



SOLUTIONS THAT MATTER. HEALTH CARE THAT WORKS.

# PACE Expansion Part 2

Anne Montgomery, Deputy Director  
Center for Elder Care & Advanced Illness  
Altarum Institute

# Huron Valley PACE Expansion Project

## ▲ Objective:

- Assess feasibility of expanding PACE to new populations
- Enroll up to 75 individuals in pilot expansion

## ▲ Timeline Overview

- March 1<sup>st</sup> 2017 through February 2019

## ▲ Funding

- Michigan Health Endowment Fund



# Expansion Populations

- ▲ 1. Near Poor - Meets nursing home level of care; not enough resources to pay Medicaid PMPM
- ▲ 2. Self Pay - Meets nursing home level of care; has resources to pay full Medicaid PMPM;
- ▲ 3. At Risk - Does not meet nursing home level of care, but at risk; need a menu or bundle of services and introduction to PACE

# Areas to address with CMS and State Medicaid

1. Flexible premium rates and services bundles for LTSS based on need
2. Enhancing Part D affordability
3. Two-way PACE contracts
4. Expanding to medically complex “at risk” Medicare beneficiaries
5. Sliding scale rate for near poor PACE participants
6. Plans for participants who convert to Medicaid
7. Plans for the time after the grant

# LTSS Tiers, Service Bundles



- Introductory package with comprehensive assessment, care planning and navigation
  - Available to Medicare beneficiaries for a modest fee (before PACE enrollment)
- Ongoing comprehensive assessment, care planning, navigation, caregiver training and support, medication management
  - Short-term day care, short-term respite, adapted transportation, 24/7 on call assistance
- All of the above plus personal care services of up to 45 hrs per week, including regular day care
  - More bundles or a menu for some services may be better
- All of the above plus personal care of more than 45 hours per week or long term nursing home placement

---

# Background

- Beginning in 2006, the responsibility of providing prescription drugs to a PACE participant shifted from the State Medicaid programs to the federal government Medicare program for all drugs other than those not-covered by the new Medicare Part D benefit
- As a result, a Part D bid was required each year to determine the amount of premium to be collected from a PACE participant not eligible for Medicaid, in addition to the Part D bid for those dually eligible
- Because of the existing provisions in the PACE three-way contract stating that a member could not be charged copayments, the Part D bid became enhanced to a 100% benefit resulting in a significant supplemental premium amount to be paid by the PACE participant without Medicaid (a.k.a., Medicare-only)
- **Under the existing Part D regulations, a PACE Medicare-only participant receives no manufacturer discounts for brand name drugs in the benefit coverage gap and no federal reinsurance for drug costs exceeding the catastrophic benefit limit**
- This PowerPoint frames the environment for discussion and change due to the desire to expand PACE in Michigan with state grant funding

