitations
  - §438.57 – Conflict of interest safeguards
  - §438.70 – Stakeholder engagements when LTSS is delivered through a managed care program
  - §438.71 – Beneficiary Support System
  - §438.74 – State oversight of minimum MLR requirement
- **Marketing**
  - §438.104 – Marketing Activities
- **Appeals & Grievances**
  - §438.400 – §438.424
- **Quality Measurement and Improvement, External Quality Review**
  - §438.310 – §438.370
- **Conditions for Federal Financial Participation (FFP)**
  - §438.818 – Enrollee encounter data

Background

PACE organizations provide a comprehensive benefits package, including all Medicare- and Medicaid-covered services to qualified persons 55 years of age and older who meet their state's eligibility criteria for nursing home level of care. Individuals voluntarily enroll in PACE programs and agree to receive all of their services through the PACE organization and its contract providers. PACE organizations receive capitated payments and are financially at risk for all benefits.

While there are some similarities between PACE and MCOs, especially plans serving dual-eligible beneficiaries and MCOs that provide managed long-term services and supports (MLTSS), there are fundamental differences as well. First and foremost, PACE organizations are provider-based health plans, not large insurers. PACE organizations directly employ or contract with a broad range of health care providers, including a statutorily-mandated interdisciplinary team (IDT) comprised of physicians, nurses, therapists, social workers, dietitians, health care aides and others. The PACE IDT must comply with extensive regulatory requirements related to team composition, training and experience, roles and responsibilities, and care planning. A key element of these requirements is that the same providers are responsible for assessing the care needs of program participants, developing and updating care plans, and providing care. The intensive, provider-based nature of the PACE model is best suited to the need of complex, high-need individuals.

Conversely, MLTSS and dual alignment plans are insurance-based models that rely on contracts with physicians, hospitals and other providers to deliver care to diverse populations in traditional settings. These plans are not subject to PACE's rigorous direct care delivery (e.g. PACE Center's primary care, rehabilitative care, in-home care and social activities), training and experience, care planning and care management requirements.

With these similarities and distinctions in mind, PACE organizations are especially concerned about sections of the NPRM that address payment, options counseling, enrollment and disenrollment, marketing, and assessment of quality. While PACE organizations are not subject to the NPRM, it is important that CMS and states consider the impact of these issues on PACE access, operations, and financial sustainability.

MCOs in North Carolina are limited currently to behavioral health care delivery. However, a proposal to convert the state's Medicaid program to MCOs is under consideration in the North Carolina legislature at this time. Thus, we are concerned about the potential impact of these rules on our PACE programs in the future.

The following is a discussion of the issues, how PACE might be affected, and, where possible, recommended changes to the rule that would address PACE concerns.

Actuarial Soundness, Rate Setting and Medical Loss Ratio

States have considerable discretion in how they approach rate setting for PACE. Typically, states set PACE rates based on either state expenditures for comparable populations under fee-for-service or using assumptions about the utilization and cost of services that will be provided by the PACE organization to its enrollees. States lack sufficient guidance within these two approaches regarding the definition of a comparable population, the range of costs to be considered, and the basis for utilization or price assumptions. Further, as states shift from fee for service long term services and supports to capitated programs for these services, the cost basis on which to establish PACE rates is diminishing. This unpredictable payment environment challenges the ability of PACE organizations to plan for their financial sustainability and invest in their growth.

The NC PACE Association applauds the NPRM's effort to encourage the use of an "actuarial soundness" standard in Medicaid managed care rate setting. Adopting an actuarially sound methodology will add consistency across states.

NC PACE Association Recommendation: If applied to rate setting for Medicaid managed care and PACE by states, an actuarial soundness standard must account for the:

- relative frailty of the populations served,
- comparability of benefits provided, and
- level of financial risk borne by the plan for permanent nursing home placement

With regard to the Medical Loss Ratio (MLR) provisions, the CMS Final Rule dated May 23, 2013 appropriately determined that PACE organizations are not subject to MLR requirements under 1857(e)(4) and 1860D-12 of the Social Security Act. This determination reflects the statutory, regulatory and operational distinctions between PACE organizations and MA and Part D plans. These distinctions include the uniqueness of PACE organizations as not only payers but as direct providers of many of the Medicare- and Medicaid-covered health care services required by PACE program participants.

NC PACE Association Recommendation:

The final Medicaid managed care rule should make clear that that MLRs applied by states to their Medicaid managed care plans do not apply to PACE.

Options Counseling

We applaud CMS for the extensive work done in the area of beneficiary support, especially provisions designed to help beneficiaries understand the choices available to them. As states transition to MLTSS, financial alignment plans and other new offerings, it is imperative that consumers have the resources they need to make informed decisions about their care.

NC PACE Association Recommendation: in its final rule, CMS should offer greater definition of the options counseling requirements under Section 438.71 to ensure that counseling is comprehensive, competent, conflict-free, continuous and timely:

- **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, including those offered under managed care arrangements, fee-for-service, or alternative models such as PACE.
- **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.

We applaud CMS for provisions in Section 438.810 that require enrollment brokers (and, by definition, options counselors) be free from conflicts of interest.

NC PACE Association Recommendation: We encourage CMS and the states 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 should 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.

Enrollment and Disenrollment

States that require passive or mandatory enrollment in Medicaid managed care products, including products for the dually eligible, do not have the authority to passively enroll individuals into PACE programs. As such, PACE organizations are disadvantaged by state enrollment policies that direct beneficiaries who might be served by PACE – often without their knowledge or consent – into health plans.

