AGENDA

1. Welcome

2. Approval of Minutes from November 14, 2017 meeting – discussion and action item

3. Approval of Bev Dahan as InnovAge board representative – discussion and action item

4. 2018 CalPACE Policy Priorities – discussion and action item

5. Recommendations of CalPACE Governance, Dues, and Bylaws Committee – discussion item

6. NPA PACE 2.0 Project – CalPACE role – discussion and action item

7. CA LTSS Exploratory Coalition budget proposal – CalPACE support – discussion and action item

8. CalPACE Quality Measures – discussion and action item

9. CalPACE Board Meeting Times – discussion and action item

10. Election of CalPACE Officers -- announcement of votes

11. Adjourn

Attachments

A. Draft Minutes of November 14, 2017 Board Meeting
B. CalPACE proposed 2018 Policy Priorities
C. Meeting notes of CalPACE Governance, Dues, and Bylaws Committee 12/12/17 Meeting
D. NPA PACE 2.0 Project Summary and summary of Institute for Healthcare Improvement Model
E. CA LTSS Exploratory Coalition budget proposal fact sheet
F. CalPACE Fact Sheet
G. Draft PACE Program Quality Measures Report as of July 1, 2017 Report for DHCS

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, Maureen Hewitt
• 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
November 14, 2017
California Endowment, 1414 K Street, Suite 500, Sacramento, CA 95814

Attendees
Board members: Arif Shaikh, CalOptima
Christie Brown O’Hanlon, Sutter SeniorCare PACE
Cheryl Wilson, St. Paul’s PACE
Eileen Kunz, On Lok Lifeways
Jennifer Spalding, AltaMed
Joyce Hayes, Redwood Coast PACE
Kevin Mattson, San Diego PACE
Linda Trowbridge, Center for Elders’ Independence
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: Maria Zamora, AltaMed
Carol Hubbard, St. Paul’s PACE
Robin Jensen, St. Paul’s PACE
Grace Li, On Lok
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 3:40 p.m.
DECISIONS

Minutes of Previous Meeting. The Board unanimously approved the August 29, 2017 meeting minutes (Forrest/Mattson).

Approval of Maria Zamora as AltaMed Board Representative. The board unanimously approved AltaMed’s nomination of Maria Zamora to serve as its CalPACE board representative, in place of Jennifer Spalding, who is retiring (Mattson/Forrest).

DHCS PACE Policy Letter. CEO Peter Hansel summarized the discussions that have been held with members on PACE Policy Letter 17-03 at the 11/14/17 member meeting and a November 9 workgroup meeting and the types of changes CalPACE is seeking to address the impact of the proposed change to limit PACE start-ups and expansions to two dates per year. There is general consensus that CalPACE should advocate to eliminate the twice per year limitation and streamline the DPH licensing and readiness review requirements for PACE, which frequently delay applications. Fred Main described three ways that CalPACE can advocate for changes, including pushing DHCS and DPH to make administrative changes, seeking support from the Governor’s Office and HHS Agency, and working with the Legislature, particularly through the budget process. After discussion the board adopted a motion directing staff to pursue all three avenues (Wilson/Spalding).

Dartmouth Atlas Data Analysis Contract. Mr. Hansel reviewed an updated project description and cost estimates for Dartmouth Atlas to develop estimates of Medicare spending on services preceding the end of life for beneficiaries who receive Medicare services outside of PACE who are similar to PACE participants. The purpose would be to create benchmarks that CalPACE members could make comparisons to by calculating their Medicare billings for similar types of beneficiaries. After discussion, a motion to enter into a contract for the Dartmouth Atlas to produce the data and to pay for it out of budget reserves was approved (Wilson/Forrest).

Consulting Contract with Brenda Klutz. Mr. Hansel presented a proposal from Brenda Klutz for consulting work related to DPH licensing issues. Ms. Klutz is a former Director of Licensing and Certification, and the consulting work would be assist CalPACE in its efforts to streamline PACE licensing and readiness review requirements. After discussion, a motion to approve a contract for work not to exceed 30 hours was adopted (Kunz/Hayes).

DISCUSSION

Getting to Know PACE Member Benefit. Mr. Hansel described the Getting to Know PACE member benefit recently adopted by the board as a benefit for new associate members who are starting the PACE application process. The purpose is to enable these members to get information and insights from members who have experience getting through the application process and operating PACE programs. To make this a meaningful benefit it will be necessary for members to commit staff to be available for these calls. The was board consensus that staff should send to board members the proposed topics for upcoming Getting to Know PACE calls and they would suggest staff to participate.