---

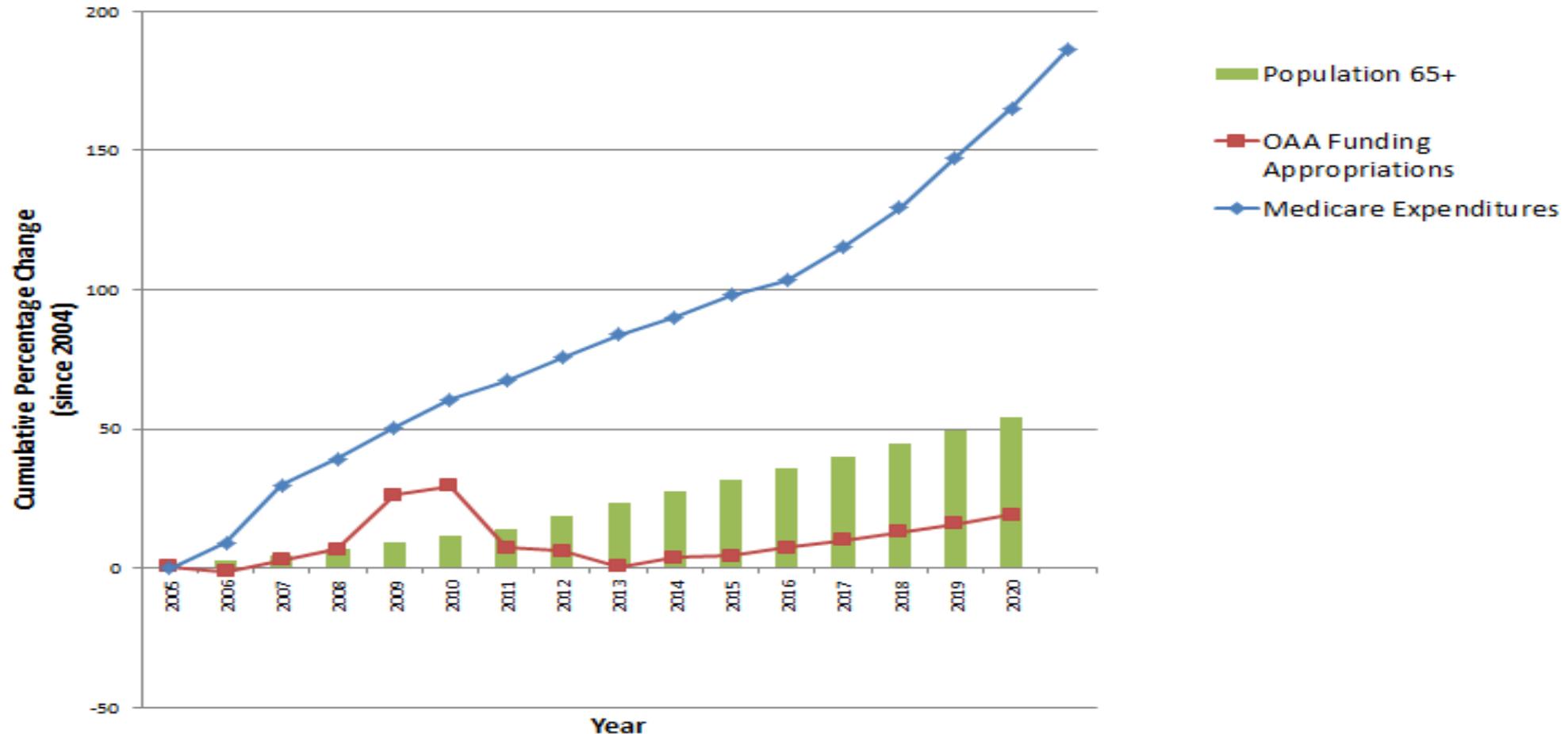
# 2017 Estimated Average Premium for an Illustrative PACE Participant

- How can the member premium be **\$840.30 PMPM**?
  - PACE acquisition price for drugs is above the Part D market
  - Formulary management and rebates are non-existent or below the Part D market
  - ABC PACE participant risk score is 1.814 compared to Part D market average of 1.00
  - PACE participant is forced to purchase a 100% drug benefit without cost sharing which creates an ABC PACE supplemental premium of \$680.50 PMPM
  - ABC PACE participant receives no federal reinsurance (estimated to be \$155.60 PMPM)
  - ABC PACE participant receives no brand name drug discount in the coverage gap
  - ABC PACE administrative cost is as much as 15 times higher than the Part D market because of low enrollment
  - PACE gain/loss or profit margin is more than two times the Part D market due to risk and claim fluctuation

