AGENDA

1. Roll Call
2. Approval of Minutes from January 31, 2018 meeting – discussion and action item
3. Approval of Minutes from February 22, 2018 meeting – discussion and action item
4. Approval of Patricia Sandoval as Fresno PACE board representative – discussion and action item
5. Rate Setting – discussion and action item
6. Other Business
7. Adjourn

Attachments
A. Minutes of January 31, 2018 meeting
B. Minutes of February 22, 2018 meeting
C. Comparison of PMA and CalPACE principles with rate methodology provisions
D. CalPACE letter to DHCS re: PACE Modernization Act – 6/6/18
F. PACE Modernization Act Provisions
G. Draft talking points for CalPACE Day in the Capitol

Board Members

• AltaMed PACE, Maria Zamora
• Brandman Centers for Senior Care, Molly Forrest
• CalOptima, Arif Shaikh
• Center for Elders’ Independence, Linda Trowbridge
• Fresno PACE, Abe Marouf
• InnovAge, Beverley Dahan
• On Lok Lifeways, Eileen Kunz
• Redwood Coast PACE, Joyce Hayes
• San Diego PACE, Kevin Mattson
• St. Paul’s PACE, Cheryl Wilson
• Sutter SeniorCare PACE, Christie Brown O’Hanlon
Minutes of CalPACE Board Meeting
January 31, 2018
Pier South Resort, 800 Seacoast Drive, Imperial Beach, CA 91932

Attendees
Board members: Arif Shaikh, CalOptima
Christie Brown O’Hanlon, Sutter SeniorCare PACE
Cheryl Wilson, St. Paul’s PACE
Eileen Kunz, On Lok Lifeways
Joyce Hayes, Redwood Coast PACE
Kevin Mattson, San Diego PACE
Linda Trowbridge, Center for Elders’ Independence
Maria Zamora, AltaMed
Molly Forrest, Brandman Centers for Senior Care

Other officers: Bing Isenberg, CEI, CalPACE CFO

CalPACE staff: Peter Hansel, Chief Executive Officer
Fred Main, Counsel
Jennifer Blankenship, Director of Operations

Guests: Carol Hubbard, St. Paul’s PACE
Robin Jensen, St. Paul’s PACE
Rosana Scolari, San Diego PACE
Susie Fishenfeld, Brandman Centers for Senior Care
Patricia Sandoval, Fresno PACE
Phil Chuang, Sutter SeniorCare

Board members absent: Abe Marouf, Fresno PACE
Maureen Hewitt, InnovAge

Note: These minutes are confidential and privileged and should not be circulated outside of the CalPACE Board.

Board Chair Linda Trowbridge welcomed members and convened the meeting at 12:00 p.m.

DECISIONS
Minutes of Previous Meeting. The Board unanimously approved the November 14, 2017 meeting minutes (Mattson/Forrest).

Approval of Beverley Dahan as InnovAge Board Representative. The board unanimously approved InnovAge’s nomination of Beverley Dahan to serve as its CalPACE board representative.

Election of 2018 Officers. The board participated in a secret ballot election to select its 2018 officers. The following individuals were elected: Linda Trowbridge, Chair; Cheryl Wilson, Vice Chair; Maria Zamora, Treasurer; Eileen Kunz, Secretary; Bing Isenberg, Chief Financial Officer.

DISCUSSION

Recommendations of Governance, Dues and Bylaws Committee. Linda Trowbridge presented the recommendations that were adopted by the Governance, Dues, and Bylaws Committee at its meeting on January 9, 2018. She noted that CalPACE will soon have more than 15 operational members; with the current limit on the number of Directors set at 15 in the CalPACE bylaws the bylaws will need to be amended in 2018. The consensus of the committee is that it is important for new incoming operational members to have a board seat and to offset the impact of having a larger board by creating an executive committee. Board members discussed that it will be important to draft a charter for an executive committee that establishes limits on its authority and how much it can commit in resources and to ensure that the board’s decision making role is not undermined. Cheryl Wilson recommended that the make-up of the committee be current officers plus one at-large member and that terms be limited to one year. Staff will bring proposed bylaws and other changes back to the board to increase the number of directors and to create and charter a new executive committee. Board members also discussed whether the CalPACE CFO should be appointed by the board or CEO; after discussion the consensus was to refer this issue back to the Governance, Dues and Bylaws Committee.

PACE 2.0. Peter Hansel provided a brief overview of NPAs PACE 2.0 growth initiative and informed the board of NPAs interest in delegating to CalPACE responsibility for convening one of the rapid growth collaboratives outlined in the initiative. As part of this, NPA would subcontract with CalPACE to provide some of the foundation grant monies available to it, in particular the $35,000 it has received from the Gordon and Betty Moore Foundation. Maria Zamora and Carol Hubbard outlined the roles they are playing as examples of fast growing programs. Board members expressed general support for CalPACEs participation in the initiative but expressed concerns about the amount of commitment required from member organizations and the amount of funding that NPA is proposing to provide to CalPACE. There was consensus that staff should get more information and prepare a draft plan and budget for the board to consider.

