

Resource Provided by Altarum's Program to Improve Eldercare

Middle-Class Medicare Beneficiaries Should Not Be Barred from Choosing PACE Due to Exorbitantly High Part D Costs

The Program of All-Inclusive Care for the Elderly (PACE) is widely acknowledged to be among the most effective, comprehensive and reliable models for cost-effective delivery of medical services, social supports and personal care for older adults living in the community who have chronic conditions and functional limitations. Despite its proven ability to provide tightly coordinated medical and community-based long-term services and supports (LTSS) that keep most out of the hospital and the nursing home, as originally designed, PACE enrollment was not broadly scoped. Rather, it was primarily aimed at low-income, mostly dually-eligible (Medicare and Medicaid), beneficiaries. But given that **older adults will soon comprise 20% of the total U.S. population**, it's an excellent time to re-examine PACE as a possible model for many more/millions of middle-class Medicare population who want to age in place at home—and avoid spending down a lifetime of accumulated savings.

Standing in the way of broad PACE accessibility, however, is a regulatory cost barrier – the extremely high cost of the PACE Medicare Part D benefit that Medicare-only PACE participants are required to purchase, which results in monthly premiums ranging from as much as \$800 to \$1100. This compares to an average monthly premium of about \$35 per month for a comparable Part D Prescription Drug Plan (PDP). When the cost of covering deductibles and co-payments is factored in—which for one Michigan PACE plan, Huron Valley, amounted to about \$285 per month in 2018—**beneficiaries stand to save as much as 70% relative to the cost of the PACE Part D plan.**

Unfortunately, Medicare beneficiaries wishing to enroll in PACE are currently prohibited from selecting another more affordable Part D PDP, with the result that today, less than 1% of all PACE participants are middle-class Medicare beneficiaries.

In fact, Medicare beneficiaries who enroll in PACE are uniquely disadvantaged. They are the only Medicare population that is denied two of the major benefits of the 2003 Medicare Modernization Act's Part D cost subsidization:

1. Coverage Gap manufacturer brand-name drug discounts, and
2. Federal reinsurance for catastrophic drug costs.

Instead, PACE Medicare-only beneficiaries are required to pay these costs. Unsurprisingly, only a tiny number of potential PACE participants who are confronted with the very high premium of the PACE Part D benefit conclude that this price tag is reasonable and affordable, and so they opt to enroll. Those who do not enroll in PACE miss out on **their access to highly coordinated medical care, LTSS and social supports—all of which are needed to maintain nursing-home eligible individuals in the community.**



Fortunately, there is a policy solution for the Part D cost barrier that now effectively closes PACE off to the vast majority of middle-class Medicare beneficiaries who have not yet spent down to Medicaid: **Allow PACE participants to access their prescription drug coverage either through the PACE Part D plan, or through a local Part D PDP.** Doing so would provide them with access to the same coverage, rebates and limits on out-of-pocket costs that all other Medicare beneficiaries get today. Providing Part D choice can be accomplished via a legislative route, and possibly through a PACE administrative waiver.

Possible Solution #1: Legislation

As illustrated in [Infographic #1](#), Congress can amend the Social Security Act to allow Medicare beneficiaries to select either a PACE Part D plan or a local Part D PDP. Draft legislation prepared in 2019 by Reps. Earl Blumenauer (D-OR) and Jackie Walorski (R-IN) in the House of Representatives, and Sens. Thomas Carper (D-DE) and Patrick Toomey (R-PA) in the Senate, calls for:

“a PACE program...to monitor drug utilization, medication adherence, and spending throughout the year with respect to any applicable PACE program enrollee who elects to enroll in a qualified standalone prescription drug plan...in order to coordinate with the PDP sponsor of such plan regarding the drug benefits offered by the plan, including the filing of any grievances or appeals with the plan on behalf of the applicable PACE program enrollee.”

Beneficiaries with multiple chronic conditions and functional limitations would continue to enjoy the well-thought-out care coordination between medical and long-term care that is the hallmark of the PACE model. They would also slow their spend-down to Medicaid and would have a realistic alternative to much more costly long-stay nursing home placement. In the House of Representatives, are expected to introduce legislation to try to improve the situation of PACE beneficiaries.