# Coordinating with Part D in an Alternate PACE Environment (cont.)

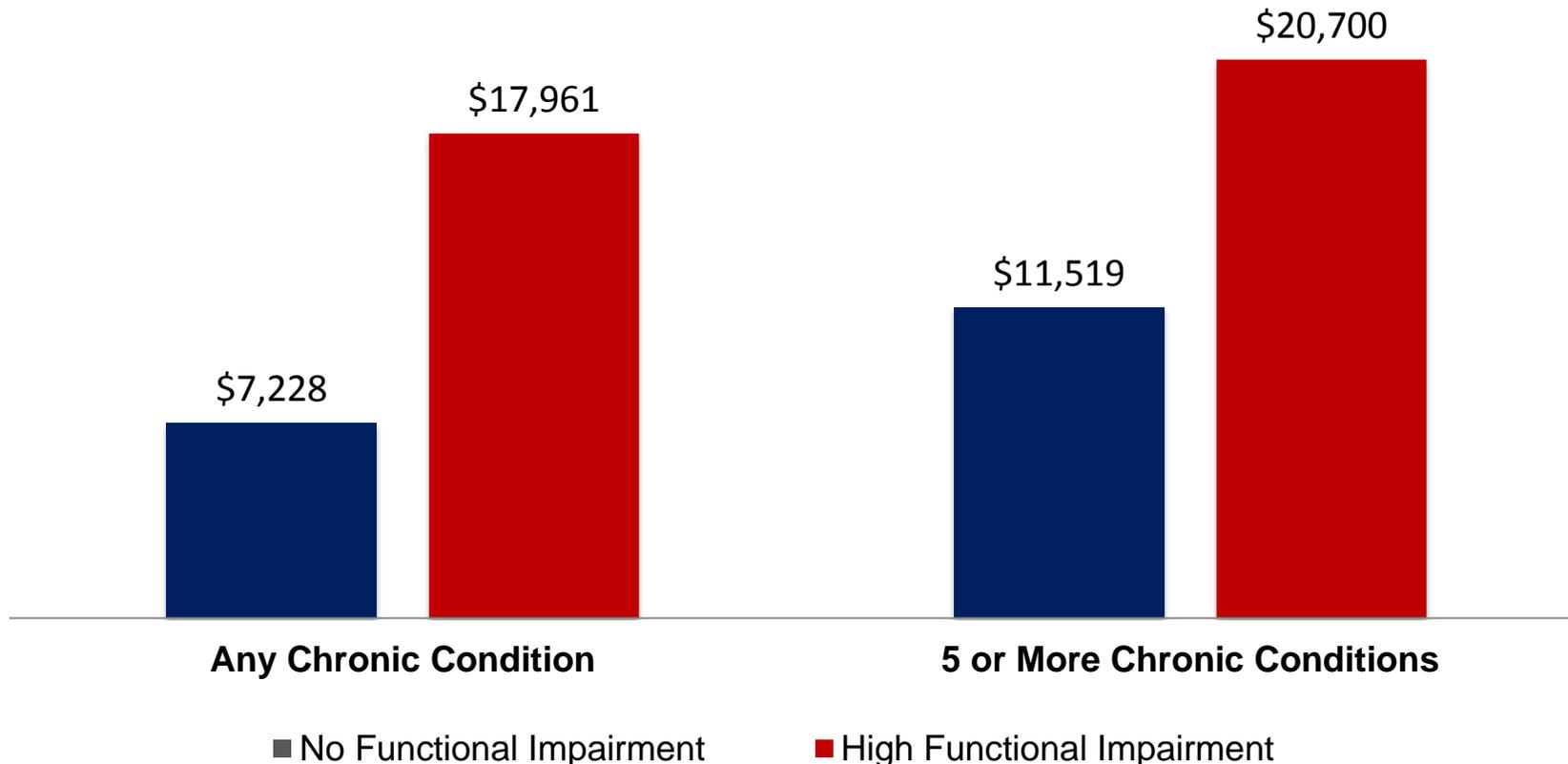
<b>Illustrative ABC PACE 2017 Medicare-Only Eligible Population Part D Bid Development</b>		
<b>Part D Cost Corridors</b>	<b>Current</b>	<b>Alternate Estimated</b>
<b>\$0-\$399</b>	\$49.76	\$49.76
<b>\$400-\$3,699</b>	79.01	70.33
<b>\$3,700-Catastrophic Limit</b>	162.15	108.46
<b>Catastrophic Limit +</b>	223.98	13.38
<b>Drug Cost Before Rebates</b>	\$514.90	\$241.93
<b>Rebates</b>	(13.61)	0.00
<b>Drug Cost After Rebates</b>	\$501.28	241.93
<b>Non-Benefit Expenses</b>	152.01	73.36
<b>Gain/(Loss)</b>	27.22	13.14
<b>Enhanced Benefit/Revenue</b>	\$680.50	\$328.43
<b>Basic Premium</b>	159.80	35.63
<b>Direct Subsidy</b>		
<b>Reinsurance Subsidy</b>		
<b>LICS Subsidy</b>		
<b>PACE Subsidy</b>		
<b>Supplemental Premium</b>	680.50	\$328.43
<b>Revenue/Premium</b>	\$840.30	\$364.06