CalPACE 2018 retreat. Jennifer Blankenship reviewed the arrangements that have been made for the member retreat on January 31 – February 1, 2017 in Imperial Beach. In order to limit the number of people attending and to focus retreat participation on board members, CEOs, and senior staff, the consensus of the board was to invite board members to the retreat and to allow them to designate additional staff they wish to have participate. To help mitigate the costs of the retreat, there was consensus that each CalPACE Member and Associate provider organizations, with exception of “Exploring PACE” level, will receive two complimentary retreat registrations with reception and dinner included; the complimentary registrations are intended for the board member and one senior staff member. Each board member may designate additional staff to attend the retreat for a $350 fee, which includes the reception and dinner. Additional staff and significant others may attend the reception and dinner only for a $100 fee.
The meeting was adjourned at 4:45 p.m.

Respectfully submitted,

Molly Forrest
Secretary

Prepared by:  Peter Hansel, Chief Executive Officer
Jennifer Blankenship, Director of Operations
## 2018 CalPACE Legislative & Policy Priorities Staff Recommendations

<table>
<thead>
<tr>
<th>POLICY AREA</th>
<th>BACKGROUND</th>
<th>COMMENTS</th>
<th>STAFF RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PACE Rate Setting</td>
<td>The PACE Modernization Act authorizes the use of experience based rate setting for PACE starting in 2017. CalPACE succeeded in getting DHCS to recognize several important principles including recognizing unique aspects of PACE, adjusting for geographic disparities, and providing transitional protections and protections for new POs. POs have completed rate development templates for use of experience based rate setting for 2018 rates and are awaiting the issuance of draft rates from DHCS.</td>
<td>It will be difficult to change back to upper payment limit (UPL) based rates given the lack of fee-for-service data for developing rates. The only alternatives may be requiring DHCS to set rates by type of population, not by plan, for all entities, including PACE, or being paid 95 percent of UPLs calculated from managed care cost data. CalPACE will need to analyze the progress that is being made in implementing the principles that DHCS has agreed to and to determine whether further changes in the authorizing legislation are needed.</td>
<td>Advocate for changes to the rate development templates to ensure greater ease in reporting by POs and to align with the principle of recognizing the unique aspects of each PO. Advocate for further changes to the rate methodology as necessary to ensure that the principles on geographic disparities, transitional protections, and protections for new POs are met.</td>
</tr>
<tr>
<td>PACE Flexibility – State Level</td>
<td>At the state level, DHCS has implemented several PACE flexibility initiatives but has recently revised the application processes for new PACE organizations and PACE expansions to limit PACE start-ups to twice per year. DPH is backlogged with licensing applications which is stretching out the amount of time needed to secure licenses. DHCS states that it needs to link PACE start-ups to the rate development process, which takes roughly one year.</td>
<td>If PACE start-up dates need to be more closely linked to the rate development process and timeline, it will be necessary to seek changes to streamline the rate development process, e.g. through use of estimated or provisional rates, and/or to streamline the facility licensing process to ensure that PACE start-ups and expansions are not delayed.</td>
<td>Advocate for changes to streamline DPH licensing and readiness review requirements for PACE applications and expansions, including use of estimated or provisional rates to allow monthly start-up, consolidating or better coordinating the readiness review and licensing processes, and allowing exceptions to the requirement to have at least one license (clinic or ADHC) for POs that have received exemptions from DPH and have policies and procedures in place to address all licensing requirements. Ensure that POs can use clinic licensing streamlining measures such as affiliate clinics, consolidated licenses, consolidated clinic administration, and single point of contact for DPH.</td>
</tr>
</tbody>
</table>
| **PACE Flexibility – Federal Level** | CMS has issued two RFIs related to PACE pilots but has not implemented any to date.  
NPA is seeking support for Congressional proposals to provide POs with greater flexibility to serve Medicare-only beneficiaries, including by being able to enroll in PACE with their own Part D coverage and to be charged flexible premiums linked to their level of need.  
Some CalPACE members have expressed interest in having greater flexibility to serve Medicare only beneficiaries and beneficiaries at risk of needing nursing home level of care. | Advocate for CMS to implement PACE pilots, particularly those targeting Medicare only beneficiaries and those at risk of needing nursing home level of care.  
Support Congressional proposals to provide POs with greater flexibility to serve Medicare only beneficiaries. |
| **Managed Care Enrollment Materials & PACE** | DHCS has included PACE in the choice books and forms it has developed for Cal MediConnect.  
For non-duals and duals not eligible for Cal MediConnect, and for SPDs in non-CCI counties, DHCS provides inserts with information about PACE in the managed care enrollment materials they provide to beneficiaries who must enroll in managed care. | The inserts that DHCS has developed with info about PACE in the managed care enrollment materials for beneficiaries who must enroll in managed care do not appear to meet the intent of the 2017 budget language that beneficiaries in CCI counties be informed of their option to be assessed for PACE in lieu of enrolling in a managed care plan or receiving LTSS through a managed care plan.  
Advocate administratively for DHCS to develop more consistent and more meaningful materials about PACE and to provide them to SPDs and duals who are subject to managed care enrollment in all counties, and to more clearly inform beneficiaries who are subject to mandatory enrollment in managed care that they may elect to be assessed for PACE as an alternative. |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>CalPACE</td>
<td>CalPACE managed to get language adopted in the 2017 budget which allows beneficiaries who are subject to mandatory enrollment in managed care in CCI counties to be informed that they may alternatively request to be assessed for PACE eligibility.</td>
<td></td>
</tr>
<tr>
<td>Federal Medicaid Funding and ACA Repeal</td>
<td>Several proposals to move Medicaid to block grant or a per capita grant funding basis were considered but not adopted in the Congress in 2017. These would have had severe impacts on the ability of states to maintain optional programs and services, including PACE. Pressure to make these types of changes, as part of the tax reform, ACA repeal, and/or appropriation and spending bills that Congress considers, will likely continue in 2018.</td>
<td>Continue to support through NPA proposals at federal level that maintain federal Medicaid funding levels.</td>
</tr>
<tr>
<td>Senior and Supportive Housing</td>
<td>The Legislature passed three housing finance bills in 2017 which are expected to provide new revenues for development of affordable housing. There is a growing demand for senior housing and supportive housing arrangements, in which residents have access to services to enable them to age in place. However, none of the bills passed by the Legislature direct funds into senior or supportive housing.</td>
<td>Advocate with Leading Age CA for incentives or set asides to steer greater housing resources into senior and supportive housing arrangements. Advocate to ensure that PACE is eligible to provide supportive services under any proposals designed to encourage development of senior and supportive housing.</td>
</tr>
<tr>
<td>Loan Forgiveness &amp; Residency and Clinical Training</td>
<td>Several POs have pursued or implemented supportive housing projects with developers including co-location of PACE centers and set asides of units for PACE participants.</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>POs are facing increasing difficulties attracting primary care providers including physicians, NPs, PAs, and nurses. POs in some areas face competition from other health providers and systems such as Kaiser while those in other areas have problems attracting professionals to live and provide services in their areas. Existing Geriatrician residency slots go unfilled and POs with training sites have difficulty attracting residents. State and federal loan forgiveness programs don’t target enough resources for geriatric primary care training.</td>
<td>The Health Professions Education Fund within OSPHD currently provides a few loan forgiveness programs tied to specified funding sources, e.g. the Steven M. Thompson Physician Corps Loan Repayment Program (physician licensing fees) and the County Medical Services Program Loan Repayment Program (CMSP governing board funding) within OSHPD. The challenge is coming up with a source of funding. According to the HPEFs website, most POs currently operate within qualifying areas for HPEF loan forgiveness programs.</td>
<td></td>
</tr>
<tr>
<td>Search for funding to establish a state loan forgiveness program targeted to geriatric primary care providers. Work with other organizations such as the California Primary Care Association to jointly request that OSHPD establish the program. Explore whether there is support for earmarking a portion of recent budget augmentations for health workforce development for PACE or for geriatric training.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Attendees: Arif Shaikh, CalOptima
Eileen Kunz, On Lok Lifeways
Kevin Mattson, San Diego PACE
Linda Trowbridge, Center for Elders’ Independence
Maria Zamora, AltaMed

