NATIONAL PACE ASSOCIATION
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November 1, 2021

The Honorable Ron Wyden
Chairman
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the National PACE Association (NPA), please accept this letter in response to the Committee on Finance Behavioral Health Request for Information (RFI).

NPA is a national organization representing 130 operating Programs of All-Inclusive Care for the Elderly (PACE) organizations in 28 states, and numerous 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. The objective of PACE is to maintain the independence of program participants in their homes and communities for as long as possible. POs currently serve almost 58,000 patients, known as participants, nationwide.

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, such as behavioral health. In exchange for monthly capitated payments, POs 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 capitated and fully risk bearing payment model underlying PACE provides a strong incentive for POs to avoid duplicative or unnecessary services while encouraging the use of appropriate community-based alternatives to avoidable hospital and nursing home care. PACE programs have the regulatory and financial autonomy to provide care and services as needed.

The hallmarks of this unique model of care are the broad scope of services, the interdisciplinary team (IDT) and the PACE center. The person-centered 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. Door to door transportation, home care, personal care, meals and adult day services, among others, are provided routinely to participants. Members of the IDT practice at the PACE center, and participants receive primary care, therapy, meals, recreation, socialization and personal care there, among other services. Care and services also are provided at home as appropriate. Behavioral health services are no exception. The PACE model of care addresses

mental and substance use disorders, trauma and other care supportive of recovery, resilience and overall wellbeing.

While PACE staff do their utmost to provide care in the PACE center and at home, at times a participant's condition may warrant admission to a hospital or skilled nursing facility, the cost of which is covered by the PO. During these stays, PACE staff remain involved, actively planning for and managing the discharge, transition and follow up care. IDT members ensure transportation home is arranged, as well as any follow up care needed at the PACE center or elsewhere. The IDT also plans for and makes sure other post-discharge needs are addressed, such as medication, home care, durable medical equipment, and meals. The substantial, hands on care rendered by PACE staff results in better outcomes as well as decreased anxiety for participants and their families over care expenses and access.

Identified as an evidence-based care model by the Administration for Community Living, PACE programs achieve high quality outcomes for their participants as well as for Medicare and Medicaid. Despite being at the nursing home level of care, participants enrolled in PACE experience a low risk of long-term nursing home admission; in fact, 95 percent of participants live in the community. Furthermore, lower rates of hospitalization, readmission and potentially avoidable hospitalization were found among PACE enrollees than in similar populations. The hospitalization rate was 24 percent lower than that for dually eligible beneficiaries receiving Medicaid nursing home services. For readmissions, the rate for PACE participants was 16 percent less than the national rate of 22.9 percent for dual eligibles 65 years of age and older. For potentially avoidable hospitalizations, the rate for PACE participants was 44 percent lower than that for dually eligible Medicaid nursing home residents. And for emergency department visits, the incidence rate is lower than one visit per participant, per year. In fact, the efficacy of the PACE model of care was highlighted in a recently published analysis of integrated care models by the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation Office of Behavioral Health, Disability, and Aging Policy as a consistent 'high performer'."

Under PACE, typically fragmented health care financing and delivery systems come together to serve the complex biopsychosocial and medical needs of frail, elderly and disabled patient populations. On average PACE participants live with 5.8 chronic conditions simultaneously. The top five most common categories of conditions experienced by PACE participants are in order: vascular disease; major depressive, bipolar, and paranoid disorders; diabetes with chronic complications, congestive heart failure, and chronic obstructive pulmonary disease. Dementia co-occurs in nearly half (46%) of all participants.

Given the noted characteristics of the population served by the PACE model of care, NPA considers behavioral health to be an integral part of any and all care delivered to participants. To support PO's integration of behavioral health care with other care services they provide, NPA has developed a number of resources for its member POs:

- the NPA Behavioral Health Operational Resources Toolkit is a compilation of best practices aimed at those POs looking to achieve a greater level of behavioral health integration;

- the Behavioral Health Webinar Series, is a recorded series of topics related to delivering and integrating behavioral health. This series is based on the NPA Behavioral Health Training Manual; and
- the Behavioral Health Integration Coaching Program (BHICP) is a two year project, funded by the RRF Foundation for Aging. Individual POs seeking to heighten their ability to integrate behavioral health services are coached by a two-person team with experience achieving a high level of integration in their own POs. Through participation in the BHICP, POs will assess their current level of integration, identify priorities for increasing integration, and apply rapid cycle testing to achieve improvements in their level of integration.

