A G E N D A

1. Welcome

2. PACE rate methodology and PACE application process budget proposal – discussion and action item

3. Other business

4. Adjourn

Attachments

- Draft CalPACE letter to DHCS re: PACE rate methodology – 03/27/2018
- PACE application process budget proposal fact sheet

Board Members

- AltaMed PACE, Maria Zamora
- Brandman Centers for Senior Care, Molly Forrest
- CalOptima, Arif Shaikh
- Center for Elders' Independence, Linda Trowbridge
- Fresno PACE, Patricia Sandoval
- InnovAge, Maria Lozzano
- 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
March 2018

Mari Cantwell
Chief Deputy Director
CA Department of Health Care Services
1501 Capitol Mall MS 00100
Sacramento, CA 95814

Dear Chief Deputy Director Cantwell:

In 2016, CalPACE and its members agreed to and helped facilitate the department’s goal of transitioning PACE to an experience-based rate methodology through the passage of the PACE Modernization Act (PMA). Based on the provisions of the PMA, our work with the actuarial work group, and meetings with DHCS staff, as reflected in our June 6, 2016 letter to the department, we understood that the new rate methodology would be applied in a manner that would reflect the unique characteristics of and enhance the PACE model of care, and support the continued expansion of PACE to areas of the state that can benefit from the PACE model.

Based on the initial application of the new experience-based methodology, it is our position that many of the underlying goals, purposes, and principles on which the new methodology was based are not reflected in the department’s implementation of the new methodology. We believe that, absent a number of changes and adjustments, the department’s application of the proposed rate methodology will have the effect of reducing rates below feasible levels and undermining PACE expansion and development, making it difficult to sustain this model of care moving into the future. Below is a summary of our concerns.

**Recognizing the Unique Features of PACE**

Despite the provisions of the PMA and commitments made in the actuarial workgroup and other meetings, the methodology does not address key features of the PACE model that distinguish it from other managed care models (Welfare and Institutions Code, Section 14301(n)(2)). For example, the model as implemented does not explicitly provide for capital expenditures, which is a fundamental difference between traditional Medi-Cal managed care plans and the facility-based nature of the PACE model. It is essential that a percentage add-on for capital reserves be added to the upper and lower bounds for the non-medical load, given that PACE organizations are required to operate a PACE center and to invest in and upgrade buildings and equipment in order to deliver services. This problem is compounded by DHCS’ stated intent to move POs to the lowest point in the rate range for administration and underwriting gain, which will provide no room for these costs to be recognized. In addition to capital, the methodology should consider the cost of carrying accounts receivable, start-up losses associated with expansion, and the volatility of utilization associated with the size and risk of operating PACE compared to traditional Medi-Cal managed care plans.

**Utilizing POs costs and utilization experience as the primary source of data**

We are also concerned that the methodology does not adhere to the principle outlined in the PMA and committed to by DHCS of making each POs cost and utilization data the primary source of data for rate...
setting (Welfare and Institutions Code, Section 14301.1(n)(3)). The methodology as implemented overrides individual PO’s cost data in several areas. We note three areas as examples: (1) The methodology uses a living wage study to account for regional differences in developing the credibility adjusted base data. This approach does not appropriately adjust for services that are not provided by hourly employees (e.g., hospital and nursing home services); (2) The methodology applies uniform ranges for allowable administrative costs instead of using actual administrative costs based on each POs size and model of service delivery; and (3) The methodology does not consider a PO’s projected costs, including costs of staff vacancies and local projected wage increases. We strongly urge that the methodology be adapted to more closely base rates on each POs cost and utilization data and the cost projections included in the RDTs and, where credibility adjustments need to be made, to incorporate all aspects of interregional cost differences, such as acute and institutional care.

The methodology also deviates from these principles by explicitly taking into account POs reported margin levels in setting rates. POs are at-risk for any benefit required, regardless of whether it is a DHCS-covered service, and a margin reflects a POs success in managing that risk. In many cases the margin is affected by a POs success in managing risk on the Medicare side, which has nothing to do with the costs of serving Medi-Cal beneficiaries. Further, rates developed under the methodology constitute a savings for the state when compared to the amounts that would have otherwise been paid (AWOP), and any positive margins are generally put back into the PO to improve health outcomes for PACE enrollees. In addition, POs rates are not similarly adjusted upward if they incur losses. For those reasons, we strongly believe that a POs margin should not be used as a factor in setting its rate.

**Ensuring that rates reflect the underlying level of care of PACE participants**

The methodology also does not adhere to principles outlined in the PMA that rates reflect the level of care associated with PACE participants (Welfare and Institutions Code, Section 14301.1(n)(4)). We would note that under the new methodology, the AWOP is increasing at a greater rate (or decreasing by a lesser rate) than the proposed rates themselves, indicating that the methodology is not appropriately aligned with the underlying risk of the population. Since the AWOP is intended to reflect the level of care associated with PACE participants, a methodology that reduces rates relative to the AWOP is not consistent with the principle of ensuring that rates reflect the level of care associated with PACE participants (Welfare and Institutions Code, Section 14301(n)(4)). We urge that the model incorporate a floor that reflects a reasonable level of savings, such as no less than 90 percent of the AWOP.

