PACE & Part D: A Tale of Two Statutes in Need of a Solution for Medicare Beneficiaries

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Altarum's Delivery Systems Transformation (DST) team has completed key research—"PACE & Part D: A Tale of Two Statutes in Need of a Solution for Medicare Beneficiaries"—that aims to shine a light on policy that would, if implemented, advance expansion of the PACE model of care to middle-class Medicare beneficiaries. The report was done with grant support from The Rx Foundation, providing recommendations to address a longstanding policy barrier—the PACE Part D dilemma.

Over a three-year period, the grant provided the DST team with resources to thoroughly explore the policy and political landscape around the impact of high-cost PACE Part D plans on Medicare beneficiaries. The PACE Part D dilemma arises from the fact that non-dual Medicare beneficiaries buying into PACE are required to purchase a very expensive PACE Part D plan—with no other choices offered—that costs them an eye-popping $1000 per month.

To lower beneficiary costs, the report presents three feasible policy solutions—two are waivers and one is legislative—that would provide Medicare-only PACE participants with access to competitively priced, affordable Part D Prescription Drug Plans (PDPs) that offer affordable prescription drug coverage, including rebates at point of service and access to catastrophic coverage, which all other Medicare beneficiaries enjoy. It makes a strong case for resolving a longstanding misalignment between the PACE program, enacted in 1997, and the Medicare Part D benefit, enacted as part of the Medicare Modernization Act of 2003.

Currently, PACE organizations provide services in 30 states to about 57,000 older adults. One reason for the relatively slow growth of PACE has been the high cost of drugs for Medicare-only PACE participants. Changing this requires policy fixes.

Activating any of the options described below would provide Medicare-only PACE participants with access to exactly the same coverage, rebates and limits on out-of-pocket costs that all other Medicare beneficiaries enjoy today. Part D possible solutions include:

- **Proposed Solution #1: Waiver Approach for Individual PACE Organizations.** Allow PACE organizations to apply for a BIPA 903 and Part D waiver. Once approved, PACE organizations would enroll Medicare-only PACE participants, who at the time of enrollment would be offered the choice of paying for their Part D coverage through the PACE Part D plan, or obtaining it through a PDP. One example of this approach was developed by Altarum and Huron Valley PACE.
- **Proposed Solution #2: Systemwide Waiver.** Offer Medicare-only beneficiaries a choice of the PACE Part D plan or a local Part D PDP. A precedent for this approach is the 2011 BIPA 903 and Part D waiver granted for Medicare-eligible veterans enrolled in PACE.

- **Proposed Solution #3: Legislative Approach.** Permit PACE participants choice of prescription drug coverage, at time of enrollment. If coverage will be through PACE organization's Part D plan or through a local Part D PDP. This possible pathway is embodied in the bipartisan PACE Part D Choice Act, championed by Reps. Earl Blumenauer (D-OR), Jackie Walorski (R-IN), Debbie Dingell (D-MI) and Chris Smith (R-NJ) and strongly backed by the National PACE Association (NPA).

With regard to the systemwide waiver approach (#2) CMS's approved PACE waiver granted in 2011 for veterans who are Medicare-only PACE participants also came with an accompanying waiver of Section 423.458(d)—which addresses the need to improve the coordination of Part D with the benefits offered by the PACE organization. This precedent suggests that a similar approach could be taken to improve coordination between PACE and PDPs across all PACE organizations enrolling Medicare-only PACE participants. The systemwide waiver was provided by CMS in the form of an administrative action issued by the Medicare Drug and Health Plan Contract Administration Group [add link].

For those who know the PACE program and the PACE model of care well, such an action would be warmly welcomed.

> *"It's long past time to take the brakes off of PACE and make it a program that can serve the middle class. But this won't happen until the federal government fixes the problem of aberrant and extraordinary prescription drug premiums that middle income Medicare beneficiaries have to pay for their Part D coverage to enroll in PACE. Let's take a look at the solutions on the table, choose one—and go forward to more fully allow middle income beneficiaries to benefit from the PACE program."*
> *—Jennie Chin Hansen, former senior staff and CEO of On Lok PACE (1980-2005)*

As a well-established program—a high-quality, flexible model of integrated care that has significant potential to slow middle-class spend-down to Medicaid—it seems likely that if the PACE Part D dilemma can be resolved, more Medicare beneficiaries will opt to buy into PACE. In part, this is because PACE is a highly regarded program, and a growing number of Medicare beneficiaries are or will be seeking reliable sources of long term supports and services (LTSS) as they age and develop functional limitations. The federal government is in an ideal position to expand high-quality Medicare integrated care by making PACE more available to the middle-class "pre-duals" population.