Please find below our responses to several of the specific information requests contained in the RFI.

b. Increasing Integration, Coordination and Access to Care

Given the notable outcomes achieved by the PACE model of care in integrating behavioral health, primary care, as well as any other needed care or service for high need, high cost Medicare and Medicaid beneficiaries, increasing the availability and affordability of PACE is clearly warranted.

As our nation ages, Congress and the Administration should foster increased interest in high quality, cost-effective and evidence-based models of care, such as PACE. A recent WebMD/John A. Hartford study found that the number of Americans 65 years of age and older is expected to comprise close to 25 percent of our nation's population by 2060, up from 16 percent today (52 million). The incidence of behavioral health conditions is higher among older adults at almost 25%, than all adults (21%).

Further, the Substance Abuse and Mental Health Services Administration (SAMSHA) reports those Americans 65+ are the most likely of all age cohorts to live with chronic conditions, with mental health disorders, substance abuse disorders and cognitive impairments among them. Of those living with mental disorders, SAMSHA states that this population also is more likely both to experience chronic conditions and to have higher rates of emergency department visits and hospitalizations.

The capitated funding methodology used by PACE allows for unprecedented flexibility for POs in meeting medical and other needs in creative ways since it allows the sole focus to be the provision of high-quality care. Health care providers drive care and coverage decisions in PACE, and thus are empowered to nimbly combine preventive, acute and long-term care services/supports to best meet the needs of each participant. These efforts result in positive outcomes.

By integrating Medicare and Medicaid coverage, POs directly provide or contract for all medical and social needs of participants 24 hours a day, seven days a week, 365 days a year. Care and services are delivered both in the PACE center and at home, which enables participants to achieve their highest level of functioning possible. The person-centered care plans constructed and executed by the high-touch PACE IDT prevent lapses in care provision,

regardless of setting or provider. These interventions often result in either the reduction or elimination of hospital and nursing home admissions. But when there is such an admission, PACE staff actively manage the transition home so that the participant's care is seamless.

Oftentimes, the non-clinical services and supports provided by POs enhance physical and mental health as well as the overall well-being of participants. Activities, meals and socialization are available to all participants in the day center. During the COVID-19 pandemic, POs began to provide activities and other interpersonal interactions through audio/visual devices such as GrandPads, smart phones and land lines to keep in touch with participants and reduce loneliness.

However, not every older American has access to PACE presently, so policy changes are required. NPA strongly encourages Congress to pass The PACE Plus Act, S. 1162, and The PACE Part D Choice Act, H.R. 4941, to eliminate existing access and affordability barriers and facilitate expanding the spread, scale and scope of this innovative model of care.

The PACE Plus Act, if enacted, would eliminate many of the identified barriers and thereby increase access for older Americans to this proven model of care. The bill also streamlines some of the administrative challenges experienced by PACE organizations as they seek to grow and expand to serve more aging adults and people with disabilities. See Attachment 1 for more details.

The PACE Part D Choice Act seeks to rectify the high cost of Part D for Medicare-only PACE participants. PACE programs are required to provide all Medicare and Medicaid benefits to a participant, including Part D. Therefore, a Medicare-only beneficiary is limited to the Part D plan offered by the PACE program for prescription drug coverage. Unlike dually-eligible beneficiaries, Medicare-only beneficiaries must pay a monthly premium for Part D coverage. As such, they should have the freedom to select the Part D plan of their choice. Greater selection and flexibility are critical so that Medicare beneficiaries may receive the Part D coverage best suited to their medical and financial needs. Attachment 2 offers more information.

d. Furthering Use of Telehealth

PACE is the lifeline enabling enrolled people with disabilities and aging adults to live at home instead of in a nursing facility—95% of participants live safely in the community with the support of their PACE program. Overall, the PACE model of care ensures that care is person-centered and supports individuals' choices in where, how and from whom their care is provided.

