NATIONAL PACE ASSOCIATION
Support. Innovate. Lead.

June 6, 2019

The Honorable Richard Neal
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
2322 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Neal, Chairman Pallone, Ranking Member Brady and Ranking Member Walden,

On behalf of the National PACE Association (NPA), I am submitting comments on improvements the Committees should consider with respect to low-to-moderate income Part D beneficiaries and out-of-pocket costs below the catastrophic level.

NPA is a national organization representing 117 operating Programs of All-Inclusive Care for the Elderly (PACE) organizations in 30 states, and more than 50 additional entities pursuing PACE development and supportive of PACE. PACE organizations (POs) serve among the most vulnerable of Medicare and Medicaid populations—medically complex older adults over age 55 who are State certified as requiring a nursing home level of care. Fully integrated, POs provide program participants with all needed medical and supportive services, including the entire continuum of Medicare- and Medicaid-covered items and services. In exchange for monthly capitated payments, PACE organizations assume full financial risk for the full range of community-based and, as needed, institutional services they are responsible for providing, either directly or through contracts with other community-based providers, hospitals, nursing homes, etc. The objective of PACE is to maintain the independence of program participants in their homes and communities for as long as possible; despite their eligibility for nursing home care, ninety-five percent of all PACE participants reside in the community.

The hallmarks of this unique model of care are: the broad scope of services, the interdisciplinary team and the PACE center. The PACE care model combines excellence in clinical care and care coordination from a dedicated staff of providers with the focus on quality and efficiency. The scope of services provided spans all Medicare Parts A, B and D benefits, all Medicaid-covered benefits, and any other services or supports that are medically necessary to maintain or improve the health status of participants. Under PACE, typically fragmented health care financing and delivery systems come together to serve the complex needs of this frail, elderly patient population.

Issue: Part D Premiums for Medicare-only PACE Participants Are Cost-Prohibitive
When the Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108–173) was enacted, it overlaid Medicare Part D as the payment source for prescription drug coverage on the existing PACE program. Statute (42 USC 1395w-131(f)) requires that PACE participants must obtain Part D prescription drug benefits through their PO. Consequently, each PO must establish its own individual Part D plan to serve only its enrolled participants. And, because POs are prohibited from charging their participants any deductibles and copayments (42 USC 1395eee(b)), Part D plans must reflect all beneficiary Part D costs in their Part D premiums. Since PACE participants do not incur out-of-pocket costs, they cannot access manufacturer discounts in the coverage gap and POs cannot access catastrophic reinsurance. Other factors contributing to the high cost of PACE Part D plans include: higher drug acquisition costs due to the small size of these plans in comparison to marketplace and other Part D plans; higher beneficiary acuity, as measured by Part D risk scores (PACE's average risk score is 1.814 compared to the Part D market average of 1.00); and the small size of PACE Part D plans resulting in higher per capita administrative costs.

Given that PACE Part D plans must establish monthly premiums inclusive of deductible and cost-sharing amounts that are based on notably higher drug and administrative expenditures, PACE Part D premiums differ greatly from those for marketplace plans. In 2019, the national average monthly premium for PACE Part D plans is $680.70, in contrast to the national average monthly premium of $42.17 for marketplace plans. Costly Part D premiums for Medicare-only PACE participants serve as a disincentive for this population to enroll in PACE. As of January 1, 2019, less than 1 percent (191) of the approximately 49,000 PACE participants are Medicare-only beneficiaries; the remainder are either Medicaid-only or dual-eligible beneficiaries for whom Part D premiums and co-payments are subsidized. For Medicare-only beneficiaries, the current mandate that PACE participants obtain their Part D benefits through POs' Part D plans renders PACE an unaffordable option.

While the higher PACE Part D premium may be offset for some Medicare-only participants by savings from no deductibles or coinsurance, for most, the considerable monthly cost would remain prohibitive. Even though Medicare-only PACE participants enrolled in marketplace Part D plans would pay monthly premiums as well as copays and deductibles, they could access savings from manufacturer rebates in the coverage gap and comprehensive coverage effect of catastrophic cost—unlike those enrolled in the PACE Part D plan.

Recommendation: Allow Medicare-Only PACE Participants to Enroll in Marketplace Part D Plans
To address this significant impediment to Medicare-only beneficiaries' access to PACE services, NPA recommends Congress provide Medicare-only beneficiaries enrolling in PACE with the option of either: 1) enrolling in the Part D plan offered by their local PO; or 2) enrolling in a marketplace Part D plan. Allowing Part D plan choice would increase affordability and access to PACE for all PACE-eligible Medicare-only beneficiaries, but especially those with low-to-moderate income. NPA believes that this is a critical equity issue with respect to Medicare-only beneficiaries who now are disadvantaged with respect to PACE access. Furthermore, reducing Part D costs may lead to higher levels of enrollment in PACE as an alternative to nursing home placement. Suggested legislative language and a summary are attached.