CalPACE Staff: Peter Hansel, CalPACE
Jennifer Blankenship, CalPACE
Fred Main, Clear Advocacy

Not in attendance: Cheryl Wilson, St. Paul’s PACE

1. Number and Makeup of Board of Directors
Current bylaws place a cap of 15 members on the CalPACE board; at present time, there are 11 members and CalPACE is fast approaching the board member cap. Committee members discussed two broad sets of changes to the current board number and makeup to deal with this, one to limit the number of board seats and have directors be elected by the membership, and a second to increase the number of board seats to allow new members to continue to have seats on the board and to create an executive committee. There was consensus that CalPACE should follow the second alternative approach.

After discussion, committee members agreed to make recommendations to the CalPACE board in 2018 to remove or increase the current cap of 15 directors, continue allowing new members to have a board seat, and establish an Executive Committee. There was consensus that this will encourage new PACE organizations to continue to become CalPACE members and ensure that they have a voice in association matters.

There was consensus that an executive committee should be comprised of the Chair, Vice Chair, Treasurer, and Secretary – as well as one at-large position that is elected by the board. The committee would act in lieu of the full board on budgeting, staffing, membership approval, administrative contracts, policy positions, approval of nominations for board representation, and the like. Recommendations on items requiring board approval would be included on a consent calendar at the next board meeting with opportunity for discussion. Fred Main advised that creation of an Executive Committee is within the scope of existing bylaws. Mr. Main also noted that the committee could either make a separate recommendation to change the bylaws to increase the number of board seats now and follow-up with other recommendations later in the year, or combine them into one set of recommendations for the board to act on later this year. There was consensus to do the latter. Mr. Main recommended that terms be applied to Executive Committee members to allow the membership to rotate among board members.

• There was also consensus that a Finance Committee, as listed in the existing bylaws, be enacted.