Since the advent of the COVID-19 pandemic, PACE organizations have significantly increased their use of telehealth services. The Centers for Medicare and Medicaid Services (CMS) reported dually eligible beneficiaries are at significantly greater risks of both contracting and being hospitalized for COVID-19, as compared to Medicare-only beneficiaries. Thus, PACE organizations deliberately have sought to minimize the risk of COVID-19 exposure for participants, their families and staff.

Throughout the ongoing public health emergency (PHE) all 141 PACE organizations across the nation have continued to care for their nearly 58,000 participants by shifting the delivery of primary care, rehabilitative and social services, which were previously often provided in PACE centers, to providing almost all of these services in the home. This shift supplemented the already robust array and frequency of personal care and skilled nursing care provided by PACE organizations in the home.

This pivot was enabled in part through greater use of telehealth services which allowed PACE programs to remain in constant contact with their participants and deliver care and services remotely. As a result, the risk of COVID-19 exposure was significantly mitigated. Despite being economically disadvantaged, frail, and highly medically complex with cognitive and/or functional limitations, PACE participants' risk of contracting or dying from COVID-19 has been approximately one-third that of nursing home residents.

While PACE organizations have been able to rapidly increase the amount of telehealth services provided during the COVID-19 pandemic, the Centers for Medicare and Medicaid Services has not considered, and indeed does not accept from PACE organizations, diagnoses associated with audio-only telehealth services for the purpose of risk adjusting Medicare payment. Whenever possible, PACE organizations employ audio-visual telehealth technology to interact with their participants at home, but often are limited to audio-only options. Many older Americans and those living with disabilities do not have ready access to or the ability to use devices suitable for audio and visual telehealth communications due to fiscal, cognitive and/or functional limitations. In fact, CMS found that of the 9 million FFS Medicare beneficiaries receiving a telehealth service from mid-March to mid-April 2020, 3 million, or one-third, received an audio-only telehealth service.

The Pew Research Center found 91% of seniors use cell phones, but only 53% have smart phones needed for audio-visual telehealth. Moreover, only 60% of those 65 and older have internet access according to the HHS Assistant Secretary for Planning and Evaluation. Dual-eligibles living in the community experience even greater challenges– 53% use the internet rarely, in contrast to 27% of Medicare-only beneficiaries. These trends are consistent with the PACE experience with audio-only telehealth since the vast majority of PACE participants are dually-eligible. Further challenging the use of audio-video telehealth, PACE organizations are serving an exclusively older adult population in which 50% have a diagnosis of dementia, greatly diminishing their ability to use smart phones, tablets and computers for audio-visual telehealth purposes. Thus, it is difficult or impossible for many PACE participants to access audio-visual telehealth. Moreover, many PACE participants require language translation services which may only be available via telephone.

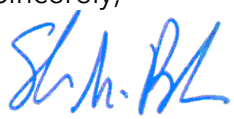
NPA believes it is poor public policy that any diagnoses made through an audio-only telehealth visit will not be accepted by CMS for the purposes of risk adjustment. Failing to include all appropriate diagnoses in the Medicare risk adjustment calculations will likely cause payment rate inaccuracies. Given the average size of a PACE organization's enrollment is approximately 400, the impact of payment errors for even a small number of participants due to missing diagnoses will be significant for the program.

To address this unfair discrepancy, NPA urges swift passage of The Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021, S. 150/H.R. 2166. We applaud the recognition that CMS should be collecting all available risk adjustment data from POs to use in calculating future Medicare payments for PACE—not just data stemming from audio with video encounters. Thus, The Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021, H.R. 2166, will ensure PACE organizations will not be financially penalized for prudently avoiding face-to-face encounters in order to protect participants and staff.

In closing, HHS found that the PACE program preserves, enhances, and, in many cases, restores the independence, health and well-being of its participants [,]" HHS stated to Congress. "PACE also reduces burden among family care-givers . . . . This report finds overall favorable experience by beneficiaries, [and] communities." Additionally, participants shared with HHS that although "they had been depressed and lonely before coming to PACE; they felt that PACE saved their lives and helped them feel like life was worth living again."