# Here's Why We Need to Act: OAA Funding vs. Medicare Expenditures and Steady Increase in 65+ Population



# High Need, High Cost Medicare Beneficiaries Have Complex Needs

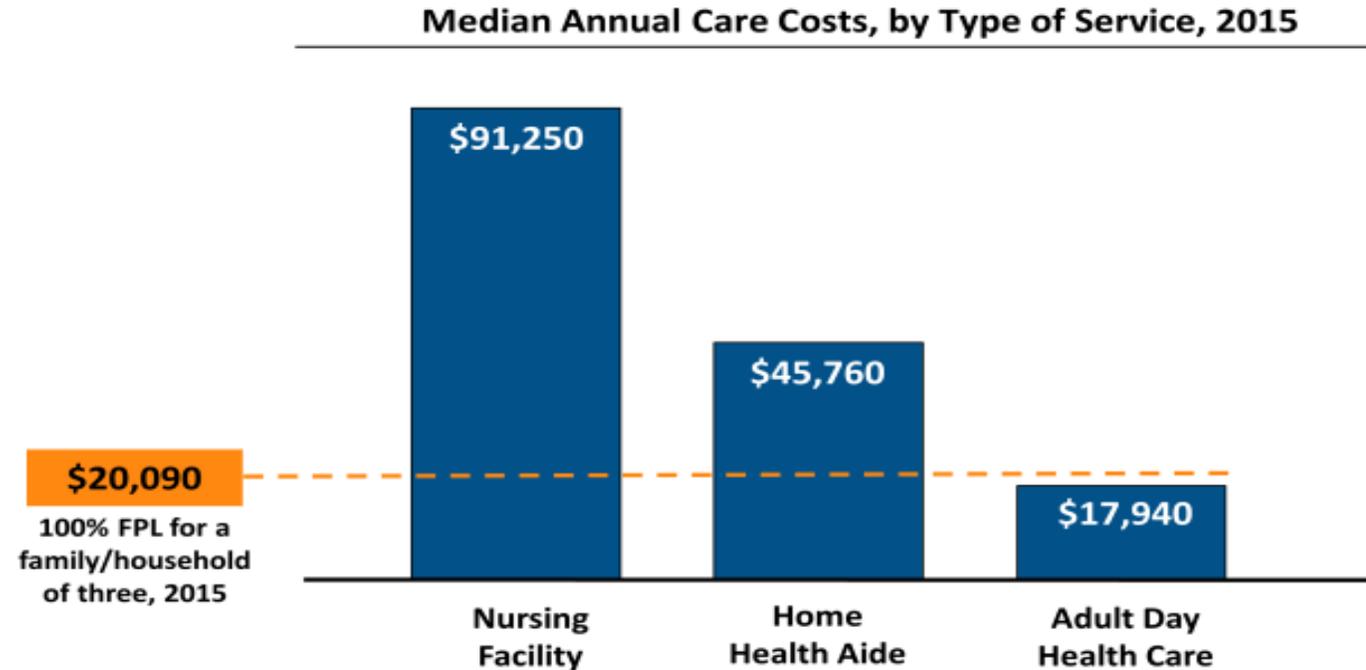
Annual per capita Medicare spending twice as high for beneficiaries with high functional impairment (2+ ADLs) and chronic conditions than for beneficiaries with chronic conditions only.



