State of California—Health and Human Services Agency
Department of Health Care Services

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DIRECTOR

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GOVERNOR

October 14, 2016

RE: Proposed Rules on Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE) (CMS-4168-P)

Submitted electronically via: http://www.regulations.gov/

The California Department of Health Care Services (DHCS) submits the enclosed comments for your consideration in response to the notice of proposed rulemaking (NPRM) published August 16, 2016, entitled "*Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE)*."

DHCS shares the same goals and priorities cited by the Centers for Medicare and Medicaid Services (CMS) in updating the regulatory and financing frameworks for the PACE program. California has been at the forefront in expanding the PACE program and identifying opportunities for increased flexibility and efficiency. Since the original inception of the PACE program here in California, we have expanded our partnership with 11 distinct PACE Organizations (POs) to provide services to over 5,000 members in 12 counties. California's collaborative emphasis with our PACE Plan partners helps to promote our members' access to high quality integrated and coordinated care

The narrative comments included in this letter center on key areas of focus from the California Medicaid perspective. In general, DHCS recommends that the final rule:

(1) provide sufficient time for states to build the necessary infrastructure and administrative capacity to bring PACE programs into sustainable compliance;
(2) prioritize state flexibility in improving and tailoring the delivery, rate-setting, and contractual segments of its PACE program; and
(3) provide for regulatory payment standards in PACE that are based in actuarial practice rather than those associated with fee-for-service delivery.

DHCS has specific comments on the following NPRM components:

(1) the flexibility to include either the Medicaid rate or the rate-setting methodology in the PACE Program Agreement in proposed 42 CFR 460.32(a)(12) and 460.182(b);

(2) the requirement that contracted services be in compliance with the Home and Community-Based Settings Final Rule in proposed 42 CFR 460.70(b)(1)(iv) and 460.98(b)(4);
(3) the requirement that POs only use directly employed staff to conduct marketing in proposed 42 CFR 460.82(e)(4); and
(4) the Medicaid payment rate standard in proposed 42 CFR 460.182(b)(3).

Contents and Terms of PACE Program Agreement

DHCS supports the flexibility presented in the proposed language at 42 CFR 460.32(a)(12) which allows states the option to include either the current Medicaid capitation rate or the Medicaid rate methodology in the PACE Program Agreement. DHCS recommends that the final rule provide clarity on the level of detail expected in the PACE Program Agreement for states that opt to provide the rate methodology. Like other states, we note that DHCS already undergoes a comprehensive review of its PACE rate methodology by CMS on an annual basis. Therefore, we recommend that a more general methodology description be allowed in the Program Agreement to further the flexibility afforded in the NPRM and in recognition of the extensive methodology review process already taking place. This would avoid the burden of frequent updates to the PACE Program Agreement while leveraging, rather than duplicating, the comprehensive rate review process that CMS already undertakes. We also request that CMS clarify any timeframe expectations it has of states that elect to include the actual Medicaid capitation rate in the PACE Program Agreement on a yearly basis.

Contracted Services should comply with the Home and Community-Based Settings Regulation

This proposed rule would require that all contracted services comply with the Home and Community-Based Services (HCBS) regulation, 42 Code of Federal Regulations (CFR) Chapter IV Subchapter C Part 441 Subpart G 441.301(c)(4)(i) – (v), when non-institutional settings are used to house and/or provide services to PACE participants. The proposed rule also requires the contract between the State and the POs be amended to require that these HCBS regulation provisions apply to individuals providing contracted services to the Interdisciplinary Care Team or performing the duties of program director or medical director.

Prioritizing the implementation of the Statewide Transition Plan (STP) for compliance with the HCBS regulation is of utmost importance to DHCS, but we are concerned that the timing for release of the proposed PACE rule does not align with the existing timeline for compliance with the HCBS regulation. For a state the size of California, it is imperative that implementation of a rule requiring PACE compliance with the HCBS regulations occur no sooner than the March 2019 compliance date already set for the HCBS regulations. DHCS recommends that alignment be postponed to a later

rulemaking in recognition of the already integrated delivery structure and person-centered approach in PACE.

Marketing

This provision (proposed 42 CFR 460.82(e)(4) would limit the ability of individuals and organizations that are conducting community-based outreach and enrollment assistance to talk about PACE as part of their outreach efforts, and for POs to receive referrals and inquiries based on those efforts. It would also preclude some POs from receiving indirect referrals from agents where an agent incidentally identifies persons who may be eligible for PACE but is not paid by the PO to refer persons to PACE.

DHCS agrees that it is important to have strong marketing protections in place for the PACE program due to the vulnerable nature of the PACE population. DHCS also finds it essential to recognize the unique challenges POs face in facilitating continued program growth due to the specific PACE eligibility requirements and states shifting Medicaid delivery of Long-Term Services and Supports that preclude POs from taking advantage of options like direct enrollment available to other managed care models operating in California. It is important to note the distinction between marketing, outreach and enrollment and we urge against adopting such an absolute requirement that would restrict all forms of marketing and outreach to only direct staff employed by the PACE Organization. The limitation to directly-employed staff may provide a false sense of security and may actually impair POs from deploying the best-qualified persons to inform the public about PACE programs. Instead we recommend that the regulation be modified to specify that all enrollment activities and functions (including initial pre-enrollment interviews and assessments) may only be performed by direct PACE staff but provide POs the flexibility to utilize referrals received from various community sources to assist in setting up pre-enrollment meetings conducted by direct PACE staff.

Medicaid Payment

DHCS supports inclusion of the general standard that PACE rates be adequate or sufficient to provide the services required under the PACE program for the enrolled population. However, we recommend utilizing the "reasonable, appropriate, and attainable" terminology of 42 CFR 438.4(a), which is the established actuarial standard in Medicaid managed care, instead of the "consistent with efficiency, economy, and quality of care" terminology that governs Medicaid fee-for-service payments in 42 USC 1396a(a)(30)(A). Actuarial soundness, consistent with defined actuarial standards of practice, is a more appropriate standard against which to measure the sufficiency of a prepaid capitation payment model. In contrast, the specifics of the imported Fee-For-Service standard are less defined, and would present uncertainty in the PACE rate-setting process and in regulatory oversight of payment sufficiency.

In response to CMS' request for comments on "other rate setting methodologies for PACE", DHCS recognizes and values CMS' desire to encourage more consistent and competitive rate-setting methodologies for PACE. We recommend that the final rule promote the use of experience- and risk-based methodologies in general, and strongly support state flexibility in tailoring rate-setting methodologies to best reflect the specific circumstances of each state's PACE program. For states that elect to employ experience- or risk-based approaches based in established principles of actuarial soundness, we also recommend that CMS not mandate a fee-for-service equivalence (or UPL-like) analysis, at least as part of a state's underlying PACE rate development methodology so as to prevent instances where these sometimes distinct frameworks may conflict. While recognizing the current statutory requirement at 42 U.S.C. §1396u-4 (that the PACE capitation amount not exceed what would have been paid if the individuals were not enrolled in PACE), we believe CMS holds interpretive flexibility as to when and how this overarching principle is assessed.

Conclusion

DHCS appreciates the opportunity to comment and urges CMS to finalize the proposed regulation to account for the aforementioned issues. Doing so will enable California to maintain and grow robust PACE delivery systems for the most frail beneficiaries who rely on this program to avoid institutionalization and instead age with dignity in their homes and communities.

Sincerely,

Mari Cantwell
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California State Medicaid Director