NC PACE Association Recommendation: To assure consumers have access to all of their options, we recommend that state enrollment systems, supported by strong options counseling (see above), be required to enable enrollment in PACE:

- at the time of initial entry into a capitated program (Medicaid managed care plan, Dual managed care plan or PACE)
- upon disenrollment from a Medicaid managed care health plan,
- during open enrollment periods,
- upon a change in health status that requires a nursing home level of care, and
- upon a change in the consumer's choice regarding the best source of care and coverage.

NC PACE Association Recommendation: We recommend that Section 438.56 be modified to include beneficiary protections that allow individuals to disenroll from their plans in order to enroll in PACE if a state places a limit on the period of time during which beneficiaries may disenroll without cause. The *Eligibility Criteria for Special Enrollment Period* under the Medicare Advantage program serves as a guide and would ensure consistency and alignment of Medicaid and Medicare beneficiary protections.

Marketing

The NC PACE Association (NCPA) supports efforts to prevent consumer confusion and marketing advantages by placing limits on MCO marketing activities. Specifically, NCPA agrees that MCO marketing materials be precluded from stating or implying that enrollment in one of the MCO's health plans requires enrollment in an additional plan sponsored by the MCO. Further, we believe that all Medicaid managed care marketing materials should be required to advise Medicaid beneficiaries of their right to consider and choose other capitated, or if available fee for service, options.

NC PACE Association Recommendation: NCPA recommends that CMS require states to issue educational materials that notify consumers, "As your health care needs change, other plans may be better designed to meet your needs." Such education would encourage consumers to be prudent purchasers of Medicaid managed care plans.

NC PACE Association Recommendation: In implementing state education programs for consumers, we recommend that the disenrollment information required under Section 438.104 include a referral to conflict-free options counseling.

Appeals and Grievances

The North Carolina PACE Association supports the CMS proposal for streamlining the appeals and grievances process with programs like Medicare Advantage and private health plans. Adopting consistent terminology, timelines and notice requirements will assure beneficiaries a more manageable framework for navigating the appeals grievances processes. PACE participants covered by Medicaid utilize the State Fair Hearing Process for grievances and appeals. Based on our experience, we support the alignment of appeal policies by defining a 60-day appeal timeline at the federal level. However, we note our concern that health plans' utilization management determinations may routinely limit access to services and that a 60-day period of time to address systematic denials of coverage may be too long.

PACE programs have the benefit of a direct care relationship with their enrollees. As a result, the services provided by PACE reflect a considered and informed understanding of care plan needs, and denials of services are not broadly applied.

NC PACE Association Recommendation: We recommend CMS develop a process by which appeals and grievances can be expedited if denials are based on broadly applied, population-based utilization management determinations rather than care plans that reflect an individual's needs.

Quality Measurement and Improvement, External Quality Review

The North Carolina PACE Association supports CMS efforts to align quality requirements for MCOs with other CMS quality programs. As CMS works to determine a core set of performance measurements, we suggest that CMS consider the diversity of the Medicaid population (e.g., age, level of chronic illness, level of frailty, home or institutional setting).

NC PACE Association Recommendation: In order for quality measures to be comparable across all options available to Medicaid beneficiaries, measures should be risk adjusted for the frailty and acuity of the populations served.

NC PACE Association Recommendation: Furthermore, quality measures should reflect the consumer's individual preferences and goals. In PACE the goals of care for participants can be divided into three broad categories: promotion of longevity, optimization of function, and palliative care. Accordingly, quality measurement should take different approaches depending on whether the goal is life extension, function or palliation.

The North Carolina PACE Association also applauds the interest of CMS in developing a quality rating system (QRS) that focuses on clinical quality management, member experience, plan efficiency, affordability and management.

NC PACE Association Recommendation: As CMS develops the QRS, we recommend that CMS consider the following:

- performance measurement selection: CMS should select measures that differentiate performance, can be described in layperson's language, and are organized to reduce the number of factors a person must consider before making a choice;
- data collection and system capabilities;
- format and content of QRS reports (i.e., system design, use of mobile technologies, and automated systems);
- education and outreach to promote use of the information;
- evaluation and continuous refinement of QRS; and
- the need for ongoing campaigns to raise awareness of and demand for quality.

Enrollee Encounter Data

CMS recently indicated that the current rules for PACE concerning encounter data reporting will likely remain in place through 2016. This timeframe reflects CMS' recognition of the challenges of adequately defining the services rendered by PACE, notably those services provided in the PACE centers. Many long term services and supports provided by PACE have been historically covered by Medicaid and do not have an associated encounter code. Medicaid managed care programs that provide long-term services and supports may find themselves equally challenged to provide encounter data that captures the full scope of their services.

The National PACE Association developed encounter codes for eight categories of PACE-centric professional and paraprofessional services and compared them to a list of HCBS codes developed by the T-MSIS project. NPA found very little overlap. This reflects the unique services provided by PACE programs that do not lend themselves to current categorization in the CPT code set. In the absence of a federal code set for these services, individual states are moving to create state-specific codes for uncategorized services. These codes lack consistent definitions and terminology, creating significant information system challenges and costs for plans.

NC PACE Association Recommendation: We recommend that CMS work to standardize an encounter data code set that is capable of comprehensively describing the range of long-term services and supports offered by both PACE and Medicaid managed care plans, particularly MLTSS plans. The data set should be broad enough to capture the diverse preventive benefits, services and supports offered to meet the needs of high-risk, frail and medically complex individuals. A standardized data set would support the capture of comparable encounter, utilization and cost data across all plans and states.

Summary

In closing, as CMS continues to refine and modify this NPRM, we hope you will consider the alignment of PACE with Medicaid managed care to ensure that consumers have access to the most effective care and coverage option to meet their needs and preferences.

Thank you again for the opportunity to share comments on the proposed rule. Please contact me at linda.shaw@ncpace.org if you have any questions.

Sincerely,

Linda S. Shaw
Executive Director

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