# LTSS: They're Expensive

Figure 2

**Long-Term Services and Supports Are Expensive, Often Exceeding What Beneficiaries and Their Families Can Afford**



SOURCES: Genworth, *Genworth 2015 Cost of Care Survey* (Richmond, VA: Genworth Financial, Inc., April 2015), [https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568\\_040115\\_gnw.pdf](https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_040115_gnw.pdf); U.S. Department of Health and Human Services, 2015 Poverty Guidelines, <https://aspe.hhs.gov/2015-poverty-guidelines>.



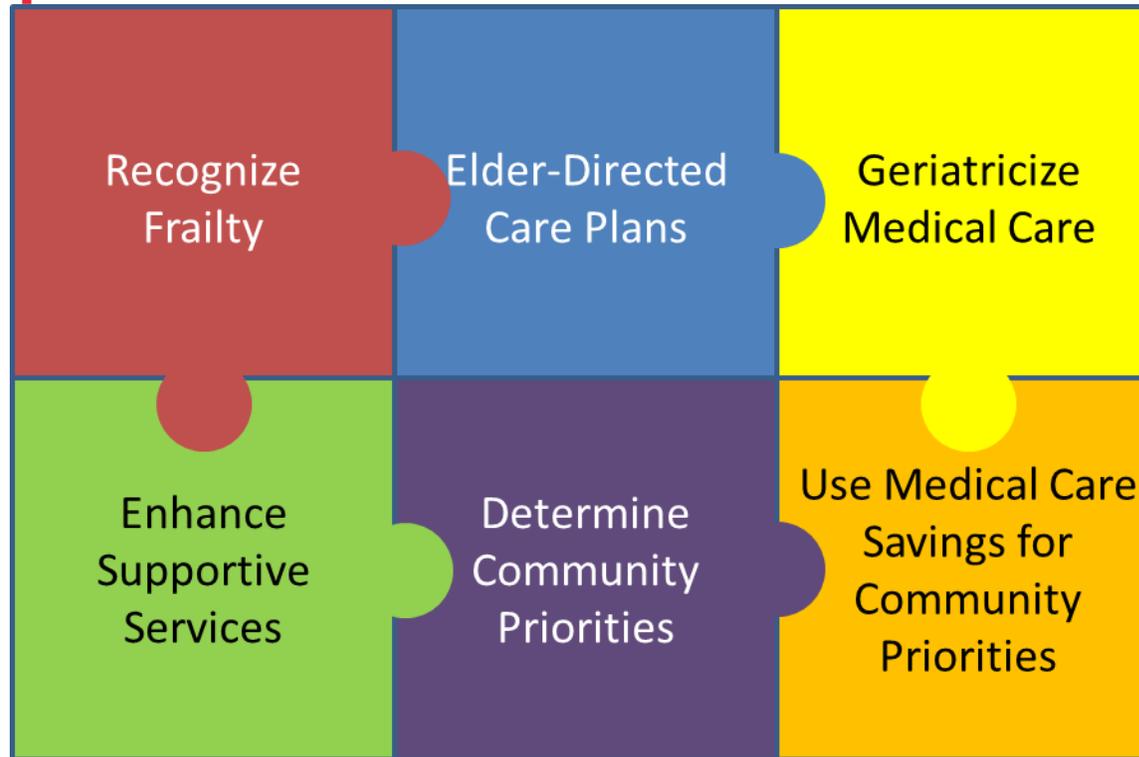
# Promising Legislation

- ▲ CHRONIC Care Act (Sec. 302 on MA plans is a standout)
- ▲ Care Corps Demonstration Act – Rep. Lujan Grisham, Ros Lehitnen
- ▲ RAISE Family Caregivers Act – bipartisan, bicameral, prime goal for ACT Congressional Caucus
- ▲ Money Follows the Person extension bill to be introduced shortly
- ▲ Future possibilities include a “BIP 2.0” proposal and improvements to private long-term care coverage