NPA looks forward to working with you as you explore this topic further. We cordially invite you and your staff to tour a PACE program and experience this unique and innovative model of care firsthand. We appreciate the 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

NATIONAL PACE ASSOCIATION
Issue Brief
Attachment 1
April 2021

Enable More Older Americans to Age in Place: Cosponsor the PACE Plus Act, S. 1162

Programs of All-Inclusive Care for the Elderly (PACE®) face many systemic challenges and obstacles to growth and expansion. If these barriers were eliminated, PACE organizations could serve many more of the 10 million people age 55 and over needing long-term care services and supports, rather than just the nearly 55,000, or 0.001 percent, currently enrolled. The PACE Plus Act not only would eradicate most federal impediments but encourage the expansion of existing PACE programs and the establishment of new ones. The National PACE Association (NPA), on behalf of our 119 PACE programs, requests your support of the PACE Plus Act.

Background

PACE programs enable people age 55 and over with chronic, complex medical conditions to live at home safely, despite needing a nursing home level of care. Through the innovative and integrated PACE model of care, program participants receive the entire continuum of Medicare services, Medicaid services, and any other services or supports determined to be medically necessary to maintain or improve their health status from 138 organizations in 30 states. PACE meets the needs of each individual participant through a personalized care plan that is developed and delivered by an interdisciplinary team of health care providers 24 hours a day, seven days a week, 365 days a year. Most participants (90 percent) are dually eligible for Medicare and Medicaid, but less than 1 percent are just Medicare eligible.

U.S. Census Bureau projections show the population of older Americans (age 65 and over) will continue to swell to 77 million by 2034, when for the first time it will surpass the number of Americans under age 18 (76.5 million).[i] By 2029, approximately 14.4 million middle-income adults, representing 43 percent of all aging adults,[ii] will be seeking ways to obtain the care they need outside of Medicaid since an estimated 20 percent will have high health care and functional needs, while 60 percent will experience mobility limitations.

According to the Commonwealth Fund, 83 percent of adults with high needs have public health insurance, 20 percent are dually eligible for Medicare and Medicaid, 50 percent are Medicare beneficiaries,[iii] and 13 percent are Medicaid beneficiaries. Considering this significant reliance on Medicare and/or Medicaid among those with high health care needs, it is critical for our nation to encourage increased use of evidence-based, proven, cost-effective care models such as PACE.

PACE is well suited to meet the needs of dually eligible beneficiaries, Medicaid-only beneficiaries and Medicare-only beneficiaries. However, there are several barriers that impede Medicare beneficiaries from readily accessing PACE. A recent report from the Milken Institute states, "67 percent of adults 55 and older with complex care needs cannot access a PACE program due to geographic, financial and regulatory barriers."[iv] The PACE Plus Act, if enacted, would eliminate many of the identified barriers and facilitate increased access by Medicare beneficiaries to this proven model of care. The bill also streamlines some of the administrative challenges experienced by PACE organizations as they seek to grow and expand to serve more aging adults and people with disabilities.

Summary

Allow Medicare Beneficiaries to Access PACE Organizations in States Not Exercising the Option to Establish PACE in Their Medicaid State Plan

Currently, PACE organizations can operate only in states that have added the PACE program to their Medicaid plans and agree to enter into three-way PACE program agreements with PACE organizations and the Centers for Medicare & Medicaid Services (CMS). To date, 18 states have not elected PACE as a state option, so Medicare beneficiaries do not have access to the program in those states. Allowing for two-way agreements would enable Medicare beneficiaries to enroll in PACE and

For more information, contact Francesca Fierro O'Reilly, VP, Advocacy at FrancescaO@npaonline.org or 703-535-1537.

have their long-term services and support needs met and coordinated with their medical care and other recommended services without spending down to Medicaid. (See Section 3.)