2. Status of Officer Nominations
CalPACE staff updated committee members on the officer nomination and election process that is being followed for election of officers for 2018. That a nomination form for officers was issued to all board members. The forms are due to CalPACE on January 16, 2018. CalPACE staff will verify that all nominees are interested in the position(s) for which they were nominated. A vote for 2018 Officers will be held by secret ballot at the January 31, 2018 board meeting.

3. Future Issues
There was consensus that treatment of membership by for-profit organizations and board representation of for-profit organizations, further changes to the officer nomination process, and dues structure should be addressed in future meetings of the Governance, Dues and Bylaws Committee.

<table>
<thead>
<tr>
<th>Committee Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>• AltaMed PACE, Maria Zamora</td>
</tr>
<tr>
<td>• On Lok Lifeways, Eileen Kunz</td>
</tr>
<tr>
<td>• San Diego PACE, Kevin Mattson</td>
</tr>
<tr>
<td>• Center for Elders’ Independence, Linda Trowbridge</td>
</tr>
<tr>
<td>• CalOptima, Arif Shaikh</td>
</tr>
<tr>
<td>• St. Paul’s PACE, Cheryl Wilson</td>
</tr>
</tbody>
</table>
PACE 2.0: Adapting and Disseminating PACE to Serve High Need, High Cost Populations

Executive Summary

The Program of All-Inclusive Care for the Elderly (PACE) serves one of the health care delivery system’s most challenging high need, high cost populations – low income, frail, older adults. PACE provides these older adults with an age friendly health system that supports their ability to live at home, have their care needs met, and enjoy a high quality of life. Recent enactment of the PACE Innovation Act allows for PACE to serve a wider range of high need, high cost adults through one or more pilots. For example, in addition to low income, frail, older adults, PACE could serve people with physical, intellectual or developmental disabilities, severe and persistent mental illness, or end stage renal disease. While the legislation authorized payments to PACE pilot organizations for service delivery, it did not fund the development of PACE model adaptations for new populations or dissemination strategies related to these new opportunities. The development of these adaptations and strategies, combined with increased operational flexibility proposed by federal regulators, is required to set the stage for an exponential, rather than linear, rate of PACE growth.

With the goal of supporting PACE’s exponential growth from 40,000 to 200,000 individuals, the PACE 2.0 project sets forth a plan for adapted PACE models to serve a wider range of adults with high needs and high costs, inclusive of but not limited to PACE’s current focus population of low income, frail older adults. PACE is a comprehensive, community-based care model that integrates preventive, primary and acute care with services and supports across the full range of care settings, including at home. As care providers, PACE organizations bring access and expertise to meeting the needs of the high need, high cost older adults they serve. Further, the direct care relationship that PACE interdisciplinary team members have with the people they serve results in person centered, timely and effective needs assessment, care planning and care delivery. The strong evidence basis for the quality and cost-effectiveness of the
PACE care model supports the value of extending PACE to a greater number of frail older adults and a wider range of high need, high cost populations.

Extending PACE 2.0 services will require adapting the care model’s essential strengths to (1) meet the unique needs of different high need, high cost subpopulations and (2) support accelerated growth and access. The PACE 2.0 project provides the foundation for achieving these goals. The project will estimate by high need, high cost subpopulation the number of people an adapted and more broadly disseminated PACE 2.0 model could serve. Using this estimate, the project will develop dissemination strategies for achieving exponential growth in PACE 2.0 services across a range of scenarios. These scenarios will consider (1) the scope and type of high need, high cost subpopulations served (2) the PACE model adaptations required, (3) competing programs and services and (4) the impact of current and potential state and federal policy constraints.

Across the range of scenarios, the project will develop both a scale and spread strategy for achieving broader PACE 2.0 dissemination. In large population areas, the scale strategy looks to establish PACE 2.0 organizations that serve a high number of people. For smaller population areas, the spread strategy looks to establish a larger number of PACE 2.0 organizations serving significantly more communities than currently served. A modified spread strategy that addresses rural areas will also be specified. To propel PACE 2.0 growth under these strategies, the project will communicate its findings and share its resources with current or prospective providers; state and federal policy makers; and potential partners interested in contracting for PACE 2.0 services.
Applying the Institute for Healthcare Improvement

Breakthrough Collaborative Model to PACE

The National PACE Association (NPA) launched the PACE 2.0 project this past August with support from The John A. Hartford Foundation and the West Health Policy Center. The initiative is designed to expand access to Programs of All-Inclusive Care for the Elderly (PACE) for complex high-need, high-cost populations across the country. The two-year grant funded initiative will chart a course for exponential PACE growth, from approximately 40,000 participants served today to 200,000 participants.

A chief component of the project will involve adapting the Institute for Healthcare Improvement’s (IHI) Breakthrough Collaborative Model (BCM) to test and apply strategies for growing existing PACE organizations by increasing net monthly enrollments and market penetration levels. The origins of BCM date back to 1994 and it was initially conceived by Paul Batalden, MD. In developing the model, Batalden and other members of IHI’s leadership sought to create a structure that would support organizations in their endeavors to generate “real, system-level changes that would lead to dramatic improvements in care.”¹ The main premise of BCM is to use subject matter experts to guide and engage Collaborative participants in rapidly testing and implementing change.