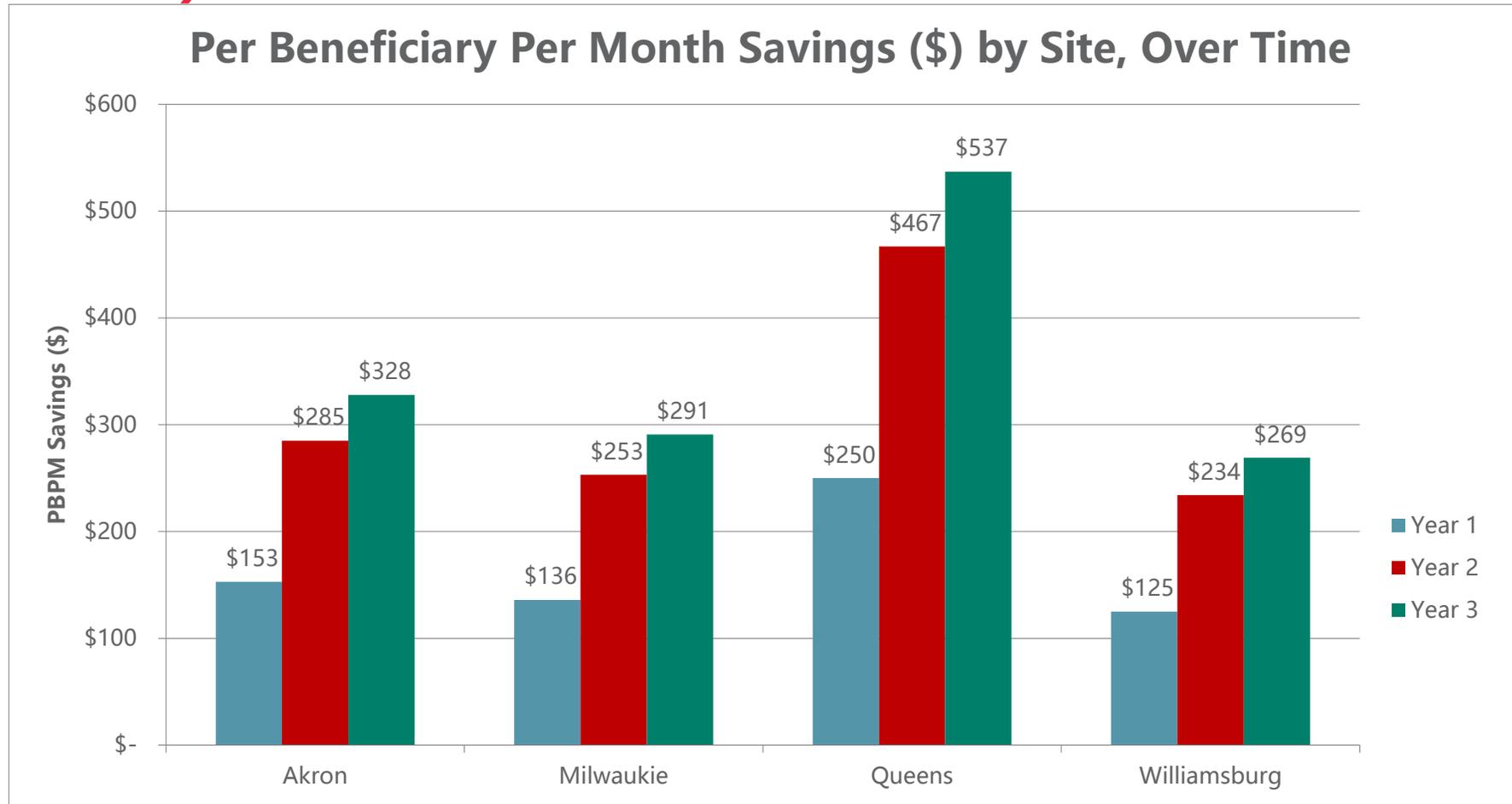
# Empowering Communities to Undertake Reform: What Would It Take?