PACE plans are at full financial risk and held responsible for providing all Medicare and Medicaid-covered services. PACE programs deliver some of these services directly in the PACE center, which serves as a medical center and a place for social activities and LTSS support, through its 11-member interdisciplinary team. PACE programs also commonly contract with other organizations, e.g., a hospital or a rehabilitation center and with specialists for other services. PACE frequently chooses to cover services that are determined necessary by the interdisciplinary team to improve or maintain an individual's overall health status. For complex older adults, outcomes described in the literature generally show that PACE participants experience fewer hospitalizations and less institutional care than other similarly situated beneficiaries. Once enrolled, few PACE participants choose to leave, and the program typically enjoys high levels of satisfaction.

> *"For Medicare beneficiaries able to pay for their own care who are interested in remaining living in their homes, rather than in nursing homes, PACE is not only an affordable service option but also includes and fully coordinates all Medicare and all long- term services and supports. However, the Part D benefit designed for PACE is significantly more costly than alternative Part D options, creating a barrier for non-Medicaid eligible seniors wishing to enroll in PACE."*
> *—Shawn Bloom, President and CEO, National PACE Association*

Although PACE has excellent potential to slow spend-down to Medicaid among a middle-class "pre-dual" Medicare population, the high cost of PACE Part D plans has long stymied the ability of PACE to attract this group of beneficiaries. As of December 2021, there were 142 PACE plans in 30 states serving nearly 60,000 adults. Only a tiny fraction—less than 1% of PACE enrollees—were Medicare-only, suggesting that many more beneficiaries could benefit from being able to access PACE's highly integrated care model. The program's highly coordinated services, which span primary and specialty care, and are combined with robust LTSS, is particularly helpful for those living in the community who need daily, ongoing support for functional and/or cognitive limitations, or assistance with social determinants of health (SDH), e.g., meal preparation and household help.

To help make the case that providing Medicare beneficiaries with the freedom to choose an affordable Part D option would not adversely impact other stakeholders—CMS, Rx manufacturers and Part D plan sponsors—Altarum's DST team partnered with Milliman's Frank Kopenski to produce a financial impact analysis. As shown in the far-right hand column in the chart below, this rigorous analysis concludes that permitting all Medicare beneficiaries currently enrolled in PACE and paying for their prescription drug coverage through a costly PACE Part D plan to choose an affordable PDP would result in significant savings—$1.7 million in 2022. Other stakeholders would experience a slight increase in costs on a one-time basis, spread across numerous PDPs and Rx manufacturers, and the federal government.

The alternative to solving the PACE Part D dilemma is the status quo, which is tantamount to keeping PACE a small, boutique program that exacts a high economic toll on the savings and retirement income of middle-class Medicare beneficiaries.

> *"To Medicare beneficiaries, being told you have to pay $1100 a month for your prescription drug coverage when every other drug plan in the market costs less than $35 sounds like a scam, or a mistake. Huron Valley PACE has developed a federal waiver to solve this problem, and there are legislative solutions available too. There is a real desire to decrease prescription drug costs, and we can start here."*
> *—Sonja Love Felton, Executive Director, Huron Valley PACE*

2202 Stakeholder Financial Impact Analysis

Prepared by Milliman, Frank Kopenski, Jr., ASA, MAAA

Benefits Available	PACE MO Eligible (Not enrolled in PACE)	PACE MO Eligible (Enrolled in PACE)	Part D Option Cost Impact	Assume 200 MO Enrolled in PACE
Standard Part D	Yes	No	N/A	N/A
Equivalent Alternative	Yes	No	N/A	N/A
Enhanced Alternative	Yes	No	N/A	N/A
100% Drug Coverage	Unlikely	Yes	N/A	N/A
Participant Estimated Average Cost PMPY:				
Benefit Annual Cost Sharing	$2,256.48	$0.00	$2,256.48	
Benefit Annual Premium	$400.44	$11,398.80	($10,998.36)	
Total Out-of-Pocket	$2,656.92	$11,398.80	($8,741.88)	($1,748,376)
CMS Estimated Average Cost PMPY:				
Federal Reinsurance	$2,186.40	$0.00	$2,186.40	
Premium Subsidy	$387.46	$2,041.69	($1,654.23)	
Total CMS Cost	$2,573.86	$2,041.69	$532.17	$106,434
Drug Manufacturer Estimated Cost PMPY:				
Coverage Gap Direct Rebates	$1,281.28	$0.00	$1,281.28	
CMS and Part D Sponsor Rebates	$2,358.37	$531.61	$1,826.75	
Total Manufacturer Cost	$3,639.65	$531.61	$3,108.03	$621,607
Part D Sponsor Average Cost PMPY:				
Premium Shortfall	$1,622.08	$0.00	$1,622.08	
Total Part D Sponsor Cost	$1,622.08	$0.00	$1,622.08	$324,417