In applying BCM to the PACE 2.0 project, NPA anticipates developing up to three distinct Collaboratives, one of which could be specifically focused on California PACE organizations. NPA will identify five to fifteen subject matter experts, with expertise in enrolling eight to fourteen participants monthly or in achieving a high level of market penetration (20% or more), to guide Collaborative members. The experts will function as PACE faculty. The faculty will participate in the Collaborative and will assist in creating content to support non-faculty participating members identify and test small scale changes to increase net monthly enrollment rates. Collaborative members will be expected to commit between six and fifteen months to participate and test strategies. A vital factor in ensuring the success of the Collaborative will require members to openly share their strategies and experiences.

Over the course of the commitment, participating organizations will take part in about three separate Learning Sessions, during which they will come together to learn about and discuss strategies to significantly increase net monthly enrollment. Each organization will be expected to send three team members to attend these one to two day in-person sessions. In between the Learning Sessions, members will return to their programs and share the information they learned, then test and implement small-scale changes through what is known as Action Periods. During the Action Periods, participating organizations will adapt the Model for Improvement,

which was developed by Associates in Process Improvement, to test and implement changes to
grow monthly enrollment rates. The Model will guide participants in addressing the following
three questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

In performing tests of change, Collaborative participants will engage in Plan-Do-Study-Act
(PDSA) cycles as indicated below:

I. Plan: plan the test/observation;
II. Do: try out the test on a small scale;
III. Study: set aside time to analyze the results; and
IV. Act: refine the change, based on what was learned from the test.

During the second and third Learning Sessions, ample time will be devoted to allowing
members to share more with each other as they present on the various strategies they tested
and discuss outcomes as well as refinements in approaches.

While in-person Learning Sessions are critical pieces of BCM, virtual communication also will be
expected. The Collaborative will include regular conference calls, online dialogue, written
updates and web-based meetings to facilitate shared learning and improve enrollment
strategies.

Throughout the entire Collaborative process, senior leadership at participating organizations
will serve as Champions. These Champions will guide, support, and encourage the improvement
teams. They will ultimately bear responsibility for the work performed.

NPA would like to launch the first Breakthrough Collaborative in 2018 with programs in
California. A sample timeline of events is depicted on page three.

At the conclusion of BCM, NPA intends to disseminate the successful strategies/tools to help
support exponential growth in PACE across the nation.

Please feel free to contact Peter Fitzgerald or Sam Kunjukunju for more information.
Sample Breakthrough Collaborative Timeline

04/18 - Develop Framework for Change
05/18 - Launch Learning Session 1
06/18 - Recruit PACE Faculty
07/18 - Finalize BCM Members
08/18-09/18 - Action Period 1
10/18 - Action Period 2
11/18-12/18 - Action Period 3
1/19 - Launch Learning Session 2
2/19-3/19 - Launch Learning Session 3
4/19 - Virtual Meeting Summary of Tests & Results
Long-Term Services and Supports (LTSS) Data Budget Proposal
Fact Sheet

Proposal
Funds shall be appropriated to the Health and Human Services Agency and the Department of Health Care Services for the purpose of contracting with UCLA for collection and analysis of data on LTSS access and needs in California by incorporating questions on LTSS access and needs in the California Health Interview Survey (CHIS) in the 2019-20 and 2023-24 survey cycles.

Background
California currently has close to 8 million persons who are either seniors age 65 and over or are persons under age 65 who have disabilities. This population is expected to grow significantly over the next decade, primarily due to the aging of the population, but also due to the growing number of persons with developmental disabilities who are aging out of their systems of care and of persons with traumatic injuries who are surviving their injuries due to advances in medical care. Concurrent with this will be a growing need for long-term services and supports (LTSS). The number of seniors with self-care difficulties who live in the community in California, for example, is projected to double by 2030 (PPIC, 2015).

Despite this unprecedented growth in needs for LTSS, California does not collect the data it needs to accurately track and plan for these needs. While national surveys collect data on the prevalence of disabilities and cognitive and functional impairments, they do not provide state and county level estimates of the population that needs and uses LTSS in California, nor assess the needs for LTSS by income level, age, type of disability, geographic region, or racial or ethnic group.

Studies show lack of access to long-term services and supports contributes to higher health care needs and increased utilization of health care services. For example, significant percentages of Med-Cal beneficiaries who have unmet LTSS needs indicate they have limited mobility, making it difficult to get to medical appointments and do household chores, they go without groceries, and they make medication mistakes (UCSF and UC Berkeley, 2017). Studies also show that most Medi-Cal beneficiaries experience high rates of utilization of health services before they begin accessing LTSS, which diminish after they begin receiving LTSS (CAMRI, 2014). Without data to identify populations and areas of the state that experience barriers to access to LTSS, the state lacks the ability to develop and target interventions that can improve health status and reduce state expenditures.