Exploratory Coalition for LTSS. Mr. Hansel presented to the board that CalPACE has been participating in a coalition of provider, labor, and consumer organizations that is seeking to develop policies to improve access to long-term supports and services. As part of this, the coalition has developed a budget proposal to develop better data on needs for LTSS among seniors and persons with disabilities. The budget proposal would allocate funds to include questions in the California Health Interview Survey on LTSS use and needs. After brief discussion, the consensus of the board was to support the budget proposal.

2018 CalPACE Policy Priorities. Board members received a briefing from Tim Doyle, Senior Actuary with Optumas, on how the 2018 rate methodology presented by DHCS and Mercer in January compares to versions presented and discussed by the actuarial work group. While the recent version
of the methodology generally compares well many details have not been provided, including how credibility adjustments are made. In addition, the methodology uses a relatively wide rate range and a narrower range may be better. Board members and staff expressed several concerns about the methodology, including that it potentially punishes efficient organizations, doesn’t provide sufficient funds for growth, and that it could produce volatile rates over time. There was consensus that Optumus should develop a set of questions for members to use for their one-on-one calls with the department and Mercer, including regarding the level of information and data will be provided supporting the rates.

The meeting was adjourned at 1:30 p.m.

Respectfully submitted,

Molly Forrest, Secretary

Prepared by: Peter Hansel, Chief Executive Officer
Jennifer Blankenship, Director of Operations
Minutes of CalPACE Board Meeting
February 22, 2018
CEI San Leandro PACE Center, 1850 Fairway Drive, San Leandro, CA 94577

Attendees
Board members: Arif Shaikh, CalOptima
Beverley Dahan, InnovAge
Cheryl Wilson, St. Paul’s PACE
Eileen Kunz, On Lok Lifeways
Linda Trowbridge, Center for Elders Independence
Maria Zamora, AltaMed

Other officers: Bing Isenberg, CEI, CalPACE CFO

CalPACE staff: Peter Hansel, Chief Executive Officer
Fred Main, Counsel
Jennifer Blankenship, Director of Operations

Guests: Carol Hubbard, St. Paul’s PACE
David Nolan, On Lok Lifeways
Gary Campanella, On Lok Lifeways
Lenore McDonald, Center for Elders’ Independence
Robin Jensen, St. Paul’s PACE
Rosana Scolari, San Diego PACE
Susie Fishenfeld, Brandman Centers for Senior Care
Patricia Sandoval, Fresno PACE
Phil Chuang, Sutter SeniorCare
Pamela Ansley, Sutter SeniorCare
Elizabeth Lee, CalOptima
Joanne Handy, Consultant and Facilitator
Patricia Sandoval Fresno PACE
Gilbert Fimbres, San Diego PACE
Brian Wallace, St. Paul’s Senior Services
Tim Doyle, Optumas
Steve Schramm, Optumas

Board members absent: Abe Marouf, Fresno PACE
Christie Brown O’Hanlon, Sutter SeniorCare PACE
Joyce Hayes, Redwood Coast PACE
Kevin Mattson, San Diego PACE
Molly Forrest, Brandman Centers for Senior Care
Note: These minutes are confidential and privileged and should not be circulated outside of the CalPACE Board.

Board Chair Linda Trowbridge welcomed members and convened the meeting at 12:45 p.m.

**PACE Antitrust Statement** Fred Main provided the board with the following antitrust statement. “The purpose of this association is to explore avenues of mutual interest and cooperation in public policy and to promote awareness of the contributions and commitments that the PACE organization make to the private and public sectors of our society.

It is important to recognize that these activities are subject to certain legal limits imposed by state and federal antitrust laws. One central concern of these laws is with combinations or agreements in restraint of trade whereby competition is reduced by design. Business people generally are cognizant of the restrictions of price fixing imposed by the law. In addition, there are many other areas in which legal implications are raised. For example, agreements to reduce prices, standardize discounts, or to divide territorial markets or customers are illegal.

Consequently, in the course of all trade association activities, discussions among members involving pricing, sale terms, territories or other aspects of competition, must be avoided. In the event any member ever feels that the course of association activities or statements or actions in association meetings is headed into such an area, members should raise the issue immediately so that further discussion of such matters can be suspended pending receipt of advice satisfactory to the members that the topics addressed do no give rise to antitrust problems.”

