Huron Valley PACE

ALTARUM

February 21, 2020

Ms. Kathryn Coleman
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail stop C4-21-26
Baltimore, MD 21244

Dear Ms. Coleman:

We write this letter to request a meeting with a cross-cutting group of officials at the Centers for Medicare and Medicaid Services (CMS) in order to undertake a thoughtful dialogue aimed at devising a solution that addresses a longstanding inequity: the artificially high Medicare Part D premium that confronts Medicare-only beneficiaries who wish to enroll in the Program of All-Inclusive Care for the Elderly (PACE). This program, enacted into federal law in 1997, is widely acknowledged to be one of the highest quality care systems for nursing home eligible seniors needing comprehensive, enduring, and well-coordinated medical and long-term services and supports (LTSS). But we have found that enrollment in PACE by Medicare-only elders is stunted by the exceptionally high premium required to pay for Medicare Part D coverage.

A 2018 BIPA 903 waiver requested by Huron Valley PACE (HVP) proposed to maintain the PACE Organization's (PO) responsibility to offer Medicare-covered prescription drug coverage under Part D to all Medicare-only participants, by enrolling those participants in a locally available Part D Plan (PDP) and then supplementing that coverage to provide a 100% drug benefit.

As submitted, the BIPA 903 waiver request from HVP would allow a nursing home eligible individual access to comprehensive PACE home and community-based services without disenrolling from their existing Part D coverage. This is because PACE Part D coverage creates two enrollment barriers:

1) PACE cannot sell the Standard Part D coverage but can only provide 100% drug coverage with a 2018 estimated HVP $1,100 monthly premium; and

2) There are no cost sharing subsidies, federal reinsurance or manufacturer brand discounts available for PACE Medicare-only enrollees.

These adverse impacts were addressed in the HVP BIPA 903 waiver, which proposed to provide Medicare-only PACE participants with 100% drug coverage at a re-calculated combined basic (local PDP-covered) and supplemental (HVP-covered) premium of $321 per month in 2018 -- a 70% member savings. However, a September 26, 2019, letter from CMS rejected this proposal.

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Below, we explain why we believe CMS should reconsider its position.

Background:

All seniors who are eligible for Medicare qualify for a Standard Part D benefit under the Medicare Modernization Act (MMA) of 2003. Yet the final implementing rules for the Part D program as applied to Medicare-only beneficiaries aiming to enroll in PACE have served to create a conflict with the PACE three-way contract between the State, Federal Government and the PO. Since PACE cannot collect member cost-sharing for drugs, PACE Medicare-only participants can only purchase a 100% drug benefit, effectively denying this Medicare beneficiary population access to the Standard Part D benefit and the federal reinsurance and manufacturer brand discounts to which they are entitled. For a variety of reasons, the drug coverage provided by the PACE Part D plan costs 20-30 times more than the local PDP. Few Medicare-only elders can or, quite appropriately, have been willing to afford this.

As designed, the Standard Part D benefit spreads out payments over time and over a large population to reflect the 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. In contrast, because a PO is prohibited from collecting any deductible, coinsurance or copays, a PO cannot sell a Standard Part D benefit to a Medicare-only participant. Since a PO is allowed to collect only *premium payments* from a Medicare-only participant, POs are forced to sell Medicare-only participants a plan with extremely high monthly premiums, which must cover the full cost of all medications, administrative costs and estimated member cost sharing. For HVP Medicare-only enrollees in 2018, the premium amount was *$1,100 per month, or $13,200 over the year.* In other Part D plans, this same beneficiary would pay around $35 per month based on the national average, plus the deductible, copays and coinsurance, while benefiting from federal reinsurance and manufacturer brand discounts.

This severe price distortion represents a substantial inequity for Medicare-only beneficiaries who could otherwise be well served by enrolling in PACE. Nationally, PACE enrollment for the Medicare-only population is less than 1%. The conflict between Part D regulations and the PACE three-way contract, means that *Medicare-only PACE participants are the only Medicare population to be denied two of the major benefits of the MMA's Part D cost subsidization, namely manufacturer brand discounts and federal reinsurance protection for catastrophic drug costs.*

Moreover, creating an artificial and unintended financial barrier to enrolling in PACE runs counter to the stated desire of many experts and policymakers who have pointed out that more affordable, easily accessible LTSS options are badly needed for middle-income beneficiaries. PACE offers one excellent option to provide that, so it is important that seniors who are willing and able to pay privately for their LTSS are empowered to do so and thereby slow their spend-down to Medicaid.

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Huron Valley BIPA 903 Waiver:

As part of the HVP research project, in 2017 and 2018, Altarum conducted interviews with Medicare beneficiaries and their family members in the Ypsilanti, Michigan community who also needed LTSS. We sought to determine whether they were willing to enroll in PACE if they were charged LTSS premiums of around $4,000 per month (the amount that Medicaid would pay if they were dually eligible). In general, elders and their families expressed a willingness to pay this LTSS cost out-of-pocket while they could – particularly for the respondents who had experience with out-of-pocket costs for nursing home services, which were much higher, at about $8,000-$10,000 per month. However, the extraordinarily high premium costs for a Part D PACE plan shocked families and potential participants. In the case of HVP, the 2018 monthly Part D premium of $1,100 a month dwarfed local PDP premiums of about $35 per month (the 2018 national average premium). Even when it was explained that the PACE Part D plan's very high cost included the deductible, co-pays and coinsurance, the potential PACE participants and their families still rejected this as unworkable and unfair.