Arguments in Support
• A modest investment in developing better and more accurate state and county level data will enable the state to engage in better planning for the LTSS needs of its growing population of seniors and persons with disabilities;
• Better data will enable the state to determine the amount of funding necessary to address the needs of those who will require LTSS in the future, and to develop sustainable funding mechanisms that are not dependent upon the General Fund.
• A portion of the costs of developing and analyzing the data can be matched with federal funds as an allowable Medicaid administrative cost.
Organizations in Support
AARP
Alzheimer’s Association
California Association for Adult Day Services
California Association of Area Agencies on Aging
California Commission on Aging
California LTC Ombudsman Association
CalPACE
Caring Across Generations
Congress of California Seniors
Disability Rights California
Disability Rights Education and Defense Fund
Hand in Hand: The Domestic Employers Network
Justice in Aging
LeadingAge California
Service Employees International Union
UDW/AFSCME

Proposed Budget Language
Up to $1 million shall be appropriated to the California Health and Human Services Agency and to the Department of Health Services to contract with the University of California, Los Angeles to incorporate questions on LTSS needs to the California Health Interview Survey (CHIS) in the 2019-20 and 2023-24 survey cycles. The questions shall be vetted by a working group of researchers and policy experts designated by the Secretary of Health and Human Services and shall be designed to gather data at the state and local level on the prevalence of disabilities, cognitive and functional impairment, need for and use of LTSS, unmet needs, and factors that mitigate or offset needs for LTSS.

Funds appropriated pursuant to this item shall be used to continue the inclusion of questions on caregiver burdens, which are scheduled to be included in the 2019-20 survey cycle and funded by foundation sources, in the 2023-2024 survey cycle; for the analysis of data gathered in the 2019-20 survey cycle on LTSS needs; and to examine health and other impacts associated with LTSS needs.

Funds appropriated to the Department of Health Services shall be used for collection and analysis of data on LTSS needs and usage by Medi-Cal beneficiaries to enable the state to receive federal matching funds as a Medicaid administrative activity.
About PACE
The Program of All-inclusive Care for the Elderly (PACE) model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area. Although all PACE enrollees must be certified to need nursing home care to enroll in PACE, only about seven percent of PACE enrollees nationally reside in a nursing home. If a PACE enrollee does need nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care.

Total Enrollees Served
Since 2005, the operational PACE programs in California have served more than 14,000 enrollees. As of July 1, 2017, total enrollment statewide is 6,924 participants.

Enrollee Characteristics
The data below is reported as of July 1, 2017.

Age & Residency: The average enrollee age is 76. In California, 97 percent of PACE enrollees reside in the community, with only 3 percent living in nursing homes. 83 percent of participants are 65 or older and 37 percent are 85 or older.

Multicultural & Multilingual: Primary languages spoken are Spanish (42%), English (33%), and Chinese (14%).

Eligibility for Medi-Cal & Medicare: 100% of enrollees are eligible for Medi-Cal. Currently 75% of enrollees are dually eligible for Medi-Cal and Medicare, and 24% are Medi-Cal eligible only.

Functional Status: The average Activities of Daily Living (ADL) level of PACE enrollees is 3.5.

Enrollee ADL Levels

<table>
<thead>
<tr>
<th>% 5 ADLs or more</th>
<th>% 3 ADLs or more</th>
</tr>
</thead>
</table>

Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>60%</td>
</tr>
<tr>
<td>Asian</td>
<td>20%</td>
</tr>
<tr>
<td>White</td>
<td>10%</td>
</tr>
<tr>
<td>Black</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
</tr>
</tbody>
</table>
**CalPACE Program Characteristics**

CalPACE, the California PACE Association, is a 501 (c)(6) association dedicated to the expansion of comprehensive health care services to the frail elderly though the Program of All-Inclusive Care for the Elderly (PACE). CalPACE was officially incorporated in August 2007 and is one of the first state-wide PACE Associations established in the United States.

As of 2017, our membership includes eleven operational PACE programs: AltaMed PACE, Brandman Centers for Senior Care (Los Angeles Jewish Home), CalOptima PACE, Center for Elders’ Independence, Fresno PACE, On Lok Lifeways, Redwood Coast PACE, San Diego PACE, St. Paul’s PACE, Sutter SeniorCare PACE, and InnovAge Greater California PACE. CalPACE members provide services through 37 PACE centers and alternative care sites in twelve counties—Alameda, Contra Costa, Fresno, Humboldt, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, and Santa Clara.