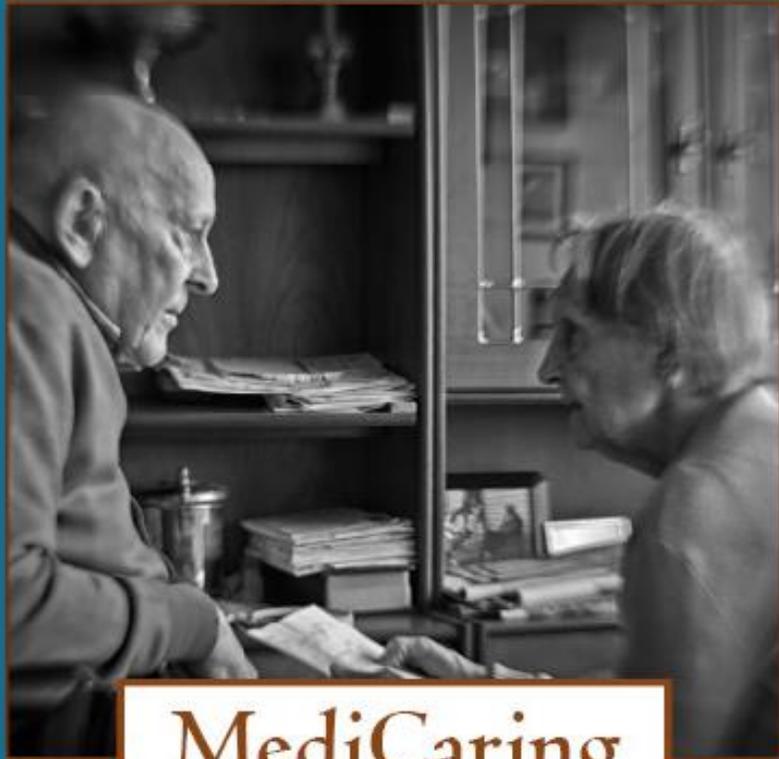
- ▲ Comprehensive, longitudinal care plans that include treatments, personal goals, prognosis
- ▲ Fully integrated service delivery (medical, LTC)
- ▲ Geriatricized, prudent medical care
- ▲ Estimated savings of 20% of Medicare spending
- ▲ A portion of total savings reinvested for monitoring, prioritizing, and improving area-wide services
- ▲ Slowed Medicaid spend-down
- ▲ Platform for generating substantial volunteer activity
- ▲ Reliably good care to the end of life for millions more elders at no higher cost per capita than today

# CECAI Research Agenda: "MediCaring Communities" -- Core Components



# Four Communities: Financial Simulation (Milbank 2016)





## MediCaring Communities

GETTING WHAT WE WANT  
AND NEED IN FRAIL OLD AGE  
AT AN AFFORDABLE COST

JOANNE LYNN, MD

# MediCaring Communities: Getting What We Want and Need in Frail Old Age at an Affordable Cost

[medicaring.org/book](http://medicaring.org/book)

“For decades, Joanne Lynn’s has been the clearest, strongest, most soulful voice in America for modernizing the ways in which we care for frail elders. This essential book is her masterpiece. It offers a magisterial, evidence-based vision of that new care, and an entirely plausible pathway for reaching it. Facing a tsunami of aging, our nation simply cannot afford to ignore this counsel.”

--**Donald M. Berwick, MD**, President Emeritus and Senior Fellow, Institute for Healthcare Improvement, and former Administrator, Centers for Medicare & Medicaid Services.

“MediCaring Communities integrates good geriatrics and long-term services and supports, and building upon an expanded PACE program can be a tangible start. We should try this!”

--**Jennie Chin Hansen**, Lead in Developing PACE; Past President, AARP; and Past CEO of On Lok Senior Health Services and the American Geriatrics Society