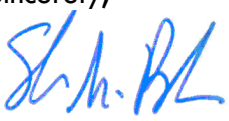
To ensure continued coordination of all aspects of care for a PACE participant regardless of how he or she accesses his/her Part D benefit, as is the case currently, all prescriptions would be ordered by the PACE primary care provider or contracted specialists. POs also would be responsible for ensuring access to prescribed drugs through the pharmacy network of any Part D plan providing coverage to enrolled participants. POs are well-positioned to facilitate participants' acquisition of drugs.

It is in the best interests of the Medicare program as well as beneficiaries and their families to increase access to PACE, a program that would, in many cases, improve both quality of care and quality of life via a community-based alternative to a nursing home. PACE and other alternatives to nursing homes will be in demand to meet the needs of Medicare beneficiaries in the coming years. According to MedPAC, approximately 10,000 baby boomers turn 65 each day and become eligible for Medicare, leading to a 50 percent increase in beneficiaries that will result in over 80 million in 2030. While individual care needs will vary, people age 65 and over have a 68 percent probability, on average, of either experiencing cognitive impairment or requiring assistance with at least two activities of daily living (ADLs). Increased access to PACE is vital for Medicare beneficiaries as these older Americans with cognitive and functional impairments seek community-based, long-term care options.

In our experience, unaffordable Part D premiums in PACE force many otherwise eligible Medicare-only beneficiaries to forego PACE as an option. A recent study by Mathematica Policy Research determined that PACE costs to the Medicare program are comparable to the costs of other Medicare options, while delivering better quality of care for an extremely frail, complex population. PACE enrollees were also found to experience lower mortality rates than comparable individuals either in nursing facilities or receiving home and community-based waiver services. Additionally, PACE incorporates many of the reforms the Medicare program seeks to promote, including: person-centered care, delivered and coordinated by a provider based, comprehensive system, with financial incentives aligned to promote quality and cost effectiveness through capitated financing. Addressing the high cost of Part D premiums for Medicare-only beneficiaries seeking to enroll in PACE by allowing participation in marketplace prescription drug plans in lieu of PO-operated plans, would increase access to this innovative model of care.

NPA appreciates your consideration of our comments; should you need additional information, please contact Francesca Fierro O'Reilly, Vice President, Advocacy, at either FrancescaO@npaonline.org or 703-535-1537.

Sincerely,



Shawn M. Bloom
President and CEO

Attachments

[Discussion Draft]

116th CONGRESS

1st Session

S. _____ / H. R._____

To amend title XVIII of the Social Security Act to permit Medicare PACE enrollees who are not dual eligible beneficiaries to select a Medicare prescription drug plan operated by an entity that is not a PACE provider, and for other purposes.

_____

IN THE [SENATE OF THE UNITED STATES] / [HOUSE OF REPRESENTATIVES]

___, 2019

M_____ introduced the following bill; which was _____.

_____

A BILL

To amend title XVIII of the Social Security Act to permit Medicare PACE enrollees who are not dual eligible beneficiaries to select a Medicare prescription drug plan operated by an entity that is not a PACE provider, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled

SECTION 1. SHORT TITLE.

This Act may be cited as the "PACE Part D Choice Act of 2019".

SEC. 2. PERMITTING PACE BENEFICIARIES TO CHOOSE MEDICARE PART D PLANS OFFERED BY ENTITIES OTHER THAN THE PACE PROGRAM.

(a) IN GENERAL.—Section 1860D–21(f) of the Social Security Act (42 U.S.C. 1395w-131(f)) is amended—

(1) in paragraph (1), by striking "paragraphs (2) and (3)" and inserting "paragraphs (2), (3), and (4)"; and

(2) by adding at the end the following new paragraph:

"(4) PERMITTING PACE MEDICARE-ONLY PARTICIPANTS TO ELECT TO ENROLL IN A PRESCRIPTION DRUG PLAN THAT IS NOT OFFERED BY THE PACE PROGRAM.— Notwithstanding paragraph (1) and subject to the applicable requirements under section 1894(j), a Medicare-only PACE program eligible individual (as defined in section 1894(j)(4)(A)) who is enrolled under a PACE program only under section 1894 may make an election to enroll in a prescription drug plan (as defined in section 1860D-41(14)) in lieu of receiving qualified prescription drug coverage through the PACE program in which such individual is enrolled.

