



**CalPACE Public Policy Conference Call**  
February 27, 2018 10:00am – 11:00am  
Phone: (267) 930-4000; Participant Code: 759-479-640#

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**A G E N D A**

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1. Welcome
2. Legislative Update
3. 2018 Policy Priorities
4. PACE Application Process
5. PACE Rate Setting Update
6. PACE 2.0 Initiative
7. Adjourn

**Attachments:**

- A – CalPACE letter to DHCS regarding Policy Letter 17-03
- B – PACE Trailer Bill Language
- C – 2018 CalPACE Policy Priorities
- D – PACE 2.0



December 20, 2017

Jennifer Kent  
Director  
CA Department of Health Care Services  
1501 Capitol Ave, MS 0000  
Sacramento, CA 95814

Dear Director Kent:

CalPACE and its members have reviewed the Department's recently issued guidance on the PACE application process (PACE Policy Letter 17-03) and have significant concerns about its provisions to only allow two dates per year for start-up of new PACE organizations and PACE expansions.

CalPACE and its members appreciate the changes the department has made to the PACE application and level of care review processes to date, which have greatly simplified and streamlined the processes needed to get new programs and expansions approved, and to get beneficiaries who need PACE enrolled in PACE in a timely way. These changes have enabled PACE to grow in California and to reach more older adults and seniors who need the level of care that PACE provides.

However, we are quite concerned that some of the changes to the application process outlined in the recent policy letter will stall and impede PACE expansion in the state, which is not an outcome that we believe the department is intending. In particular, we strongly urge the department to reconsider the proposal to only allow two dates per year for start-up of new programs and expansions and would request a meeting with you and your staff to discuss our concerns in greater detail. We believe that with further changes, it will be possible to meet the department's goal of better aligning its resources and staffing needs and ensuring continued, healthy development of PACE in California.

As you know, the process for developing a new PACE organization or expansion is complicated and involves numerous steps, many of which are outside the control of the PACE organization. Those include purchasing or leasing land and buildings, obtaining local building permits and approvals, and obtaining applicable clinic, ADHC, and home health agency licenses from the CA Department of Public Health (DPH). At the point of the readiness review survey, PACE organizations usually have invested several million dollars in facilities and staffing. The uncertainty of the timing of these steps, and frequent delays, make it virtually impossible for PACE organizations to align their development and application steps with the start-up windows outlined in the policy letter. This places PACE start-up and expansion applications at a very high risk of missing applicable start-up windows and forcing them to incur substantial losses before they can begin operating and generating revenue.

While CalPACE and its members are committed to utilizing available procedures to streamline the PACE application and licensing processes, we believe a number of further changes in the recent guidance are necessary to ensure that communities who need the services PACE provides are not delayed in receiving them and that PACE organizations do not incur substantial losses.

AltaMed PACE  
Los Angeles, CA

Brandman Centers  
for Senior Care  
Reseda

CalOptima PACE  
Orange County

Center for Elders'  
Independence  
Oakland

Fresno PACE  
Fresno

InnovAge  
San Bernardino

On Lok Lifeways  
San Francisco

Redwood Coast PACE  
Eureka

St. Paul's PACE  
San Diego

San Diego PACE  
San Ysidro

Sutter SeniorCare  
Sacramento

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Among the changes we would like to discuss with the department are:

- Use of estimated or interim rates for PACE start-ups and expansions that may be quicker to develop, as well as the use of rate trending to adjust rates, if applications are delayed for reasons beyond the control of PACE organizations, to allow start-ups and expansions to occur on a month-to-month basis;
- Better coordination of the PACE readiness review and DPH licensing processes, including possible revisions to the readiness review process that would eliminate the need for separate DPH licensing surveys;
- Waiver of the department's policy that PACE organizations obtain at least one license if they obtain exemptions from licensing from DPH and have policies and procedures in place to ensure that they meet all licensing requirements;
- Working with DPH to ensure that PACE organizations are able to utilize existing clinic license streamlining measures, and that license applications are processed by the central applications unit in a manner that is consistent with the DHCS PACE application and rate development timelines. Streamlining measures include use of intermittent clinics, affiliate clinics, consolidated clinic licenses, and consolidated clinic administration;
- Commencing the rate development process for expansions of PACE organizations in good standing upon the filing of the letter of intent rather than upon approval of the initial expansion application.

We appreciate the department's support of PACE to date and its attention to our concerns. We look forward to working with department on solutions that will meet the department's goals and continue to ensure a healthy environment for PACE development in California.