**PACE 2.0 Growth Initiative.** Joanne Handy reviewed for board members the two strategic planning priorities identified at the CalPACE board retreat on January 31 and February 1 -- PACE growth; and rates and cost effectiveness. For the growth initiative, discussion at the retreat centered around whether CalPACE should subcontract with NPA to implement a California based growth collaborative based on the Breakthrough Collaborative Model (BCM), as part of NPAs overall implementation of its PACE 2.0 growth initiative. Chair Linda Trowbridge and CEO Peter Hansel summarized for board members their discussions with NPA staff about this concept and what it would entail. Board members raised several questions, including whether participating PACE organizations have to buy into all of the identified change elements that are part of the BCM, the resource and staffing commitments that would be expected of participating POs, the role of BCM faculty, how CalPACE would provide the project management needed to carry out the collaborative, whether training on the Plan-Do-Study-Act system for testing change elements under the BCM would be provided to participating POs, and whether results would be disseminated to all POs. Based on the discussion, staff will get answers to these questions from NPA and report back to the board to enable it to make a decision on whether to proceed with this. In response to questions posed by Ms. Handy, it appears that most CalPACE members are interested in and would possibly participate in a California based BCM.

**Rate setting and PACE cost-effectiveness.** Fred Main, CalPACE counsel, read a statement to members concerning the requirements they must follow in sharing information about and jointly discussing aspects of rates, costs, and rate setting matters, which is attached to the minutes. Members shared general information about their proposed 2018 rates and their meetings with DHCS and Mercer. Several
members indicated that at least one proposed rate represented a reduction from the 2017 level. Several indicated that DHCS and Mercer did not seem open to questions or considering revisions in the proposed rates based on their calls. Several also noted that DHCS had indicated its intention to pay rates closer to the lower end of the rate bound in future years. Several also indicated that they had been told by DHCS and Mercer that the state believes their margins are too high, and that the rates were intended to reduce the margins, which can include gains from serving Medicare beneficiaries. One member observed that the allowable ranges for the margins are too low based on prior input from actuaries. Members expressed concerns that this could make it difficult for POs to make capital investments needed to carry out expansions, which is something that makes PACE different from managed care plans. Some members expressed concerns that their rates were partly based on cost experience from other POs, or from more than one county, but they did not have enough information to determine whether the adjustments were reasonable. Others indicated that they did not have enough information to determine how the amounts that would have otherwise been paid (AWOP) were established. One member proposed that CalPACE support a change in statute to change rate setting to pay rates at 95 percent of AWOP.

Fred Main explained the options that are available to POs who wish to challenge their rates, which include negotiating with DHCS and filing formal notices of dispute, and advised that CalPACE as an association should focus its advocacy efforts on ensuring that the rate methodology is working as intended and follows the principles established in statute and agreed to in prior discussions with the department.

Steve Schramm and Tim Doyle with Optumas noted that the general approach being followed by DHCS is consistent with the methodology and process DHCS follows with rate setting for managed care plans. Tin Doyle summarized the additional information that is expected to be in the more detailed rate sheets when they are provided to the POs.

After significant discussion, there was general consensus that the board should meet again after the rates sheets come out to develop recommendations for changes to how DHCS is implementing the new rate methodology. There was consensus that CalPACE should advocate with DHCS and the administration to make these changes, and enlist support from the Legislature in doing so, in 2018, and should propose changes to the PACE Modernization Act, if necessary, in 2019. There was consensus that the changes should focus on ensuring that POs receive sufficient amounts for reserves and underwriting gain to enable them to have sufficient capital to expand and to pay wage increases, that projected PO-specific cost increases, such as local changes in the minimum wage, are taken into account, that there is greater transparency in the rate setting process, that rate setting is not based on or tied to PO operating margins, and that the methodology doesn’t automatically set rates at the lower end of the rate range.

Board members and representatives discussed the need to develop better data establishing that PACE is cost-effective relative to other models of care in terms of Medi-Cal costs. There was consensus that this issue should be discussed further when a study of PACE cost effectiveness in Colorado is released later this spring.
The meeting was adjourned at 3:40 p.m.

Respectfully submitted,

Eileen Kunz, Secretary

Prepared by: Peter Hansel, Chief Executive Officer
Jennifer Blankenship, Director of Operations
## Comparison of 2018 PACE Rate Methodology with PACE Modernization Act and CalPACE Principles

