Public Policy Conference Call
June 04, 2019 • 10:00am-11:00am Pacific
(267) 930-4000; participant code 759-479-640

AGENDA

1. Welcome

2. State Budget and Legislative Update

3. Federal Policy Update
   • Updated federal PACE regulation
   • PACE 2.0 Growth Initiative

4. State Policy Update
   • DHCS budget proposal for increased staffing for PACE
   • PACE Policy Letter 19-01 (proposed)
   • AB 1128 -- transfer of PACE licensing functions
   • Budget trailer bill -- PACE rate methodology

5. Adjourn

Attachments:

A. PACE 2.0 overview
B. CalPACE comments on PACE Policy Letter 19-01 (proposed)
C. AB 1128 – PACE licensing transfer
D. PACE rate methodology proposal
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.
<table>
<thead>
<tr>
<th>PACE Organization(s)</th>
<th>RE: Topic / Page</th>
<th>Existing Text</th>
<th>Comment/Feedback/Suggested Edits</th>
</tr>
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<tbody>
<tr>
<td>CalPACE</td>
<td>Initial State Review Page 2</td>
<td>Address of new PACE Center (if applicable) is added as a required item to be submitted with a letter of intent.</td>
<td>As we have commented before, we strongly urge that the guidance provide clarification that a planned or intended location is sufficient in the letter of intent, and specify a time by which an actual location has to be provided. It is unrealistic and very burdensome and expensive for a PACE organization to have to make a financial commitment on a location before knowing whether their application is likely to be receive initial approval from DHCS. Based on guidance we have received from CMS, CMS does not have a comparable requirement and requires only that the actual location be specified as part of the state assurance package.</td>
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<tr>
<td>CalPACE</td>
<td>PACE Growth and Expansion Pages 3-4</td>
<td>The fourth bullet under point 2, Existing PO Expansion (Existing County) states that DHCS and its actuaries must analyze requested expansion for potential rate impact. If a rate impact is identified the request will be treated in accordance with the program start dates outlined below.</td>
<td>We are not aware of any circumstances in which an in-county expansion has required the development of a new rate. This proposed change is very confusing for POs to comply with and to anticipate in their planning of SAEs. If DHCS intends to make this change, it should provide clearer guidance on the circumstances or criteria in which a SAE would require the development of a new rate.</td>
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<td>CalPACE</td>
<td>Program Start Date Page 4</td>
<td>CMS applications submitted January through June of a given calendar year may begin operations no sooner than July 1 of the subsequent calendar year; CMS</td>
<td>We have two comments: 1. Requiring a service area expansion to wait up to 18 months before it can be implemented is very onerous for existing PACE organizations and is longer than</td>
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<td>CalPACE</td>
<td>Letter of Intent Page 5</td>
<td>The LOI should identify the address for the applicant’s PACE Center</td>
<td>As noted in our first comment, the policy letter should clarify that a planned or intended location is sufficient for the letter of intent and specify a time by which an actual location has to be provided. To require applicants to have secured a location at this point in the application process is extremely burdensome and is not required by CMS.</td>
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<td>CalPACE</td>
<td>Zip Code Overlap Review Tool Page 7</td>
<td>Rather than using a certain formula or “threshold number” DHCS will consider all factors and available data and ultimately decide whether to move forward with signing the state assurances page.</td>
<td>As we have commented before, we strongly urge that the policy letter provide, in the interests of transparency, that DHCS will provide the basis for its determination that an overlapping application is feasible, including all data and analyses that it uses to make the determination.</td>
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<tr>
<td>CalPACE</td>
<td>Licensing Page 9</td>
<td>Paragraph 2 of this section establishes a process by which</td>
<td>We would point out, as we have before, that this creates disparities in the time</td>
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<td>DHCS</td>
<td>DHCS will review clinic exemption requests from for-profit entities applying to become PACE organizations.</td>
<td>required to approve applications between non-profit versus for-profit POs and moves away what should be the department's goal of aligning the requirements across PACE sponsoring organizations. We strongly urge DHCS to take all steps to maintain consistency in the requirements and timelines between non-profit and for-profit POs. We understand that this will be further addressed by pending legislation to transfer certain PACE licensing functions from DPH to DHCS. However, that change is not likely to take effect until sometime in 2020 at the earliest.</td>
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<td>CalPACE</td>
<td>CalPACE has no substantive comment on this proposed change but would ask for clarification that the Department’s intent with this change is to remove the current requirement that PACE Centers must maintain one PACE Center required license (clinic or ADHC).</td>
<td>Paragraph 2 of this section appears to remove the current requirement that PACE Centers must maintain one PACE Center required license (clinic or ADHC).</td>
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An act to add Sections 1221.18, 1575.5, and 1734.6 to the Health and Safety Code, and to amend Section 14592 of the Welfare and Institutions Code, relating to the elderly.