(b) CONFORMING AMENDMENTS.—(1) Section 1894 of the Social Security Act (42 U.S.C. 1395eee) is amended by adding at the end the following new subsection:

"(j) AUTHORIZATION FOR A PACE PARTICIPANT TO VOLUNTARILY ENROLL IN A PART D PLAN THAT IS NOT OPERATED BY A PACE PROGRAM.—

"(1) REFERENCE.—For provisions authorizing Medicare-only PACE program eligible individuals (as defined in paragraph (4)(A)) to elect to enroll in a prescription drug plan (as defined in paragraph (4)(B)) in lieu of receiving qualified prescription drug coverage (as defined in paragraph (4)(C)) through the PACE program in which such individual is enrolled, see section 1860D-21(f)(4).

"(2) INFORMED CHOICE.—In order to promote informed choice for a Medicare-only PACE program eligible individual with respect to qualified prescription drug coverage under a PACE program, the PACE provider operating the PACE program shall, upon request, provide information to such individual with respect to the qualified prescription drug coverage offered through such PACE program, including information on any formulary under such coverage and the amount of premiums that may be charged under such coverage.

"(3) COORDINATION WITH PACE PROGRAM SERVICES.—In the case of a Medicare-only PACE program eligible individual enrolled in a PACE program who elects to enroll in a prescription drug plan in lieu of receiving qualified prescription drug coverage through the PACE program—

"(A) the PACE provider operating the PACE program shall coordinate benefits for covered part D drugs under the prescription drug plan with other items and services furnished through the PACE program to such individual, including ensuring access to covered part D drugs; and

"(B) notwithstanding subsection (b)(1), the individual so enrolled shall be responsible for any premium and cost-sharing that may be imposed under such prescription drug plan with respect to such covered part D drugs while so enrolled.

"(4) DEFINITIONS.—In this subsection—

"(A) the term 'Medicare-only PACE program eligible individual' means an individual who is described in subsection (a)(1) and who is not entitled to medical assistance under title XIX, and includes the designated representative of the individual as appropriate;

"(B) the term 'prescription drug plan' has the meaning given such term in section 1860D-41(14));

"(C) the term 'qualified prescription drug coverage' has the meaning given such term in section 1860D-2(a)(1); and

"(D) the term 'covered part D drug' has the meaning given such term in section 1860D-2(e).".

(2) Section 1894(c)(5)(B)(i)(I) of the Social Security Act (42 U.S.C. 1395eee(c)(5)(B)(i)(I)) is amended by inserting before the semicolon at the end the following: ", including, in the case of an individual making an election described in subsection (j) to enroll in a prescription drug plan in lieu of receiving qualified prescription drug coverage through the PACE program, premiums for which the individual is responsible under such prescription drug plan pursuant to such an election".

(c) EFFECTIVE DATE; IMPLEMENTATION.—

(1) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

(2) IMPLEMENTATION.—Not later than the date that is one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall implement this section and the amendments made by this section. The Secretary may carry out the requirements of this paragraph through the use of interim final rulemaking, program instruction or otherwise.

PACE Part D Choice Act of 2019 Summary

Under current law, PACE program enrollees must obtain their Medicare Part D outpatient drug benefits through the Part D plan that is offered by the PACE provider. PACE program enrollees who are Medicare-eligible beneficiaries, but who are not eligible for benefits under the State's Medicaid program, must pay a premium for the Part D outpatient drug benefit.

This bill would amend the Medicare Part D statute to permit Medicare-only PACE program enrollees to purchase a standalone Part D prescription drug plan (PDP) policy from a PDP sponsor outside the PACE program. If a Medicare-only enrollee elects to purchase a standalone policy from a PDP sponsor outside the PACE provider, the enrollee would be responsible for premiums and cost-sharing imposed under that PDP plan. Total premiums and cost-sharing under a PDP policy from a PDP sponsor outside the PACE program could be substantially less than the premium that applies under the Part D plan offered by the PACE program.

The bill would also make conforming amendments to the Medicare PACE statute. The PACE provider would be required to provide Medicare-only enrollees, upon request, information on the PACE provider's Part D benefit, including the amount of the premiums as well as formulary information. The PACE provider would be required to coordinate the Part D benefits under a PDP policy offered by another sponsor with services furnished under the PACE program, and the PACE provider would be required to ensure access to Part D drugs. Additionally, the PACE provider could terminate enrollment in the PACE program of a Medicare-only enrollee who elects to purchase the standalone policy and who fails to pay premiums imposed under that policy.

The bill would take effect immediately upon enactment. CMS would have one year from the date of enactment to fully implement the bill; the agency could use interim, final rulemaking to meet that one-year deadline.