Make PACE More Affordable to Medicare Beneficiaries by Permitting PACE Organizations Flexibility in Setting Their Premiums

Existing regulations limit the ability of PACE organizations to establish the monthly premiums charged to Medicare-only beneficiaries since the amounts must be set in accordance with their Medicaid rates for dually eligible beneficiaries. Paying an average rate may make sense for Medicaid, which funds care for many, but tying the cost charged to an average does not make sense for individual Medicare beneficiaries. Since they are paying out of pocket for PACE, Medicare beneficiaries should be able to pay a rate reflecting their individual health status and corresponding level of need. Allowing Medicare beneficiaries to pay a capitation rate consistent with their health status will better align their needs with their costs and result in improved affordability of PACE services. Additionally, giving PACE organizations the flexibility to set Medicare-only premiums according to a beneficiary's needs allows for greater alignment with consumer demand. (See Section 5.)

Enable PACE Enrollment at Any Time

Currently, PACE programs may enroll beneficiaries only on the first of the month. The bill would enable PACE programs to enroll a Medicare-only beneficiary on the date the signed enrollment agreement is received. In addition, dually eligible beneficiaries would be able to enroll in PACE any time if permitted by their state. Payments by Medicare and/or Medicaid would be prorated in accordance with the date of enrollment. Allowing enrollment at any time would shorten the waiting time before enrollment and make PACE a viable option for more older adults and their families. (See Section 4.)

Streamline PACE Applications and Approvals

CMS accepts applications just once a quarter for new PACE programs and for existing programs seeking to establish a new center within its current service area or to expand into a new service area. The PACE Plus Act would eliminate this arbitrary requirement so applications of all types could be submitted faster. It also reduces the time CMS has to approve, deny, or request more information on an application to 45 days, after which an application is deemed approved. If further clarification is sought, the application will be deemed approved within 45 days of CMS receiving the material, unless the CMS secretary denies the application (See Section 6).

Facilitate Expansion of PACE Through Grants

Thirty grants of up to $1 million each would be awarded to establish new PACE programs or expand existing ones in rural or urban undeserved areas. Twenty grants of up to $100,000 each would be made to states so they may establish PACE programs (See Section 2).

Test the PACE Model of Care with New Populations

The bill allows pilots to test the PACE model of care with new high-need and high-cost populations not currently eligible to participate. Interested entities must perform an assessment of their service area to identify which new populations would be most appropriate to serve.

Enable States to Serve Expanded Populations with 90 Percent FMAP

Finally, the bill gives states offering PACE as a benefit under Medicaid the opportunity to expand their eligibility definition for PACE programs beyond those requiring a nursing home level of care. Potential participants must still be age 55 or over and live within the service area of the PACE program but may include those with incomes no greater than 150 percent of the poverty level and unable to perform at least two activities of daily living or whatever threshold a state may set. The costs of serving such expansion populations would be covered primarily through a 90 percent Federal Medical Assistance Percentage (FMAP) (See Section 8).

Endnotes

i U.S. Census Bureau. (2018). **Older People Projected to Outnumber Children for First Time in U.S. History**. March 13.

ii Pearson, C.F., Quinn, C.C., Loganathan, S., Datta, A.R., Mace, B.B., Grabowski, D.C. (2019). **The Forgotten Middle: Many Middle-Income Seniors Will Have Insufficient Resources for Housing and Health Care**, *Health Affairs,* 38 (5): 851-859.

iii Hayes, S.L., Salzberg, C.A., McCarthy, D., Radley, D.C., Abrams, M.K., Shah, R., Anderson, G.F. (2016). **High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care? A Population-Based Comparison of Demographics, Health Care Use, and Expenditures. The Commonwealth Fund. Issue Brief,** Appendix 1a, August.

iv Davis, D., Servat, C. (2021). **New Approaches to Long-Term Care Access for Middle-Income Households.**

For more information, contact Francesca Fierro O'Reilly, VP, Advocacy at FrancescaO@npaonline.org or 703-535-1537.