<table>
<thead>
<tr>
<th>PACE Modernization Act Provision</th>
<th>Principles Outlined in CalPACE 6-16-16 Letter to DHCS</th>
<th>Rate Methodology as Applied for CY18 Rates</th>
<th>Requested Changes</th>
</tr>
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<tbody>
<tr>
<td>Rate methodology shall address features of PACE that distinguish it from other managed care models</td>
<td>We understand that this will be addressed in the rate methodology</td>
<td>DHCS’ intent to move POs to the lowest point in the actuarial ranges for administration and underwriting gain doesn’t allow sufficient reserves and underwriting gain for capital needs or wage increases that distinguish a PACE program from other managed care models.</td>
<td></td>
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<tr>
<td>The primary source of data shall be each POs Medi-Cal cost and utilization data or other data sources deemed necessary by DHCS</td>
<td>We understand that DHCS’ intent is for each POs Medi-Cal cost and utilization data to be the primary source of data used to develop rates. Appreciate department’s clarification that it doesn’t intend to use Medicare revenue as an offset to calculating rates</td>
<td>Each POs’ projected increases in costs of serving beneficiaries were not used as the primary source for the POs’ trend calculations. For example, Mercer may have used inaccurate or outdated data sources to adjust for cost of living differences among counties and regions in making credibility adjustments and may have used general data on IHSS wage increases in lieu of county based data, which in some cases support higher adjustments. Based on statements made, DHCS and Mercer intend to take into account POs reported margin levels in setting rates. Generally, margins retained by POs are used to improve health outcomes for PACE enrollees by being funneled back</td>
<td></td>
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</table>
into the PACE program in the form of program investment. The PACE programs are at-risk for any benefit required, regardless of whether it is a DHCS-covered service and the current proposed rates are a significant savings when compared to the amounts that would have otherwise been paid (AWOP). DHCS is therefore already receiving significant benefit from the PACE program and does not need to drive the costs down further by limiting margins.

Rates shall reflect the level of care associated with PACE participants

Using data from 6 of the POs, the State’s actuaries calculate the AWOP to increase by approximately 12.6% for Duals and decrease by -2.8% for Non-Duals. However, the proposed rates increase by only 5.2% for Duals and decrease by -4.6% for Non-Duals. Another way to look at this same concern is to show the rate as a percentage of the AWOP. For 2017, the rate paid to the POs was 95% of the AWOP but in 2018 the rate has decreased to 88.8% of the AWOP for Duals and 93.3% for Non-Duals. The AWOP is intended to reflect the level of care associated with PACE participants and so the disconnect in the rate of change between the AWOP and the proposed rates do not reflect the level of care associated with PACE participants.
<table>
<thead>
<tr>
<th>During first three years DHCS shall pay a rate within the certified rate range as necessary to mitigate the impact during the transition to the rate methodology</th>
<th>We understand DHCS intends to pay a rate within the range as necessary to mitigate impacts on POs</th>
<th>DHCS didn’t go as far as it could have gone to mitigate rate shock by paying at the upper end of the rate range and appears to be automatically moving to set rates at the low end of the rate range after year 3. CY18 has already begun and the PO budgets for CY18 have been set for at least 150 days. It is not possible to adjust PO expenditure models for all of CY18; at this point, only the last six months can be materially impacted and so rates above the median of the rate range would have been more appropriate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the first two years of a new POs operation or an expansion into a previously unserved area, DHCS shall pay a rate within the certified rate range</td>
<td>We understand DHCS intends to make adjustments for new POs and those expanding into new areas for the first two years due to the fact that they face higher operating costs due to low initial enrollment</td>
<td>DHCS and Mercer admitted that they did not make explicit adjustments in the rate development methodology for new(er) POs or those expanding into new areas even though DHCS agreed in 2016 that such an adjustment would be appropriate in light of start-up costs and low initial enrollment.</td>
</tr>
</tbody>
</table>
June 6, 2016

Carol Gallegos
Deputy Director, Legislative and Governmental Affairs
CA Department of Health Care Services
1501 Capitol Ave. MS 0006
Sacramento, CA 95814

Dear Ms. Gallegos:

CalPACE and its member PACE organizations have appreciated the opportunity to work with the department on the administration’s proposed PACE Modernization Act budget trailer bill language. We appreciate also the department’s willingness to consider the issues and concerns we have put forward, particularly in the areas of PACE rate setting and regulatory flexibility.

Based on the May 31 amendments put forward by the department, and based on our understanding of what the department has proposed and the commitments the department has made, we are pleased to be able to remove our concerns and support the trailer bill language. A description of these understandings and commitments follows:

**PACE Rate Methodology**

- UPL adjustments. We understand that the department intends to develop upper payment limits (UPLs) and rates for individual PACE organizations in tandem and to correct the data used as necessary to ensure that the UPLs are consistent with actuarially sound rates for PACE organizations. We appreciate the recent changes the department has put forth to require these corrections to be made. We understand that corrections related to geographic disparities in costs due to underutilization of services and access barriers could be part of this process. We look forward to the implementation of these processes in the actuarial work group.
• Transitional rate protections. We understand that the department intends to pay PACE organizations at a rate within the actuarially sound rate range as necessary to mitigate impacts on PACE organizations of the transition to the new rate methodology. We also understand that the department intends for the upper end of the rate range to be consistent with the UPL. We appreciate the recent changes to require these transitional protections to be applied.

