AGENDA

1. Welcome

2. State budget and legislative update (15 minutes)

3. PACE rate setting update (15 minutes)

4. DHCS and CMS guidance and initiatives (20 minutes)
   - CalPACE letters re: PACE application process and DPH licensing delays
   - CMS 2018 PACE audit updates
   - Econometrica PACE quality measure testing

5. Upcoming meetings and events (5 minutes)

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<th>Date</th>
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<td>05.10.2018</td>
<td>Monthly Member Call</td>
<td>Phone (267) 930-4000</td>
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<td>06.05.2018</td>
<td>Member Meeting</td>
<td>California Endowment - Adelante Room, 1414 K Street, Sacramento, CA 95814</td>
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6. Other business

7. Adjourn

Attachments
A. CalPACE letter to DHCS re: PACE rate methodology
B. CalPACE letter to DHCS re: PACE application process
C. CalPACE letters to budget committees re: DPH licensing delay metrics
D. CMS memo on 2018 PACE Audit Updates
E. Econometrica letter on PACE quality measure testing
F. CalPACE 2018 Calendar (May-December 2018)
April 19, 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 PO’s 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
April 17, 2018

Carol Gallegos  
Deputy Director, Legislation and Government Affairs  
Department of Health Care Services  
1501 Capitol Mall, MS 0006  
Sacramento, CA 95814

Dear Ms. Gallegos:

Thank you for the opportunity to meet with the department regarding CalPACES budget trailer bill proposal to allow new PACE organizations and expansions to start up in the month following receipt of state and federal regulatory approvals.

PACE organizations are very concerned about the potential for delays in their start-up dates posed by the department’s recent guidance, and disagree with the guidance, limiting start-ups to two days per year. However, we appreciate the administrative tasks and resources the department has to commit to reviewing, approving, and developing rates for new PACE organizations and expansions.

We also appreciate the department’s willingness and intent to work with PACE organizations on alternative application streamlining changes that could have the effect of expediting the overall approval process and enabling PACE organizations to meet prescribed start-up dates. As discussed in the meeting, those could include allowing the DHCS readiness review process to be conducted pending receipt of licenses or exemptions from the Department of Public Health, and for readiness reviews to be transmitted to CMS to enable CMS to conduct its final 90-day review pending receipt of licenses. We believe they could also include revisiting whether PACE organizations should be required to have at least one license as a condition of approval, in light of the exemptions and exceptions that are available.

Based on this we are withdrawing our budget proposal to enable month-to-month start-up and instead would propose to work with the department to put in place alternative application streamlining processes. Please let us know if the department supports this approach. We look forward to working with the department on this.

Sincerely,

Linda Trowbridge
Chair and CEO, Center for Elders Independence

cc: Jennifer Kent, Director  
    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  
    Dr. Joaquin Arambula, Chair, Assembly Budget Subcommittee #1  
    Dr. Richard Pan, Chair, Senate Budget Subcommittee #3  
    Andrea Margolis, Consultant, Assembly Budget Committee  
    Scott Ogus, Consultant, Senate Budget Committee
April 17, 2018

Honorable Richard Pan, MD
Chair, Senate Budget Subcommittee #3
State Capitol, Room 5114
Sacramento, CA 95814

SUBJECT: CDPH Licensing & Certification – California Hospital Association request for trailer bill language on metrics related to facility licensing applications – SUPPORT

Dear Senator Pan:

CalPACE and its members support the request from the California Hospital Association (CHA) for budget trailer bill language that would require the California Department of Public Health (CDPH) to post information on the workload and timeliness of processing health facility applications by the DPH Centralized Applications Unit (CAU).

Programs of All-inclusive Care for the Elderly (PACE) provide comprehensive acute and long-term services and supports to older adults and seniors with higher needs, which enable them to stay out of nursing homes and hospitals and to remain safely in the community.

Developing a new PACE program, or expanding an existing program into a new service area or county, requires several steps, including purchasing or leasing land and buildings; obtaining local building permits and approvals; obtaining clinic and Adult Day Health Care (ADHC) licenses or exemptions from DPH, and in some cases home health agency approvals; and receiving approval from the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services. The usual length of time required to develop a new PACE program or expand an existing program is one to two years. At the point of start-up PACE programs have typically invested several million dollars in facilities and staffing and are incurring several hundred thousand dollars per month in ongoing operating and staffing costs.