NATIONAL PACE ASSOCIATION
Issue Brief
Attachment 2
August 2021

Support The PACE Part D Choice Act, H.R. 4941

Issue

Participants in the Program of All-Inclusive Care for the Elderly (PACE) must enroll in the Medicare Part D prescription drug plan offered by their PACE program rather than be able to choose an alternative stand-alone Part D plan in the marketplace that might offer a more affordable alternative.

Recommended Action

Support the PACE Part D Choice Act, H.R. 4941, which would allow Medicare-only PACE participants to choose between the PACE Part D plan as currently designed, with an all-inclusive premium and no deductible or coinsurance, or a marketplace Part D plan with a lower premium and related deductible and coinsurance amounts.

Background

Enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) significantly changed how PACE organizations are paid to provide prescription drug coverage to their participants. Prior to the implementation of Medicare Part D, prescription drugs were not covered by Medicare. Their costs were paid by Medicaid or as part of the PACE private pay premium. Upon implementation of Part D, payment for covered prescription drugs required that PACE organizations establish themselves as Part D plans. Today, all PACE organizations operate Part D plans.

Current PACE regulations prohibit PACE Part D plans from charging participants deductibles and coinsurance. In addition, participants are not subject to the coverage gap. Under existing Part D regulations, a PACE Medicare-only participant who is in the benefit coverage gap receives neither manufacturer discounts for brand-name drugs nor federal reinsurance for drug costs exceeding the catastrophic benefit limit. Other factors contribute to the high cost of PACE Part D plans: the drug acquisition price for PACE Part D plans is higher; in 2021, the average marketplace Part D beneficiary risk score was 1.00, whereas it was 1.759 for PACE participants; there is a common lack of a formulary in PACE Part D plans; and the pool for each PACE Part D plan is small, resulting in administrative costs that may be considerably higher than for marketplace Part D plans.

Therefore, the Part D coverage offered by PACE organizations provides a generous 100 percent benefit level but comes with a significant Part D premium for Medicare-only participants. The national average monthly premium for PACE Part D plans is $907.76, in contrast to the national average premium of $41.00 for stand-alone Part D plans in 2021. As such, only 172 Medicare-only beneficiaries were enrolled in PACE as of January 1, 2021.

Need for Action

While the higher PACE Part D premium may be offset for some PACE participants by savings from not having to pay cost-sharing amounts, the cost of the PACE Part D plan is prohibitive for many prospective Medicare-only participants. Consequently, the lack of affordable Part D plan options for Medicare-only PACE participants limits their access to the PACE program that would, in many cases, improve their quality of care and quality of life as they seek a community-based alternative to a nursing home. Access to community-based alternatives to nursing homes will be critical 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.[i] While individual care needs will vary, people age 65 and over have a 68 percent probability, on average, of either

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experiencing cognitive impairment or requiring assistance with at least two activities of daily living (ADLs).[ii] 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.

More than three-fourths (77 percent) of adults age 40 and over prefer to receive any necessary long-term care services in their home, according to a poll by the Associated Press and NORC Center for Public Affairs Research.[iii]

Today, PACE serves over 56,000 older Americans who have complex, chronic medical conditions and need long-term services and supports (LTSS). Of these, the vast majority are Medicaid- eligible, either dual-eligible or Medicaid-only (99%). Less than 1% have Medicare-only coverage. Part D plan choice would increase affordability and access to PACE for these participants and potentially for future Medicare beneficiaries.

Cost and Benefits of Action

A recent study by Mathematica Policy Research determined that PACE costs are comparable to the costs of other Medicare options, while delivering better quality of care for an extremely frail, complex population.[iv] 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.

[i] MedPAC. (2015). *Report to the Congress: Medicare and the Health Care Delivery System*. June, p. 37. Retrieved from **medpac.gov**.

[ii] Gibson, M.J. (2003). *Beyond 50.03: A Report to the Nation on Independent Living and Disability: Executive Summary.* AARP Public Policy Institute. April. Retrieved from **aarp.org**.

[iii] Swanson, E., Benz, J., Titus, J., et al. (2015). Long-Term Care in America: Expectations and Preferences for Care and Caregiving. The Associated Press-NORC Center for Public Affairs Research, May. Retrieved from **longtermcarepoll.org**.