• Protections for new PACE organizations. We understand that the department intends to make adjustments for new PACE organizations and those expanding into previously unserved areas. These organizations face higher operating costs on a PMPM basis during their initial two years due their initial low enrollment. We appreciate the most recent changes to extend these protections to the first two years of operation and to require them to be applied.

• Data used for rate setting. We understand that the department’s intent is for each PACE organization’s Medi-Cal cost and utilization data to be the primary source of data used to develop rates. We appreciate the department’s clarification that it doesn’t intend to use Medicare revenue as an offset in calculating each PACE organization’s cost of serving dual eligible beneficiaries. We would ask that the rate methodology be revised to clarify this. We also appreciate the department’s willingness to work with PACE organizations on developing a list of “in-lieu of” services and developing cost allocation methods for these services.

• Consideration of the unique features of PACE. We accept the department’s language with the understanding that these issues will be addressed in the rate methodology.

• Mechanisms for the costs of high-cost drugs and treatments. We appreciate the recognition of these costs.

• Use of quality incentives. We accept this change with the understanding that this will be dealt with in the broader context of managed care rate setting.

• Actuarial certification of rates. We appreciate the department’s commitment to provide actuarial certification of rates.

• Consultation with PACE organizations. We appreciate the department’s commitment to transparency and to consulting with PACE organizations in the development of the rate methodology.

PACE Regulatory Flexibility

We accept the provisions of the revised trailer bill language related to PACE flexibility with the understanding that the department will be issuing draft policy guidance outlining how the PACE application processes for new PACE organizations and those pursuing expansions will
incorporate streamlining provisions such as electronic application processes and concurrent review of applications by the department and CMS. We understand that the policy guidance will also outline and clarify the processes, analyses, and criteria the department uses to approve new PACE applications, including those involving overlapping service areas. We also appreciate the opportunity to work with the department on flexibilities regarding the PACE monthly enrollment cutoff dates and on licensing delays and issues that can impede PACE applications and expansions.

**Lifting Cap on Number of PACE Organizations and For-Profit PACE Provisions**

We appreciate the department’s commitment to monitor the need for additional staff that may arise as a result of lifting the cap on the number of PACE organizations and allowing for-profit PACE organizations to contract with the department.

In closing, we appreciate the department’s commitment to PACE and look forward to working with the department to implement the provisions of the PACE Modernization Act.

Sincerely,

Linda Trowbridge  
CalPACE Chair and CEO, Center for Elders Independence

cc: Members, Budget Conference Committee  
    Members and staff, Senate and Assembly budget committees
PACE Modernization Act Provisions (effective June 27, 2016)
(Changes enacted by PACE Modernization Act are noted in italics)

SEC. 31.
Section 14301.1 of the Welfare and Institutions Code, as amended by Section 28 of Chapter 37 of the Statutes of 2013, is amended to read:

14301.1.
(a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. Notwithstanding any other law, this section shall apply to any managed care organization, licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 commencing with Section 1340) of Division 2 of the Health and Safety Code), that has contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS for rates established on or after July 1, 2012. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.9.1 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.
(2) Supplemental utilization and cost data submitted by the health plans.
(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.
(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.
(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.
(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Division 7 commencing with Section 6250) of Title 1 of the Government Code).

(i) Notwithstanding any other law, on and after the effective date of the act adding this subdivision, the department may apply this section to the capitation rates it pays under any managed care health plan contract.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may set and implement managed care capitation rates, and interpret or make specific this section and any applicable federal waivers and state plan amendments by means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(k) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

(l) Prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan.

(m) (1) It is the intent of the Legislature to preserve the policy goal to support and strengthen traditional safety net providers who treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

(2) As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.
(n) (1) The department shall develop and pay capitation rates to entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), using actuarial methods and in a manner consistent with this section, except as provided in this subdivision.

(2) The department may develop capitation rates using a standardized rate methodology across managed care plan models for comparable populations. The specific rate methodology applied to PACE organizations shall address features of PACE that distinguishes it from other managed care plan models.

(3) The department may develop statewide rates and apply geographic adjustments, using available data sources deemed appropriate by the department. Consistent with actuarial methods, the primary source of data used to develop rates for each PACE organization shall be its Medi-Cal cost and utilization data or other data sources as deemed necessary by the department.

(4) Rates developed pursuant to this subdivision shall reflect the level of care associated with the specific populations served under the contract.

(5) The rate methodology developed pursuant to this subdivision shall contain a mechanism to account for the costs of high-cost drugs and treatments.

(6) Rates developed pursuant to this subdivision shall be actuarially certified prior to implementation.

(7) The department shall consult with those entities contracted pursuant to Chapter 8.75 (commencing with Section 14591) in developing a rate methodology according to this subdivision.