LEGISLATIVE COUNSEL’S DIGEST

AB 1128, as amended, Petrie-Norris. Program of All-Inclusive Care for the Elderly.

Existing federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center, defined, in part, as a facility that includes a primary care clinic, so that they may continue living in the community. Federal law authorizes states to implement the PACE program as a Medicaid state option.

Existing state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program), to provide community-based, risk-based, and capitated long-term care services as optional services under the state’s Medi-Cal State Plan, as specified. Existing law authorizes the State Department of Health Care Services to enter into contracts with various entities for the purpose of implementing the PACE program and fully implementing the single state agency
responsibilities assumed by the department—in pursuant to those contracts, as specified.

Existing law establishes the State Department of Public Health and sets forth its powers and duties, including, but not limited to, duties relating to the licensing and regulation of various entities, including primary care clinics, adult day health centers, and home health agencies.

This bill would require a PACE center to maintain a license both as both a primary care clinic and an adult day health center, and to either maintain a license as a home health agency or contract with a licensed home health agency for the provision of home health services. The bill would require the State Department of Health Care Services, as the single state agency overseeing the PACE program, to license and regulate any primary care clinic, adult day health center, and home health agency that is related to a PACE center, thereby transferring these duties from the State Department of Public Health to the State Department of Health Care Services, and Services, using revenues from the licensing fees that would have been attributed to the corresponding duties of the State Department of Public Health. The bill would authorize the State Department of Health Care Services to exempt certain PACE centers from these provisions.


The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) The Program of All-Inclusive Care for the Elderly (PACE) is a national model of comprehensive care for California’s frail population 55 years of age and older who qualify for nursing home placement but wish to remain in the community.

(b) Research shows that PACE produces significant improvements for the beneficiaries it serves, including fewer hospitalizations, fewer nursing home admissions, higher quality of life, and greater rates of satisfaction with overall care.

(c) The PACE model achieves savings for the State of California. In 2017, the state paid $22,600,000 less than it would have if all current PACE participants were served outside of PACE.

(d) Currently, there are 12 PACE programs operating in 42 sites across California, serving almost over 8,000 seniors.
(e) PACE organizations are currently required to obtain licensing approvals or exemptions to operate clinics, adult day health centers, and, in some cases, home health agencies, from the State Department of Public Health (DPH) in a lengthy process that is separate from the extensive approval process administered by the State Department of Health Care Services (DHCS).

(f) This bifurcated process can delay the rollout of new and expanding PACE programs by months or even years.

(g) Therefore, it is the intent of the Legislature to shift responsibility for PACE licensing from DPH to DHCS to remove redundancy and duplication between the reviews by the two departments, and expedite approval of new or expanding PACE programs that will help more seniors access PACE while remaining in their homes and communities.