**Enrollee Characteristics, Service Utilization & Satisfaction Measures**

<table>
<thead>
<tr>
<th>Enrollee Characteristics</th>
<th>% with Alzheimer’s or related dementia</th>
<th>43%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of HCCs*</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Average HCC score*</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td>Average Risk score*</td>
<td>2.3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Utilization of Services</th>
<th>Hospital admissions per 1,000</th>
<th>413</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average length of hospital stay (days)</td>
<td>5.0</td>
</tr>
<tr>
<td></td>
<td>Emergency Room visits per 1,000</td>
<td>1416</td>
</tr>
<tr>
<td></td>
<td>Average PACE center days per participant per month</td>
<td>7.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enrollee Satisfaction Ratings</th>
<th>% Very satisfied (% rating on overall PACE care)</th>
<th>92%</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Who would refer PACE to a close friend</td>
<td>86%</td>
<td></td>
</tr>
</tbody>
</table>

*Measures utilized by Medicare for number of chronic conditions

**About CalPACE**

The California PACE Association (CalPACE) works to advance the efforts of Programs of All-inclusive Care for the Elderly (PACE). PACE programs coordinate and provide all needed preventive, primary, acute, and long-term care services so older individuals can continue living in the community. To learn more, please visit www.calpace.org or call (855) 921-PACE.

**Contact Information**

Peter Hansel, Chief Executive Officer  
(916) 469-3368 | phansel@calpace.org

Jennifer Blankenship, Director of Operations  
(916) 469-3386 | jblankenship@calpace.org
## California PACE Program Quality Measures as of 07/01/2017

<table>
<thead>
<tr>
<th>Enrollment*</th>
<th>AltaMed</th>
<th>Brandman</th>
<th>CalOptima</th>
<th>CEI</th>
<th>Fresno</th>
<th>InnovAge</th>
<th>On Lok</th>
<th>Redwood Coast</th>
<th>San Diego</th>
<th>St. Paul's</th>
<th>Sutter</th>
<th>PACE Totals/ Averages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total enrollees on 07/01/2017</td>
<td>2,319</td>
<td>214</td>
<td>216</td>
<td>711</td>
<td>338</td>
<td>428</td>
<td>1,461</td>
<td>124</td>
<td>218</td>
<td>619</td>
<td>276</td>
<td>6,924</td>
</tr>
<tr>
<td>Number served since 2005</td>
<td>4,435</td>
<td>333</td>
<td>334</td>
<td>2,320</td>
<td>475</td>
<td>588</td>
<td>3,745</td>
<td>169</td>
<td>269</td>
<td>1,220</td>
<td>841</td>
<td>14,729</td>
</tr>
</tbody>
</table>

### Age*

| Average Age | 74.00 | 79.00 | 74.00 | 77.00 | 69.00 | 70.80 | 81.90 | 74.00 | 75.10 | 73.00 | 76.00 | 75.71 |
| % 65+ | 81.00% | 90.00% | 76.00% | 91.00% | 50.00% | 71.00% | 95.40% | 79.00% | 78.00% | 75.00% | 88.00% | 82.67% |
| % 80+ | 30.00% | 45.00% | 32.00% | 42.00% | 11.80% | 21.00% | 61.50% | 24.00% | 34.90% | 30.00% | 38.00% | 37.33% |

### Gender*

| % Female | 66.00% | 64.00% | 57.00% | 62.00% | 57.40% | 56.00% | 66.30% | 80.00% | 69.30% | 57.00% | 64.00% | 63.74% |
| % Male | 34.00% | 36.00% | 43.00% | 38.00% | 46.60% | 44.00% | 33.70% | 20.00% | 30.70% | 43.00% | 36.00% | 36.45% |

### Ethnicity*

| % White | 1.20% | 58.00% | 13.00% | 13.00% | 9.47% | 31.00% | 13.00% | 77.00% | 5.10% | 41.00% | 54.00% | 16.41% |
| % Black | 2.50% | 3.00% | 1.00% | 33.50% | 8.58% | 11.00% | 3.30% | 2.00% | 0.00% | 12.00% | 16.00% | 7.94% |
| % Asian | 5% | 8.00% | 23.00% | 34.00% | 65.38% | 9.00% | 59.10% | 0.00% | 0.90% | 10.00% | 4.00% | 23.43% |
| % Hispanic | 81.80% | 25.00% | 55.00% | 14.00% | 2.96% | 39.00% | 15.30% | 0.00% | 93.10% | 35.00% | 18.00% | 44.99% |
| % American Indian/Alaskan Native | 0.20% | 1.00% | 0.00% | 0.50% | 0.00% | 1.00% | 0.00% | 4.00% | 0.00% | 0.30% | 1.00% | 0.35% |
| % Other/Unknown | 9.30% | 5.00% | 8.00% | 5.00% | 13.61% | 10.00% | 9.30% | 17.00% | 0.90% | 2.00% | 5.00% | 7.99% |