Our members are encountering extensive delays in getting the clinic, ADHC, and home health agency licenses or exemptions they need to expand or begin operations. Based on the most recent information that we have received, the CAU is just now starting to process community clinic applications that were filed in April 2017. Many of our members have waited over one year for the processing of their ADHC licenses or exemptions. The delays put PACE organizations at risk of missing the start-up windows allowed them under guidance from DHCS. PACE programs that miss these dates will have to incur up to six-month delays in operations, forcing them to incur substantial losses before they care begin operating and delaying access to services for communities and beneficiaries who
It is our understanding that DPH is beginning to make changes and improvements that have the potential to reduce the backlog in processing of facility licensing applications by the CAU, including hiring additional staff, reorganizing the workload, and developing an electronic application for certain types of facilities. We believe ongoing quarterly reporting to the fiscal and policy committees and posting of information on the workload volume and timeliness of CAU reviews for each category of licensure will help ensure that the department continues to make progress in these areas. It will also assist prospective licensees by providing updated information on estimated license processing times.

For these reasons, CalPACE supports the CHA proposal to require this reporting and posting of CAU workload and timeliness information.

Thank you for your consideration of this proposal.

Sincerely,

Peter Hansel
CEO
phanzel@calpace.org; 916-469-3368

cc: Members, Senate Budget Subcommittee #3
Scott Ogus, Consultant, Senate Budget Committee
Anthony Archie, Consultant, Senate Republican Caucus
Date: April 23, 2018

To: All PACE Organizations

From: Vikki Ahern, Director
Medicare Parts C and D Oversight and Enforcement Group (MOEG)

Subject: 2018 PACE Audit Updates

The following information is provided to give an overview of the Programs of the All-Inclusive Care for the Elderly (PACE) audit process improvements and reminders for 2018. We are also excited to announce that we will be issuing our first PACE Annual Report later this year that provides an overview of the 2017 CMS PACE audits including: common conditions identified, audit scores, and lessons learned. A preview of the 2017 PACE audit trends will be presented at the 2018 Medicare Advantage and Prescription Drug Plan Audit & Enforcement Conference & Webcast on May 10, 2018.

2018 PACE Audit Process Improvements:

CMS is committed to improving communication, education, and support throughout the audit process. To help achieve that goal, we are implementing the following changes and improvements for the 2018 PACE audit year:

- PACE Organizations will still have 30 calendar days to submit all required universes; however, for 2018, auditors will start the element review approximately 2 weeks after universes are received rather than the 4 weeks used in 2017. Beginning audit fieldwork earlier helps streamline the audit process and reduces the time organizations are engaged in audit related activities while still allowing sufficient time to submit universes.

- Audit fieldwork for both routine and trial period audits will be conducted over two consecutive weeks. Week 1 of fieldwork will be performed off-site through desk review or webinar and will include the review of the Service Delivery Requests, Appeals and Grievances (SDAG) element. CMS may also review other elements remotely when necessary or feasible. During week 2 of fieldwork, the audit team will conduct an in-person review of the onsite element, and any elements not reviewed or completed in week one. By spreading audit fieldwork out over the course of two weeks, we anticipate reducing burden on PACE Organizations by allowing organizations additional time to review and respond to audit findings and documentation requests.

- The review and issuance of engagement letters, Immediate Corrective Action Required (ICAR) notifications, draft reports, and final reports will now be done by the MOEG’s Division of Analysis, Policy and Strategy (DAPS) to further centralize the audit process and review of audit deliverables.

- Core audit leads have been identified. These audit leads will be responsible for managing the CMS
audit team, ensuring the audit protocol is followed, and reporting conditions to the PACE Audit Consistency Team (PACT) following the audit fieldwork. They will also be responsible for communicating with PACE Organizations both before and during the audit. Additionally, Account Managers (AMs) will no longer participate as an audit lead or audit team member for any organization they oversee; however, AMs will be responsible for monitoring the implementation and release of all corrective action plans (CAPs) following the audit.