(8) Consistent with the requirements of federal law, the department shall calculate an upper payment limit for payments to PACE organizations. In calculating the upper payment limit, the department shall correct the applicable data as necessary and shall consider the risk of nursing home placement for the comparable population when estimating the level of care and risk of PACE participants.

(9) During the first three rate years in which the methodology developed pursuant to this subdivision is used by the department to set rates for entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), the department shall pay the entity at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), as necessary to mitigate the impact to the entity during the transition to the methodology developed pursuant to this subdivision.

(10) During the first two years in which a new PACE organization or existing PACE organization enters a previously unserved area, the department shall pay at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11).

(11) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.
(12) This subdivision shall apply for rates implemented no earlier than January 1, 2017.

(o) This section shall be inoperative if the Coordinated Care Initiative becomes inoperative pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

SEC. 32.

Section 14301.1 of the Welfare and Institutions Code, as added by Section 29 of Chapter 37 of the Statutes of 2013, is amended to read:

14301.1.

(a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.
(g) (1) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Division 7 (commencing with Section 6250) of Title 1 of the Government Code).

(i) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

(j) Prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan.

(k) (1) It is the intent of the Legislature to preserve the policy goal to support and strengthen traditional safety net providers who treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

(2) As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.

(l) (1) The department shall develop and pay capitation rates to entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), using actuarial methods and in a manner consistent with this section, except as provided in this subdivision.

(2) The department may develop capitation rates using a standardized rate methodology across managed care plan models for comparable populations. The specific rate methodology applied to PACE organizations shall address features of PACE that distinguish it from other managed care plan models.

(3) The department may develop statewide rates and apply geographic adjustments, using available data sources deemed appropriate by the department. Consistent with actuarial methods, the primary source of data used to develop rates for each PACE organization shall be its Medi-Cal cost and utilization data or other data sources as deemed necessary by the department.
(4) Rates developed pursuant to this subdivision shall reflect the level of care associated with the specific populations served under the contract.

(5) The rate methodology developed pursuant to this subdivision shall contain a mechanism to account for the costs of high-cost drugs and treatments.

(6) Rates developed pursuant to this subdivision shall be actuarially certified prior to implementation.

(7) The department shall consult with those entities contracted pursuant to Chapter 8.75 (commencing with Section 14591) in developing a rate methodology according to this subdivision.

(8) Consistent with the requirements of federal law, the department shall calculate an upper payment limit for payments to PACE organizations. In calculating the upper payment limit, the department shall correct the applicable data as necessary and shall consider the risk of nursing home placement for the comparable population when estimating the level of care and risk of PACE participants.

(9) During the first three rate years in which the methodology developed pursuant to this subdivision is used by the department to set rates for entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), the department shall pay the entity at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), as necessary to mitigate the impact to the entity during the transition to the methodology developed pursuant to this subdivision.

(10) During the first two years in which a new PACE organization or existing PACE organization enters a previously unserved area, the department shall pay at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11).

(11) This subdivision shall be implemented only to the extent any necessary federal approvals are obtained and federal financial participation is available.

(12) This subdivision shall apply for rates implemented no earlier than January 1, 2017.

(m) This section shall be operative only if Section 28 of Chapter 37 of the Statutes of 2013 becomes inoperative pursuant to subdivision (n) of that Section 28.

SEC. 33.
Section 14592 of the Welfare and Institutions Code is amended to read:

14592.
(a) For purposes of this chapter, “PACE organization” means an entity as defined in Section 460.6 of Title 42 of the Code of Federal Regulations.

(b) The Director of Health Care Services shall establish the California Program of All-Inclusive Care for the Elderly, to provide community-based, risk-based, and capitated long-term care services as optional
services under the state’s Medi-Cal State Plan and under contracts entered into between the federal Centers for Medicare and Medicaid Services, the department, and PACE organizations, meeting the requirements of the Balanced Budget Act of 1997 (Public Law 105-33) and any other applicable law or regulation.

**SEC. 34.**

Section 14593 of the Welfare and Institutions Code is amended to read:

14593.

(a) (1) The department may enter into contracts with public or private organizations for implementation of the PACE program, and also may enter into separate contracts with PACE organizations, to fully implement the single state agency responsibilities assumed by the department in those contracts, Section 14132.94, and any other state requirement found necessary by the department to provide comprehensive community-based, risk-based, and capitated long-term care services to California’s frail elderly. *(Previous version referred to non-profit organizations)*

(2) The department may enter into separate contracts as specified in paragraph (1) with up to 15 PACE organizations. *This paragraph shall become inoperative upon federal approval of a capitation rate methodology, pursuant to subdivision (n) of Section 14301.1.*

(b) The requirements of the PACE model, as provided for pursuant to Section 1894 *(42 U.S.C. Sec. 1395eee)* and Section 1934 *(42 U.S.C. Sec. 1396u-4)* of the federal Social Security Act, shall not be waived or modified. The requirements that shall not be waived or modified include all of the following:

(1) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(2) The delivery of comprehensive, integrated acute and long-term care services.