### Primary Languages Spoken*

| % English | 11.80% | 57.00% | 37.00% | 53.00% | 29.88% | 61.00% | 22.20% | 97.00% | 9.60% | 59.00% | 83.00% | 32.85% |
| % Chinese | 0.86% | 0.00% | 1.00% | 21.50% | 0.00% | 7.00% | 52.00% | 0.00% | 0.00% | 4.00% | 1.00% | 14.33% |
| % Hindi | 0.00% | 1.00% | 0.00% | 1.40% | 0.00% | 0.00% | 2.70% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.74% |
| % Hmong | 0.00% | 0.00% | 0.00% | 32.21% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 1.57% |
| % Korean | 0.04% | 2.00% | 1.00% | 7.00% | 0.00% | 0.00% | 1.90% | 0.00% | 0.00% | 0.50% | 0.00% | 1.27% |
| % Laotian | 0.00% | 0.00% | 0.00% | 0.10% | 17.16% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.85% |
| % Spanish | 83.31% | 30.00% | 46.00% | 12.00% | 5.92% | 22.00% | 13.30% | 0.00% | 89.90% | 31.00% | 11.00% | 41.99% |
| % Tagalog | 0.43% | 4.00% | 2.00% | 2.00% | 0.00% | 0.00% | 1.80% | 0.00% | 0.50% | 2.00% | 2.00% | 1.29% |
| % Vietnamese | 0.04% | 0.00% | 13.00% | 1.00% | 0.00% | 0.00% | 2.70% | 0.00% | 0.00% | 1.00% | 0.00% | 1.18% |
| % Other | 4.14% | 6.00% | 0.00% | 2.00% | 11.83% | 10.00% | 3.40% | 3.00% | 0.00% | 3.00% | 3.00% | 4.13% |

### Eligibility*

| % dually eligible for Medicare & Medi-Cal | 72.00% | 81.00% | 51.00% | 85.00% | 62.00% | 71.00% | 82.50% | 88.00% | 61.90% | 74.00% | 82.00% | 75.17% |
| % non-dually eligible | 28.00% | 19.00% | 49.00% | 15.00% | 38.00% | 29.00% | 17.50% | 12.00% | 38.10% | 26.00% | 18.00% | 24.1% |

### Place of Residence*

| % residing in community | 97.00% | 96.00% | 100.00% | 96.20% | 100.00% | 99.00% | 93.30% | 100.00% | 99.50% | 97.00% | 96.00% | 96.56% |
| % residing in nursing home | 3.00% | 4.00% | 0.00% | 3.80% | 0.00% | 1.00% | 6.70% | 0.00% | 0.50% | 3.00% | 4.00% | 3.44% |
# California PACE Program Quality Measures as of 07/01/2017

<table>
<thead>
<tr>
<th>Medical Conditions</th>
<th>PACE Totals/Averages</th>
</tr>
</thead>
<tbody>
<tr>
<td>% with Alzheimer’s or related dementia*</td>
<td>42.74</td>
</tr>
<tr>
<td>Average number of Medicare HCCs**</td>
<td>4.91</td>
</tr>
<tr>
<td>% with 3+ Medicare HCCs**</td>
<td>74.91%</td>
</tr>
<tr>
<td>Average Medicare HCC score**</td>
<td>2.22</td>
</tr>
<tr>
<td>Average Medicare Risk Score**</td>
<td>2.35</td>
</tr>
<tr>
<td>ADLs*</td>
<td></td>
</tr>
<tr>
<td>% with 3 or more ADLs</td>
<td>52.37%</td>
</tr>
<tr>
<td>% with 5 or more ADLs</td>
<td>32.97%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Utilization Measures***</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions per 1,000</td>
<td>412.89</td>
</tr>
<tr>
<td>Acute hospital days per 1,000</td>
<td>2,087.56</td>
</tr>
<tr>
<td>Average length of hospital stay</td>
<td>5.09</td>
</tr>
<tr>
<td>% 30-day hospital readmission rate</td>
<td>13.40%</td>
</tr>
<tr>
<td>Emergency room visits per 1,000</td>
<td>1,416.14</td>
</tr>
</tbody>
</table>

* Emergency room visits, including visits that become part of a hospital admission i.e. are included in a claim for an inpatient stay.

<table>
<thead>
<tr>
<th>Participant Satisfaction****</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% very satisfied (on overall care)</td>
<td>92.13%</td>
</tr>
<tr>
<td>% who would refer a close friend</td>
<td>86.31%</td>
</tr>
</tbody>
</table>

---

** Key**

* This report reflects data for all PACE organizations operating in California as of 07/01/2017.

** Data on Medicare eligible enrollees only on 07/01/2017. HCC (Hierarchical Condition Category) and Risk Score are measures used by Medicare to gauge risk and determine payments to Medicare Advantage plans and PACE. For PACE, the Medicare risk score includes a frailty adjustor.

*** Data on utilization by all enrollees from 07/01/2016 – 06/30/2017

**** Data gathered from 2017 I-SAT satisfaction survey (unless not available, then 2016 I-SAT data is utilized)

---

**For questions, please contact:**

Peter Hansel, CEO
CalPACE, 1315 I Street, Suite 100, Sacramento, CA 95814
phansel@calpace.org | (916) 469.3368