Sincerely,



Linda Trowbridge  
CalPACE Chair and CEO, Center for Elders' Independence

cc: Sarah Brooks, Deputy Director, Health Care Delivery Systems  
Sarah Eberhardt-Rios, Director, Integrated Systems of Care Division  
Joseph Billingsley, Chief, Program Policy & Operations Branch, Integrated Systems of Care Division  
Stryder Morissette, Chief PACE Unit, Integrated Systems of Care Division  
Jennifer Lopez, Chief, Capitated Rates Development Division



# PACE Application Process Budget Proposal Fact Sheet

Updated February 20, 2018

## Proposal

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

## Background

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

Developing a new PACE program, or expanding an existing program into a new service area or county, requires a complex development and regulatory review process, and the investment of significant resources on the part of the applying organization. The steps include purchasing or leasing land and buildings; obtaining local building permits and approvals; obtaining clinic, ADHC, and home health agency licenses from the CA Department of Public Health (DPH) or exemptions; completing a state readiness review, which is conducted by the Department of Health Care Services (DHCS); and waiting an additional 90 days for review and final approval by the Centers for Medicare and Medicaid Services (CMS). The usual length of time required to develop a new PACE program or expand an existing program is one to two years. The investment in facilities and salaries required to obtain approval to operate a PACE program can run into the millions of dollars.

Since the inception of the PACE program in the 1980s, PACE programs have been allowed to begin operations on the first of the month following the receipt of state and federal regulatory approvals. However, DHCS guidance adopted in October 2017 limits new PACE program start-ups and expansions to two days per year, January 1 and July 1. Due to uncertainties in the amount of time it takes to complete the application process, particularly frequent delays in the amount of time necessary to receive applicable facility licenses, it is virtually impossible for PACE organizations to align their applications with specific start-up dates. If PACE programs miss an applicable start-up date, they must wait for the next available date, which can result in up to a six-month delay, forcing them to incur substantial losses before they can begin operating and generating revenue, and delaying communities who need the services PACE provides from receiving them.

## Arguments in Support

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

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

**Sponsor of Proposal:** CalPACE

## Proposed Budget Trailer Bill Language

Add a new subdivision (f) to Welfare and Institutions Code Section 14593, to read:

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

**2018 CalPACE Legislative & Policy Priorities Staff Recommendations**

POLICY AREA	BACKGROUND	COMMENTS	STAFF RECOMMENDATION
<p>PACE Rate Setting</p>	<p>The PACE Modernization Act authorizes the use of experience based rate setting for PACE starting in 2017.</p> <p>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.</p> <p>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.</p>	<p>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.</p> <p>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.</p>	<p>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.</p> <p>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.</p>
<p>PACE Flexibility – State Level</p>	<p>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.</p> <p>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.</p>	<p>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.</p>	<p>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.</p> <p>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.</p>

	<p>DHCS is resistant to working with DPH on PACE licensing issues and exemptions.</p>		<p>Explore support with community health centers for enlarging the ½ mile radius for start-ups of new clinics under the consolidated license option.</p> <p>Explore support from clinic, ADHC and other groups for an informational hearing on DPH licensing delays.</p>
<p>PACE Flexibility – Federal Level</p>	<p>CMS has issued two RFIs related to PACE pilots but has not implemented any to date.</p> <p>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.</p> <p>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.</p>		<p>Advocate for CMS to implement PACE pilots, particularly those targeting Medicare only beneficiaries and those at risk of needing nursing home level of care.</p> <p>Support Congressional proposals to provide POs with greater flexibility to serve Medicare only beneficiaries.</p>
<p>Managed Care Enrollment Materials &amp; PACE</p>	<p>DHCS has included PACE in the choice books and forms it has developed for Cal MediConnect.</p> <p>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.</p>	<p>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.</p>	<p>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.</p>

	<p>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.</p>		
<p>Federal Medicaid Funding and ACA Repeal</p>	<p>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.</p> <p>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.</p>		<p>Continue to support through NPA proposals at federal level that maintain federal Medicaid funding levels.</p>
<p>Senior and Supportive Housing</p>	<p>The Legislature passed three housing finance bills in 2017 which are expected to provide new revenues for development of affordable housing.</p> <p>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.</p>		<p>Advocate with Leading Age CA for incentives or set asides to steer greater housing resources into senior and supportive housing arrangements.</p> <p>Advocate to ensure that PACE is eligible to provide supportive services under any proposals designed to encourage development of senior and supportive housing.</p>

	<p>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.</p>		
<p>Loan Forgiveness &amp; Residency and Clinical Training</p>	<p>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.</p> <p>Existing Geriatrician residency slots go unfilled and POs with training sites have difficulty attracting residents.</p> <p>State and federal loan forgiveness programs don't target enough resources for geriatric primary care training.</p>	<p>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.</p> <p>According to the HPEFs website, most POs currently operate within qualifying areas for HPEF loan forgiveness programs.</p>	<p>Search for funding to establish a state loan forgiveness program targeted to geriatric primary care providers.</p> <p>Work with other organizations such as the California Primary Care Association to jointly request that OSHPD establish the program.</p> <p>Explore whether there is support for earmarking a portion of recent budget augmentations for health workforce development for PACE or for geriatric training.</p>



## **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."<sup>1</sup> 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](#),

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<sup>1</sup> *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement*. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003

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