(3) The interdisciplinary team approach to care management and service delivery.

(4) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(5) The assumption by the provider of full financial risk.

(6) The provision of a PACE benefit package for all participants, regardless of source of payment, that shall include all of the following:

(A) All Medicare-covered items and services.

(B) All Medicaid-covered items and services, as specified in the state’s Medicaid plan.

(C) Other services determined necessary by the interdisciplinary team to improve and maintain the participant’s overall health status.
(c) Sections 14002, 14005.12, 14005.17, and 14006 shall apply when determining the eligibility for Medi-Cal of a person receiving the services from an organization providing services under this chapter.

(d) Provisions governing the treatment of income and resources of a married couple, for the purposes of determining the eligibility of a nursing-facility certifiable or institutionalized spouse, shall be established so as to qualify for federal financial participation.

(e) (1) The department shall establish capitation rates paid to each PACE organization at no less than 95 percent of the fee-for-service equivalent cost, including the department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the fee-for-service Medi-Cal program provided for pursuant to Chapter 7 (commencing with Section 14000).

   (2) This subdivision shall be implemented only to the extent that federal financial participation is available.

   (3) This subdivision shall become inoperative upon federal approval of a capitation rate methodology, pursuant to subdivision (n) of Section 14301.1.

(f) Contracts under this chapter may be on a nonbid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) (1) Notwithstanding subdivision (b), and only to the extent federal financial participation is available, the department, in consultation with PACE organizations, shall seek increased federal regulatory flexibility from the federal Centers for Medicare and Medicaid Services to modernize the PACE program, which may include, but is not limited to, addressing all of the following:

   (A) Composition of PACE interdisciplinary teams (IDT).

   (B) Use of community-based physicians.

   (C) Marketing practices.

   (D) Development of a streamlined PACE waiver process.

   (2) This subdivision shall be operative upon federal approval of a capitation rate methodology pursuant to subdivision (n) of Section 14301.1.

(h) This section shall become inoperative if the Coordinated Care Initiative becomes inoperative pursuant to Section 34 of Chapter 37 of the Statutes of 2013 and shall be repealed on January 1 next following the date upon which it becomes inoperative.

SEC. 35.
Section 14593 is added to the Welfare and Institutions Code, to read:

14593.
(a) (1) The department may enter into contracts with public or private organizations for implementation of the PACE program, and also may enter into separate contracts with PACE organizations, to fully implement the single state agency responsibilities assumed by the department in those contracts, Section 14132.94, and any other state requirement found necessary by the department to provide comprehensive community-based, risk-based, and capitated long-term care services to California’s frail elderly. (Previous version referred to non-profit organizations)

(2) The department may enter into separate contracts as specified in paragraph (1) with up to 15 PACE organizations. This paragraph shall become inoperative upon federal approval of a capitation rate methodology pursuant to subdivision (l) of Section 14301.1.

(b) The requirements of the PACE model, as provided for pursuant to Section 1894 (42 U.S.C. Sec. 1395eee) and Section 1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act, shall not be waived or modified. The requirements that shall not be waived or modified include all of the following:

(1) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(2) The delivery of comprehensive, integrated acute and long-term care services.

(3) The interdisciplinary team approach to care management and service delivery.

(4) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(5) The assumption by the provider of full financial risk.

(6) The provision of a PACE benefit package for all participants, regardless of source of payment, that shall include all of the following:

(A) All Medicare-covered items and services.

(B) All Medicaid-covered items and services, as specified in the state’s Medicaid plan.

(C) Other services determined necessary by the interdisciplinary team to improve and maintain the participant’s overall health status.

(c) Sections 14002, 14005.12, 14005.17, and 14006 shall apply when determining the eligibility for Medi-Cal of a person receiving the services from an organization providing services under this chapter.

(d) Provisions governing the treatment of income and resources of a married couple, for the purposes of determining the eligibility of a nursing-facility certifiable or institutionalized spouse, shall be established so as to qualify for federal financial participation.

(e) (1) The department shall establish capitation rates paid to each PACE organization at no less than 95 percent of the fee-for-service equivalent cost, including the department’s cost of administration, that the
department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the fee-for-service Medi-Cal program provided for pursuant to Chapter 7 (commencing with Section 14000).

(2) This subdivision shall be implemented only to the extent that federal financial participation is available.

(3) This subdivision shall become inoperative upon federal approval of a capitation rate methodology pursuant to subdivision (l) of Section 14301.1.