Importantly, **the federal government would pay a lower direct premium subsidy to cover the risk of a Medicare participant who chose to enroll in a local PDP.** For a Medicare-only PACE participant wishing to enroll in a PACE plan—in this example, Huron Valley PACE in Ypsilanti, Michigan—whose risk score is 1.809 (where 1.0 represents average risk), the government’s direct premium subsidy would be 64% lower if paid to a local Part D PDP than if paid to the PACE Part D plan.

Possible Solution #2: PACE Waiver

To allow PACE to grow and flourish as changes in service delivery and health care markets continue over time, Congress provided PACE with waiver authority in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. The legislative intent at the time was to provide PACE with sufficient flexibility to adapt to circumstances and to flourish and grow over time.



The law states:

“SEC. 903. FLEXIBILITY IN EXERCISING WAIVER AUTHORITY. In applying sections 1894(f)(2)(B) and 1934(f)(2)(B) of the Social Security Act (42 U.S.C. 1395eee(f)(2)(B), 1396u-4(f)(2)(B)), the Secretary of Health and Human Services—(1) shall approve or deny a request for a modification or a waiver of provisions of the PACE protocol not later than 90 days after the date the Secretary receives the request; and (2) may exercise authority to modify or waive such provisions in a manner that responds promptly to the needs of PACE programs relating to areas of employment and the use of community-based primary care physicians.”

This PACE statutory waiver authority does not reference Part D because it pre-dates the Medicare Modernization Act (MMA) of 2003, which established prescription drugs as a covered Medicare benefit. The 2002 implementing regulation for BIPA 903 does include significant discussion of contracting authority “to allow PACE organizations to provide PACE Center services through contractual arrangements” so long as participants are “afforded all benefits and protections offered by the PACE organization.” In an analogous fashion, [CMS could consider extending authority to PACE organizations to be able to offer Medicare participants’ prescription drug coverage through a Part D PDP](#)—while also guaranteeing them equivalent protections as participants who are enrolled in a PACE Part D plan. This would allow Medicare beneficiaries enrolling in PACE to access an affordable Standard Part D benefit—which they do not have today.

As designed, the MMA’s Standard Part D benefit spreads out payments over time and over a large population to reflect a beneficiary’s actual usage of prescription drugs. These payments include not only monthly premiums, but also a deductible, copayments, and co-insurance that trigger payments only at certain points of purchase. However, **under current regulatory interpretation, PACE plans enrolling Medicare-only participants are prohibited from collecting any deductible, coinsurance or copays.** This means that a PO cannot offer a Standard Part D benefit to a Medicare-only participant because it is allowed only to collect premium payments. This means that POs are forced to offer Medicare-only participants their PACE Part D plans with extremely high monthly premiums, which must cover the full cost of all medications, administrative costs and estimated member cost sharing with no manufacturer brand-name drug discounts or federal reinsurance.

If permitted, a PACE waiver could address this conundrum and allow Medicare-only PACE participants to achieve parity with all other Medicare beneficiaries who qualify for Part D coverage. [A test waiver designed by Huron Valley PACE with Altarum and Milliman, Inc., and submitted to the Centers for Medicare and Medicaid Services \(CMS\) in 2018](#), essentially proposed to provide Medicare-only PACE participants with a Standard Part D benefit. As illustrated in [Infographic #2](#), to alleviate the sticker shock of exorbitantly high monthly premiums, **the waiver sought permission to allow Medicare beneficiaries to purchase a local Part D PDP at less than \$35 per month.** A supplemental premium to cover the costs of additional copays and co-insurance beyond the Standard Part D benefit (i.e., 100% drug coverage) was calculated at \$285 per month.



Under the Huron Valley PACE waiver, the PACE organization would have remained responsible for covering all prescription drugs prescribed for the beneficiary—regardless of cost. More specifically, if the local Part D PDP elected by the PACE participant refused to pay for a high-cost drug that was not part of its formulary, Huron Valley PACE would have assumed this cost, along with drug costs during any appeals. Because Huron Valley PACE would have been obliged to pick up the costs of any drugs that the Part D PDP denied, and would not have been eligible for year-end Part D “true up” reconciliation payments (the Part D PDP would instead receive these payments). **As a result, the PACE plan would have been strongly incentivized to closely manage their beneficiaries’ drug utilization and costs.**



*In 2011, CMS created a precedent for a Part D waiver for PACE participants when it granted a system-wide waiver to all veterans enrolled in PACE organizations, enabling them to continue using high quality Veterans Affairs sponsored drug coverage. **The waiver proposed by Altarum would allow similar drug savings for non-veteran Medicare beneficiaries.***

Finally, as noted above, the direct premium subsidy provided by the federal government would be substantially lower for Medicare-only beneficiaries enrolling in a Part D PDP as compared to a PACE Part D plan.