The HVP waiver submission addresses these price concerns and fully protects PACE participants as follows:

Under the terms of the BIPA 903 waiver proposal as submitted to CMS, ***the PO would remain responsible for covering all prescription drugs that the beneficiary and his or her providers require, regardless of cost.*** As such, the prescription drug coverage afforded to Medicare-only participants who elected to enroll in a local PDP would be no different from the coverage provided currently through the PACE Part D plan. More specifically, if the local PDP elected by the PO participant refused to pay for a high-cost drug that was not part of its formulary, HVP would be required to pick up this cost (and the cost of appeals or substitution). The local PDP in which Medicare-only participants enrolled would maintain the federal risk-sharing protection provided by the year-end Part D reconciliation process; whereas the PO would not be a party to this process, since they are no longer the Part D provider.

Second, the waiver as submitted ***would not transfer financial risk from HVP to a local PDP for the following reasons:***

- First, data shows that very few Medicare beneficiaries today are enrolled in PACE (HVP had only two in 2018). Rather, the vast majority receive their Part D coverage outside of PACE -- through PDPs or MA-PD (Medicare Advantage with prescription drug coverage) plans. The risk of these Medicare beneficiaries is therefore already built into the pricing and functioning of these markets, and there would therefore be no shift of financial risk to PDPs associated with the HVP BIPA 903 Part D waiver as submitted.
- Second, PDPs typically have thousands to tens of thousands of members with a range of Rx-HCC risk scores, and these plans expect to accommodate a diverse pool of potential enrollees.

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- Third, Medicare beneficiaries with higher risk scores produce higher payments to Part D plans in the form of direct premium subsidy payments that are designed to reflect that additional risk.[1]
- Fourth, CMS Part D reconciliation payments (calculated 10 months after the calendar year) "true up" estimated Part D costs and, should these costs turn out to be higher than anticipated, would ameliorate part of a local PDP's losses.
- Fifth, under terms of the HVP waiver as submitted, the PO would pay the bills for all applicable cost-sharing amounts, including the basic premium, deductible, co-insurance, and copayments. This is parallel to a family member paying these bills on behalf of a parent, which is a common occurrence. Further, HVP would pay for any drugs that the PDP denied during an appeal and negotiation and would not be eligible for reconciliation payments. Thus, as a clinical service, HVP would be incentivized to help closely manage the beneficiary's drug utilization and costs.

In summary, the HVP BIPA 903 waiver was designed to confer substantial benefits to all parties, as follows:

a. Most important, Medicare-only middle-class beneficiaries with nursing home level of care clinical eligibility would be able to enroll in PACE, thereby gaining access to excellent care planning, comprehensive services, and peace of mind through to the end of life.
b. The Medicare-only PACE participant's monthly premium for Part D coverage would be reduced from $1,100 to $321 (2018 estimates), with eligibility for Medicaid pushed further into the future, due to slower spend-down. This increases the likelihood of Medicaid savings for CMS and for the State of Michigan.
c. The federal government would continue to pay a lower direct premium subsidy to cover the risk of a HVP participant who chose to enroll in a local PDP, such that for a participant with a Rx-HCC risk score of 1.809, the subsidy would be an estimated 63.5% lower when paid to a local PDP than would otherwise be paid to HVP's Part D plan.
d. The local PDP would maintain all of its usual risk protections, as previously described. HVP would continue to assume responsibility for all expected costs associated with medically necessary medications that were not covered by the PDP. In return, HVP would stand to gain from a higher enrollment of Medicare-only enrollees.

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[1] Note: For Medicare beneficiaries who are buying their prescription drug coverage from a local PDP, CMS subsidizes their premiums by paying the PDP about 39.5% of the actual cost of coverage, assuming an Rx-HCC participant risk score of 1.00. (In 2018, the average Part D Bid for a person with an Rx-HCC score of 1.00 was about $57.93 per month, and the resulting direct premium subsidy payment for this "average" beneficiary was $22.91 per month.) Because the Rx-HCC risk score for PACE participants is typically higher than 1.00 – about 1.809 for HVP – this implies a direct premium subsidy of $69.78 per month for a local PDP. In 2018, the HVP Standard Part D bid was $376.20, and the resulting expected direct premium subsidy paid by CMS to the PO was $191.10 per month for each beneficiary. By not disenrolling from the local PDP, the federal government saves an estimated 63.5% ($69.78/$191.10).

We hope that this explanation and analysis will lay the groundwork for further substantive conversations with CMS officials, with a clear goal of working to mitigate the unreasonably high costs of Part D coverage for Medicare-only PACE participants. We look forward to better understanding the perspectives and insights of CMS and would be pleased to have the opportunity to work together to resolve this situation. We believe it is possible to craft an acceptable path forward for reducing prescription drug costs for Medicare beneficiaries enrolled in -- and those wishing to enroll in -- PACE.

Sincerely,

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Huron Valley PACE

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Altarum Institute

Enclosures:

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Milliman Actuarial Analysis

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