Sources: 2022 CMS published national average Medicare Part D statistics and 2022 average PACE MO Part D bid results. Reproduced from Milliman Power Point presentation for Congressional Staff.

Comparing 2021 Average PACE Prescription Drug Plan Costs

Compared to 2021 Medicare Part D Standalone Prescription Drug, for a Medicare-Only Beneficiary in FFS Medicare Taking 10 Prescription Drugs

	Monthly Premium	Annual Deductible	Annual Estimated Cost-Sharing Responsibility at Preferred Pharmacy	Total Annual Patient Out of Pocket (premium + deductible + cost sharing)	All drugs on formulary?	Any drug restrictions?	Star Rating (Out of 5, with 5 being the best)
PACE Part D Plan National Average	$907.76	$0.00	$0.00	$10,893.12	Y	N	n/a
SilverScript Choice PDP	$26.70	$380.00	$0.00	$700.40	Y	Y	3.5
Humana Basic Rx Plan PDP	$27.90	$445.00	$364.44	$1,144.24	Y	Y	3.5
Express Scripts Medicare-Value PDP	$53.00	$445.00	$285.00	$1,366.00	Y	Y	3.5
AARP MedicareRx Preferred PDP	$83.40	$0.00	$804.96	$1,805.76	Y	Y	3.5

Annual PACE Plan Costs at Top, Remainder Sorted by Lowest Annual Total Participant Out of Pocket for All Available in Zip Code.

The chart above makes the following assumptions:

- Participant lives in zip code 22314;
- 30-day supply of each drug at the dosages and frequencies listed below;
- Drugs would be purchased from one of these local retail pharmacies, whichever one was considered to be in network, preferred by each plan, and offered the cheapest monthly total out of pocket drug cost; and
- The pharmacies used for this chart are CVS Store #1086, Harris-Teeter Store #398 and Walgreens #12359.

Drug List:

- Simvastatin 20mg, 1 x day
- Sertraline HCL 100mg, 1 x day
- Lisinopril 10mg, 1 x day
- Carbidopa/Levodopa 25-100mg, 3 x day
- Furosemide 40mg, 1 x day
- Escitalopram Oxalate 10mg, 1 x day
- Levetiracetam 500mg, 2 x day
- Finasteride 5mg, 1 x day
- Meclizine HCL 25mg, 1 tablet as needed, with a maximum of 10 tablets per 30 days
- Gabapentin 300mg, 3 x day

It is important to note that the range of possible future Part D reforms now being discussed by Congress would not touch the Medicare-only PACE population. As noted by Milliman's Kopenski in the financial impact analysis, "potential future Part D benefit changes, such as those under discussion and listed below, are unlikely to materially impact the magnitude of the financial stakeholders' cost shift…for 2022, [although] the actual values may change for each stakeholder depending upon the redesign."

Among those key reforms are:

- A hard out-of-pocket cap ($2000-$3500 range in 2024);
- Reducing reinsurance to ~20%;
- Elimination of the coverage gap phase;
- Moving manufacturer liability to the catastrophic phase (and potentially Initial Coverage Corridor); and
- Changes to drug formulary requirements.

As policymakers contemplate improvements for the Part D program, it is our hope that the solutions outlined in the DST report can be further refined, shaped and taken forward under administrative authority, or approved by Congress as a technical, non-controversial legislative fix in 2022.

> *"As a former PACE physician and Medical Director, I know how well this model of care works for complex older adults. Millions more Americans are going to need this type of care, and we need all options to be available. The Part D problem that has long stymied PACE enrollment is a technical error that we can all work together to solve. The status quo of asking Medicare beneficiaries to pay 20-fold more in monthly premiums than they should is a serious problem, and there is bipartisan support for solving it."*
> *—Robert Schreiber, National Medical Director of Care Model Strategy, myPlace Health*