SEC. 2. Section 1221.18 is added to the Health and Safety Code, to read:

> 1221.18. Pursuant to subdivision (d) of Section 14592 of the Welfare and Institutions Code, by no later than January 1, 2021, the State Department of Health Care Services, as the single state agency overseeing the Program of All-Inclusive Care for the Elderly (PACE), as described in Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code, shall license and regulate any primary care clinic license that is related to a PACE center, as defined in Section 460.6 of Title 42 of the Code of Federal Regulations.

SEC. 3. Section 1575.5 is added to the Health and Safety Code, to read:

> 1575.5. Pursuant to subdivision (d) of Section 14592 of the Welfare and Institutions Code, by no later than January 1, 2021, the State Department of Health Care Services, as the single state agency overseeing the Program of All-Inclusive Care for the Elderly (PACE), as described in Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code, shall license and regulate any adult day health center license that is related to a PACE center, as defined in Section 460.6 of Title 42 of the Code of Federal Regulations.

SEC. 4. Section 1734.6 is added to the Health and Safety Code, to read:

> 1734.6. Pursuant to subdivision (d) of Section 14592 of the Welfare and Institutions Code, by no later than January 1, 2021,
the State Department of Health Care Services, as the single state agency overseeing the Program of All-Inclusive Care for the Elderly (PACE), as described in Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code, shall license and regulate any home health agency license that is related to a PACE center, as defined in Section 460.6 of Title 42 of the Code of Federal Regulations.

SEC. 5. 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 shall establish the California Program of All-Inclusive Care for the Elderly (PACE program) 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.

(c) A PACE center, as defined in Section 460.6 of Title 42 of the Code of Federal Regulations, shall maintain a license as both a primary care clinic, as defined in paragraph (1) of subdivision (b) of Section 1200 of the Health and Safety Code, and an adult day health center, as defined in subdivision (b) of Section 1570.7 of the Health and Safety Code. Additionally, a PACE center shall elect to either maintain a license as a home health agency, as defined in subdivision (a) of Section 1727 of the Health and Safety Code, or contract with a licensed home health agency for the provision of home health services.

(d) (1) Notwithstanding any other law, including Division 2 (commencing with Section 1200) of the Health and Safety Code, the department, as the single state agency overseeing the PACE program, shall assume the duties of the State Department of Public Health relating to the licensing and regulation of any primary care clinic, as defined in paragraph (1) of subdivision (b) of Section 1200 of the Health and Safety Code, adult day health center, as defined in subdivision (b) of Section 1570.7 of the Health and Safety Code, and home health agency, as defined in subdivision
(a) of Section 1727 of the Health and Safety Code, that is related to a PACE center, as defined in Section 460.6 of Title 42 of the Code of Federal Regulations.

(2) The transfer of these duties shall occur by a date collectively determined by the department, the State Department of Public Health, and PACE organizations, but no later than January 1, 2021.

(3) (A) Notwithstanding any other law, moneys authorized to fund the duties of the State Department of Public Health relating to the licensing and regulation of an entity described in paragraph (1) that is related to a PACE center, including moneys collected in accordance with Section 1266 of the Health and Safety Code and deposited in the State Department of Public Health Licensing and Certification Program Fund pursuant to Section 1266.9 of the Health and Safety Code, shall be authorized to fund those same duties upon their transfer to the department pursuant to this subdivision.

(B) It is the intent of the Legislature that the duties of the department as described in paragraph (1) not be funded by an appropriation from the General Fund.

(e) Consistent with Sections 1231.5, 1580.1, and 1734.5 of the Health and Safety Code, and in accordance with Section 100315 of the Health and Safety Code, the department may exempt a PACE center from subdivisions (c) and (d).
Amend Welfare and Institutions Code Section 14301.1 (n), to read:

(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) (A) 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. (B) The rate methodology shall be consistent with actuarial rate development principles and shall provide for all reasonable, appropriate, and attainable costs for each PACE organization within each region.

(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), to reflect the lower enrollment and higher operating costs associated with
new PACE organizations relative to PACE organizations with higher enrollment and more experience providing managed care interventions to their beneficiaries.

(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.