[iv] Ghosh, A., Schmitz, R., Brown, R. (2015). *Effect of PACE on Costs, Nursing Home Admissions, and Mortality: 2006-2011.* Mathematica Policy Research, p. 15. Retrieved from **aspe.hhs.gov**.

NATIONAL PACE ASSOCIATION

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PACE Part D Choice Case Study

Comparing 2021 Average PACE Prescription Drug Plan Costs Compared to 2021 Medicare Part D Standalone Prescription Drug Plans for a Medicare-only Beneficiary in Fee for Service Medicare Taking 10 Prescription Drugs

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

2021 Plan Name	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 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
Clear Spring Health Premier Rx PDP	$15.40	$445.00	$227.40	$857.20	Y	N	n/a
Clear Spring Health Value PDP	$26.30	$445.00	$115.20	$875.80	Y	N	n/a
Mutual of Omaha Rx Premier PDP	$24.90	$445.00	$144.00	$887.80	Y	Y	2.5
Cigna Secure-Essential Rx PDP	$24.00	$445.00	$165.60	$898.60	Y	Y	3.5
Anthem MediBlue Rx Enhanced PDP	$23.70	$330.00	$285.84	$900.24	Y	Y	3.5
Elixir RxPlus PDP	$14.30	$445.00	$286.68	$903.28	Y	N	3.5
Humana Walmart Value Rx Plan PDP	$17.20	$429.20	$308.64	$944.24	Y	Y	3.5
WellCare Classic PDP	$24.50	$445.00	$217.80	$956.80	Y	Y	4.0
Cigna Secure Rx PDP	$26.10	$445.00	$223.80	$982.00	Y	Y	3.5
WellCare Wellness Rx PDP	$14.80	$445.00	$367.68	$990.28	Y	Y	4.0
Anthem MediBlue Rx Plus PDP	$55.80	$0.00	$336.84	$1,006.44	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-Saver PDP	$27.10	$285.00	$537.00	$1,147.20	Y	Y	3.5
AARP MedicareRx Walgreens PDP	$32.00	$445.00	$407.52	$1,236.52	Y	Y	3.5
Humana Premier Rx Plan PDP	$61.20	$445.00	$104.80	$1,284.20	Y	Y	3.5
Anthem MediBlue Rx Standard PDP	$56.10	$375.00	$255.00	$1,303.20	Y	Y	3.5
AARP MedicareRx Saver Plus PDP	$25.20	$445.00	$558.36	$1,305.76	Y	Y	3.5
WellCare Medicare Rx Select PDP	$20.10	$445.00	$639.72	$1,325.92	Y	Y	3.5
WellCare Medicare Rx Value Plus PDP	$74.60	$0.00	$431.20	$1,326.40	Y	Y	3.5
SilverScript Plus PDP	$63.50	$0.00	$569.70	$1,331.70	Y	Y	3.5
Express Scripts Medicare-Value PDP	$53.00	$445.00	$285.00	$1,366.00	Y	Y	3.5
Express Scripts Medicare-Choice PDP	$62.30	$100.00	$526.20	$1,373.80	Y	Y	3.5
Elixir RxSecure PDP	$26.80	$445.00	$612.85	$1,379.45	Y	N	3.5
WellCare Value Script Rx PDP	$16.30	$445.00	$802.80	$1,443.40	Y	Y	4.0
SilverScript SmartRx PDP	$7.30	$445.00	$949.08	$1,481.68	Y	Y	3.5
WellCare Medicare Rx Saver PDP	$34.50	$445.00	$666.12	$1,525.12	Y	Y	3.5
Mutual of Omaha Rx Plus PDP	$85.50	$445.00	$144.00	$1,615.00	Y	Y	2.5
Cigna Secure-Extra Rx PDP	$68.10	$100.00	$852.00	$1,769.20	Y	Y	3.5
AARP MedicareRx Preferred PDP	$83.40	$0.00	$804.96	$1,805.76	Y	Y	3.5

The chart makes the following assumptions:

- Participant lives in zip code 22314;
- 30 day supply of each drug at the dosages and frequencies listed below ; and
- 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. 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