The infographics that accompany this brief illustrate two possible solutions to the Part D cost barrier that has long stymied Medicare beneficiary enrollment in PACE. We urge policymakers to analyze and adopt them in whole or in part, and to move a solution forward as rapidly as possible.

PACE Expansion & Part D Choice

LEGISLATIVE DIRECTIVE ROUTE ➤ Amend the Social Security Act to allow for drug plan choice. ➤ Medicare-only PACE enrollees can select a stand-alone prescription drug plan.

Medicare-only beneficiaries enrolled in Program of All-Inclusive Care for the Elderly (PACE) are the only Medicare population denied two of the major benefits of the 2003 Medicare Modernization Act's Part D cost subsidization (manufacturer brand discounts & federal reinsurance protection for catastrophic drug costs).

➤ PACE Organizations (PO) are the most effective, comprehensive, and reliable programs of medical, social, and personal care for elderly persons living in the community and qualifying for nursing home placement, but it is effectively limited to Medicaid enrollees.

LEGISLATIVE AMENDMENT

PART D

Ensure choice of Medicare Part D prescription drug plans for eligible Medicare-only beneficiaries participating in PACE.

PACE participants will be able to enroll in a qualified stand alone Medicare Part D Prescription Drug Plan (PDP) from a local provider.

Eligible individuals = not entitled to title XIX medical assistance, Part D eligible, & enrolled under PACE.

Qualified drug plans = not an MA-PD plan, not operated by PACE organization in which individual is enrolled.

When PACE participant is enrolled in a standalone PDP, they are responsible for any out-of-pocket costs under that plan.

Out-of-pocket costs = PDP premiums, deductibles, co-pays, coinsurance, and other cost sharing.

PDP COST REQUIREMENTS

The estimated out-of-pocket costs & Federal subsidy for the year for standalone PDP coverage must be equal or less than the respective estimated out-of-pocket costs & subsidy for coverage under the participants PACE Organization drug plan.



THE EXISTING CONFLICT

Medicare Part D statute



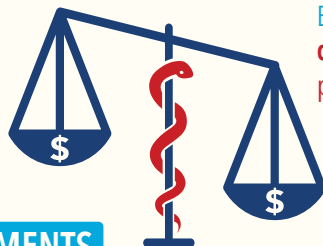
Requires co-pays & deductibles in order for beneficiaries to qualify for federal catastrophic coverage and coverage gap discounts.

Medicare-only PACE participants bear the federal government's share of costs & expenses associated with:

- A small high-risk pool.
- No discounts or rebates.
- High administrative expenses.

PACE statute

Bars co-pays & deductibles for participants.



PACE ORGANIZATION REQUIREMENTS

- Educating & helping enroll Medicare-only beneficiaries into Part D plan.
- Monitor drug utilization, adherence & expenditures.

PRICE DISPARITY



Average Part D premium for Medicare beneficiary: **\$35/mo. + copays**

vs

Average drug costs for Medicare-only PACE enrollee: **\$1,000 /mo.**

RESULT

Medicare-only beneficiaries qualifying for nursing home level of care will be able to enroll in the best eldercare program that the U.S. has yet developed (PACE), slowing spend-down to Medicaid & saving government money.