(f) Contracts under this chapter may be on a nonbid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) (1) Notwithstanding subdivision (b), and only to the extent federal financial participation is available, the department, in consultation with PACE organizations, shall seek increased federal regulatory flexibility from the federal Centers for Medicare and Medicaid Services to modernize the PACE program, which may include, but is not limited to, addressing:

(A) Composition of PACE interdisciplinary teams (IDT).

(B) Use of community-based physicians.

(C) Marketing practices.

(D) Development of a streamlined PACE waiver process.

(2) This subdivision shall be operative upon federal approval of a capitation rate methodology pursuant to subdivision (l) of Section 14301.1.

(h) This section shall become operative only if Section 28 of Chapter 37 of the Statutes of 2013 becomes inoperative.

SEC. 36.

The amendments made to Section 14131.10 of the Welfare and Institutions Code by this act shall become operative on July 1, 2016.
Draft Talking Points for PACE Members

Note: This is not a leave-behind document. This document for your personal use in preparing for your meetings. Official CalPACE Requests and Fact Sheets will be provided to you in the leave-behind packet.

PACE in California Overview

- The Program of All-inclusive Care for the Elderly (PACE) benefits the State of California, its seniors, and their families by offering a proven, cost-effective, and high-quality alternative to nursing home placement for frail seniors who wish to live in the community.

- There are currently 11 operational PACE organizations in CA serving over 7,000 frail seniors in twelve counties through 39 dedicated PACE Centers and Alternative Care Sites. Three additional PACE organizations are expected to being operations in 2018 or 2019.

- PACE serves older adults and seniors age 55 and older who qualify for nursing home care and can remain safely in the community with supports.

- PACE provides all of the services needed by frail seniors to enable them to live safely in the community, including acute care, long-term supports and services and social services.

- We have __ PACE Center(s) in your district (provide location and describe service area).

2018 CalPACE Legislative Requests

1. Contact DHCS about Medi-Cal Rate Setting for PACE

Please contact DHCS to request that the department recognize the unique features of PACE in its rate setting, including providing sufficient funding for capital investments and wage increases to allow PACE programs to continue to expand and improve their programs, recognizing cost of living and minimum wage increases, recognizing the increasing costs of serving higher needs beneficiaries, and spreading rate smoothing over a longer time period to protect POs from significant rate changes.

- Under the PACE Modernization Act, the state is implementing a new rate setting methodology for PACE organizations starting in calendar year 2018, similar to the payment methodology it uses for managed care plans.

- The Act requires the state to ensure that the new rate setting methodology recognizes the unique features of PACE, reduces geographic disparities in rates, provides protections for start-up programs and provides transitional protections for existing PACE organizations.

- Unlike traditional managed care plans, PACE provides comprehensive services and operates dedicated PACE Centers which require capital investment to build and operate.

- The Department of Health Care Services’ initial implementation of the new rate methodology does not recognize these unique features of PACE, raising questions about whether future rates will be adequate.
2. Support the CalPACE Proposed Budget Trailer Bill Language for PACE Application Process

Please support CalPACE proposed budget trailer bill language to allow new PACE programs and expansions to start-up on a monthly basis, following receipt of state and federal regulatory approvals.

- Developing a new PACE program, or expanding an existing program into a new service area or county, requires a complex development and regulatory review process including purchasing or leasing land and buildings and obtaining permits and health facility licenses or exemptions.

- The usual length of time required to develop a new PACE program or expand an existing program is one to two years. The investment in facilities and salaries required to obtain approval to operate a PACE program can run into the millions of dollars.

- Since the inception of the PACE program in the 1980s, PACE programs have been allowed to begin operations on the first of the month following the receipt of state and federal regulatory approvals.

- However, DHCS guidance adopted in October 2017 limits new PACE program start-ups and expansions to two days per year, January 1 and July 1.

- Due to uncertainties in the amount of time it takes to complete the application process it is virtually impossible for PACE organizations to align their applications with specific start-up dates. This puts them at risk of incurring substantial delays in start-up and incurring substantial losses before they can begin operating and generating revenue. It also will lead to delays in communities receiving the services PACE provides from receiving them.

3. Oppose Federal Proposals to a Block or Per Capita Grant Program for Medicaid

Please oppose proposals at the federal level that would convert federal Medicaid funding to a block or per capita grant program.

- Congress and the President are considering legislation and budget changes to repeal the ACA and convert Medicaid to block grant or per capita grant program.

- These changes could significantly reduce federal funding for Medi-Cal, forcing the state to make very painful choices of the programs and services it can continue to offer.

- Seniors and persons with disabilities are highly dependent on programs and services provided under the ACA and Medicaid (Medi-Cal), including home and community based service programs and programs like PACE.

- Although seniors and persons with disabilities comprise less than 20 percent of Medi-Cal beneficiaries, 70 percent of the funding goes for services and programs that seniors and persons with disabilities depend on.