**Mitigating the effect of rate changes**

We are concerned that DHCS is not taking sufficient steps to mitigate the size and timing of rate changes (Welfare and Institutions Code, Section 14301.1(n)(9)). These concerns are compounded by DHCS’ stated intention to automatically move rates to the lower bound after year three. In years that rates come out after the rate period has begun, it is almost impossible for PO’s to adjust their budgets and spending plans to adapt to a reduced rate. We urge that if rates cannot be provided on a more timely basis, that DHCS pick a higher point in the rate range on an ongoing basis to adhere to the principles outlined in PMA.
Recognizing the higher costs of start-up programs and the unique characteristic of small programs and subpopulations

DHCS and Mercer acknowledge that they did not make explicit adjustments in the rate development methodology for new POs or those expanding into new areas, even though DHCS agreed in 2016 that such an adjustment would be appropriate in light of higher start-up costs and low initial enrollment (Welfare and Institutions Code, Section 14301.1(n)(10)). In addition, we are concerned that the methodology blends smaller, newer POs data with larger, more mature POs data when developing the credibility adjusted base data. We would suggest that a reverse managed care adjustment be applied to the more mature PO’s experience prior to blending the data. This will more appropriately capture efficiencies than can be expected of a much smaller and newer PO. We also think DHCS and Mercer should add to the non-medical loading factors an additional amount to reflect the higher cost structure experienced by new PACE organizations and expansions. Finally, since there are certain small programs and sub-populations that will never reach a credible number of member months, we would like to work with DHCS to refine the PACE methodology for these programs and subpopulations.

Amount that would have otherwise been paid

Finally, DHCS has not shared the details behind the AWOP development and has stated that it is not necessary since the PO rates are no longer linked directly to the AWOP. However, for some POs the upper bound of the rate range is the AWOP. Therefore, it is very important that enough details be provided related to the development of the AWOP (including the base data development) to enable POs to understand how it is calculated. While the department has also not provided this data in the past as part of the development of the upper payment limits (UPLs), it is important that it be provided in the context of a new experience based rate methodology.

We would request that the department respond to these concerns and we are ready to meet with department staff at any time to go over them. We believe our goal is the same as the department’s, of ensuring that the rate methodology for PACE maintains the ongoing viability of this tremendously valuable program for older adults and seniors with higher needs.

Sincerely,

Linda Trowbridge
Chair and CEO, Center for Elders’ Independence

cc: Lindy Harrington, Deputy Director, Health Care Financing
    Jennifer Lopez, Chief, Capitated Rates Development
    Sarah Brooks, Deputy Director, Health Care Delivery Systems
    Jacey Cooper, Assistant Deputy Director, Health Care Delivery systems
    Sarah Eberhardt-Rios, Chief, Integrated Systems of Care Division
    Joseph Billingsley, Chief, Program Policy & Operations Division
    Stryder Morrisette, Chief, PACE Unit
Proposal
Adopt 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.

Background
The Program of All-inclusive Care for the Elderly (PACE) has operated as a Medi-Cal benefit since 2003 as a capitated, comprehensive care program for adults and seniors over age 55 with higher needs who qualify for nursing home placement but who wish to remain in the community. Medi-Cal beneficiaries enroll in PACE in lieu of receiving Medi-Cal services on a fee-for-service basis or through a managed care plan.

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, and the investment of significant resources on the part of the applying organization. The steps include purchasing or leasing land and buildings; obtaining local building permits and approvals; obtaining clinic, ADHC, and home health agency licenses from the CA Department of Public Health (DPH) or exemptions; completing a state readiness review, which is conducted by the Department of Health Care Services (DHCS); and waiting an additional 90 days for review and final approval by the Centers for Medicare and Medicaid Services (CMS). 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, particularly frequent delays in the amount of time necessary to receive applicable facility licenses, it is virtually impossible for PACE organizations to align their applications with specific start-up dates. If PACE programs miss an applicable start-up date, they must wait for the next available date, which can result in up to a six-month delay, forcing them to incur substantial losses before they can begin operating and generating revenue, and delaying communities who need the services PACE provides from receiving them.

Arguments in Support
Allowing new PACE programs and expansions to start up on a monthly basis, once applicable approvals are obtained, will ensure that PACE can continue to expand and provide frail elderly participants with PACE services in a timely way in areas of California that need the services that PACE provides.

At the point of start-up, PACE programs typically have invested several million dollars in facilities and staffing and are incurring several hundred thousand dollars per month in ongoing operating and staffing costs. Allowing PACE programs and expansions to start-up on a monthly basis will enable the programs to be financially viable and to recoup these investments in a timely way.

Sponsor of Proposal: CalPACE

Proposed Budget Trailer Bill Language
Add a new subdivision (f) to Welfare and Institutions Code Section 14593, to read:

A new PACE program, or the expansion of an existing PACE program into a new service area or county, shall be allowed to commence operations in the month following its receipt of state and federal regulatory approvals.