SOLUTION

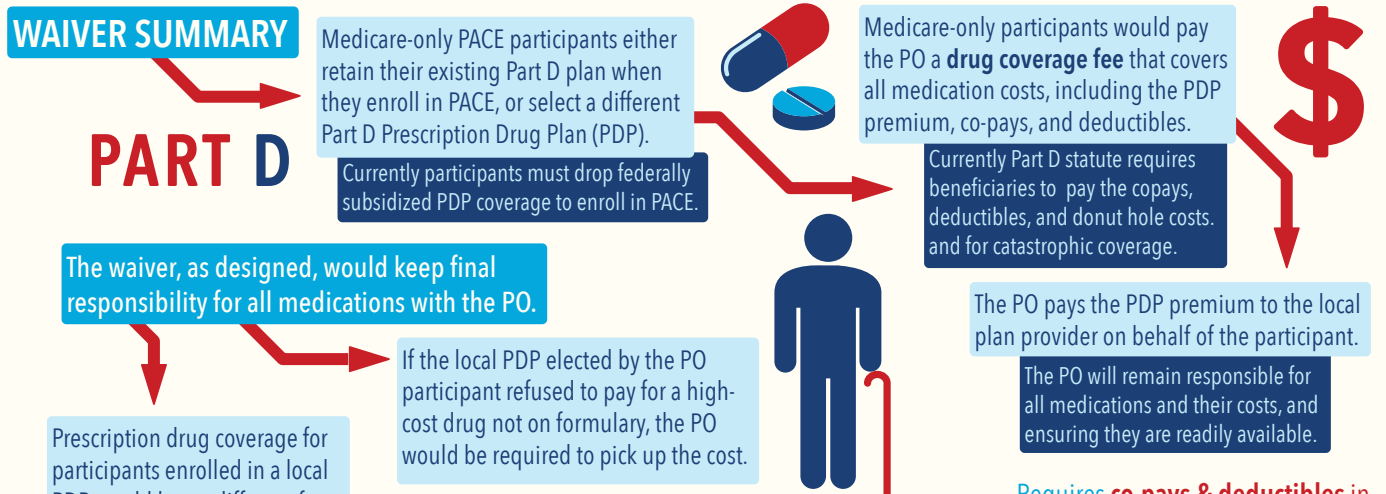
A legislative directive amending Section 1860D-21(f) of the Social Security Act (42 U.S.C. 1395w-131(f)) to resolve the conflict for Medicare-only beneficiaries between Part D regulations & the three-way contract between the State, Federal Government, and PACE.

PACE Expansion & Part D Choice

ADMINISTRATIVE WAIVER ROUTE ▶ Medicare-only PACE participant pays drug coverage fee. ▶ PACE Organization Purchases Part D from local PDP. ▶ Fee covers all drug costs.

Medicare-only beneficiaries enrolled in Program of All-Inclusive Care for the Elderly (PACE) are the only Medicare population denied two of the major benefits of the 2003 Medicare Modernization Act's Part D cost subsidization (manufacturer brand discounts & federal reinsurance protection for catastrophic drug costs).

▶ PACE Organizations (PO) are the most effective, comprehensive, and reliable programs of medical, social, and personal care for elderly persons living in the community and qualifying for nursing home placement, but it is effectively limited to Medicaid enrollees.



THE EXISTING CONFLICT

Medicare Part D statute ▶ Requires **co-pays & deductibles** in order for beneficiaries to qualify for federal catastrophic coverage and coverage gap discounts.

PACE statute ▶ Bars **co-pays & deductibles** for participants. ▶ Medicare-only PACE participants bear the federal government's share of costs & expenses associated with:

- A small high-risk pool.
- No discounts or rebates.
- High administrative expenses.

WAIVER ROUTE ADVANTAGES

- **Faster** : No requirement for Congressional action.
 - **Precedent**: In 2011, CMS granted a system-wide waiver* to Veterans enrolled in PACE, enabling them to continue using high quality Veterans Affairs sponsored drug coverage.
- *Waiver issued under the authority of §423.458(d) which permits waivers of requirements as necessary to improve coordination between Part D and PACE.

PRICE DISPARITY

Average Part D premium for Medicare beneficiary: **\$35/mo. + copays** **VS** Average drug costs for Medicare-only PACE enrollee: **\$1,000 /mo.**

RESULT

▶ Medicare-only beneficiaries qualifying for nursing home level of care will be able to enroll in the best eldercare program that the U.S. has yet developed (PACE), slowing spend-down to Medicaid & saving government money.

SOLUTION

▶ An administrative waiver E.G. (BIPA 903) to resolve the conflict for Medicare-only beneficiaries between Part D regulations & the three-way contract between the State, Federal Government, and PACE.