- All CMS audit elements, samples, and supporting documentation will be reviewed and collected by the CMS audit team. We value our State Administering Agency (SAA) partnerships and will continue to share all information, data, and documentation received and reviewed by CMS during the audit process. While CMS is ultimately responsible for collecting and documenting all findings related to the CMS protocol, SAAs may be onsite with the CMS team and may choose to review the information collected by CMS. We also encourage SAAs to conduct any State specific reviews of the PACE organization that the State determines necessary.

- The Health Plan Management System (HPMS) requirements have been updated to allow for easier navigation and response to CMS requests within the audit module. These updates include: allowing organizations to upload and download multiple files at the same time (excluding universe files); entering draft audit report comments and responses directly into HPMS; and allowing for ICAR notification directly from the HPMS.

2018 PACE Audit Process Reminders:

- We want to remind PACE Organizations that the 2018 PACE audit process is conducted in the HPMS audit module. PACE Organizations should ensure appropriate staff have HPMS and audit module specific access (active User IDs and passwords). For assistance with HPMS user access please send an email to CMSHPMS_Access@cms.hhs.gov.

- Please ensure you have filled out the “Medicare Compliance Officer” contact information within the HPMS with an appropriate contact. This contact type will be used for most of the audit related communications during the 2018 PACE audit year.

We welcome any feedback to help us further refine our audit process and clarify guidance. In addition, if you have any questions about the PACE audits, please send them to: PACEAuditQs@cms.hhs.gov. This will be our centralized point of contact for everything related to PACE audits. Thank you for your continued dedication to serving some of the most vulnerable beneficiaries.
Dear PACE Administrator,

Under contract from the Centers for Medicare & Medicaid Services (CMS), Econometrica, Inc., requests your assistance in the development of health care quality measures for the PACE program. Three measures have been selected for pilot testing: (1) participants with depression receiving treatment, (2) participants with advance directives, and (3) annual review of advance directives.

Your program has been randomly selected to participate in the development of the three health care quality measures. Our research team, located at the University of Kansas School of Nursing, would like to request your assistance in pilot data collection to explore the feasibility of collecting standardized data and reliability of that data on the measures for the PACE program. In addition, we would like to solicit your feedback about the clarity of the data collection guidelines, the usefulness of the data collection forms, and the level of effort expended to collect the data. Your input is vital to the development of quality measures that are meaningful to the PACE program and to estimate the effort required for data collection.

Specifically, you will be asked to do the following:

1. Affirm your acceptance of this invitation to enroll in the pilot study.
2. Attend webinar training on the measures and the data collection guidelines. The teleconference will occur during April, 2018. The specific date and time will be provided to you after enrollment.
3. Coordinate and oversee the special data collection over a 1-month period (April 26 through May 31). The data elements will include the following:
   a. Participants diagnosed with depression.
   b. Participants diagnosed with depression for whom treatment was ordered.
   c. The type of treatment received by participants who were diagnosed with depression.
   d. Documentation of an advanced directive.
   e. Documentation of an annual review of advanced directive.

Data may be collected from paper or electronic medical records maintained by health care providers, and from administrative records.

4. Submit the data electronically once you have completed data collection, but no later than May 31st.
5. Participate in a follow-up survey about your experience with collecting data for the measures.

Please complete this brief survey with your intent to participate by April 12, 2018.
Our research team is located in Bethesda, MD, and Kansas City, KS. If you have questions about participation, please contact the Econometrica team’s lead researcher, Nancy Dunton, Ph.D., FAAN, at (913) 588-1456 or ndunton@kumc.edu.

Thank you very much for your interest and consideration.

Sincerely,

Kristie McNealy, MD
Project Director – CMS PACE Quality Measurement Project
Econometrica Inc.

Nancy Dunton, Ph.D., FAAN
Research Professor
University of Kansas Medical Center School of Nursing
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This calendar was updated on May 01, 2018. Please do not use any calendars issued prior to May 01, 2018.
For questions, please contact Jennifer Blankenship, Director of Operations, at "jblankenship@calpace.org" or (916) 469-3386.