CalPACE

**Public Policy Conference Call**
March 26, 2019 ▪ 10:00am-11:00am Pacific
(267) 930–4000; participant code 759-479-640

# A G E N D A

1. Welcome

2. State Budget and Legislative Update

3. Federal Policy Update
   - Final PACE regulation
   - Part D waivers

4. State Policy Update
   - PACE Policy Letter 19-01 (proposed)
   - CalPACE policy priorities for 2019
   - Cal MediConnect extension

5. NPA Spring Policy Forum

6. Adjourn

**Attachments:**

A. PACE Policy Letter 19-01 (proposed)
B. AB 1128 fact sheet
C. PACE Modernization Act amendments – PACE rate setting – fact sheet
D. CalPACE comments on Cal MediConnect program

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
*DIRECTOR*

GAVIN NEWSOM
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Date: February xx, 2019

**Policy Letter 19-01**

*Supersedes PACE Policy Letter 18-01*

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

## Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (PO's) and potential applicant organizations of the Department of Health Care Services' (DHCS) application review process and timeline for new PO applications and PO Expansion applications.

## Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, S
tatutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of PO's that could operate in the state, and allowed for-profit entities to become POs~~. As a result, DHCS has seen renewed interest in PACE and an increase in new/expansion applications submitted to DHCS for review. Therefore, DHCS is issuing revised guidance to clarify the Department's expectations with respect to the competitive nature of the review process.~~

## Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services (CMS) releases annual updates to its PACE Application Guidance to address its electronic PACE application submission timelines, requirements, and review process. Applicants should review this guidance and be aware of CMS requirements for accessing Health Plan Management System (HPMS). The downloadable PDF of the application and additional information can be found at: https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

## State Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial

submission components are detailed in this letter, which aims to provide DHCS with key organizational background and financial viability documentation. This information is necessary for DHCS to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.

Upon submission of the full application to CMS, DHCS will align its review of the remaining application with the CMS ~~initial 45/90-day~~ clock cycle, dependent upon the type of application, to create a concurrent review process. Expansion only applications will be on two 45/90 day clock cycles. New PACE center applications will be on two 90 day clock cycles. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

Initial State Review

All new and expansion applications received by DHCS will follow the below initial state review timeframes for application submission:

| Action | Due Date | Documents for Submission | Reviewer | Review Timeframe |
|---|---|---|---|---|
| Notification of Intent to DHCS | 30 days prior to Initial Application Submission to DHCS | • Letter of Intent<br>• Letter for Support from COHS (if applicable)<br>• Address of new PACE center (if applicable)<br>• Estimated operational date (subject to DHCS approval) | DHCS | N/A |
| Initial Application Submission to DHCS | 60 days prior to CMS application submission deadline | • Market Feasibility Study<br>• Letters of Support<br>• Application sections (see Attachment III)<br>• Address of PACE center | DHCS | 60 Calendar Days |
| Full Application Submission in HPMS | Align with CMS PACE Application Submission Deadline | • Remaining application sections<br>• State Assurance Page | DHCS/CMS | Align with CMS 45/90 day review clock |

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received (Initial Application or Service Area Expansion). Please see Attachment I (PACE Application Required Attestations and Uploads).

Upon completion of the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock during this period while the applicant responds to either the CMS and/or DHCS RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS. It is also during this period that DHCS conducts the State Readiness Review (SRR) onsite survey of the applicant PACE Center, as required. All initial applications and any Service Area Expansion (SAE) application that includes the addition of a new PACE center requires a SRR of the new center. All deficiencies that may be identified during the DHCS SRR onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted to and accepted by DHCS.

Once CMS and/or DHCS have accepted the applicant's RAI response and the Readiness Review onsite survey has been completed by DHCS and the applicant and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial.

**PACE Growth and Expansion**

All PACE growth and expansion falls into one of the below categories:

1. New PACE Organization – New entity applying to establish a PO
    - Entity must identify specific zip codes to be served in one or more counties
    - Entity must be able to serve all requested zip codes from PACE Center ~~(subject to 60-minute one way travel time adult day health center (ADHC) requirement)~~(subject to the 60-minute one-way travel time to and from the participants' homes to the adult day health center (ADHC))
    - Rate development required for each county requested

2. Existing PO Expansion (Existing County) – PO's adding additional zip codes within existing county service area, opening a new PACE Center within existing county service area, or both

- Entity must be able to serve all requested zip codes from PACE Center(s) ~~(subject to 60-minute one-way travel time ADHC requirement)~~(subject to the 60-minute one-way travel time to and from the participants' homes to the ADHC requirement)
- Entity must identify zip codes that overlap with any existing PO's
- PO's can add zip codes and use Alternative Care Settings (ACS) and Community-based physician waiver as an interim step before building new PACE Center
- DHCS and its actuaries must analyze requested expansion for potential rate impact. If a rate impact is identified (requiring new rate development), the request will be treated in accordance with program start dates outlined below. ~~Consider rate development/adjustment to account for expansion within the county and account for potential variance and/or changes in utilization~~
- Zip code only expansions subject to shorter CMS review period

3. Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

   - Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by existing PACE Center and interdisciplinary team (IDT)
   - Entity must identify zip codes that overlap with any existing PO's
   - Rate development required for each county requested

**Program Start Date**

To align with DHCS budget and rate development processes, all new and existing PO ~~Initial Applications and Service Area E~~expansion applications requiring new rate development ~~will~~ may only be able to begin operations on either January 1 or July 1 of a given year in accordance with the timeline below~~following receipt of final approval from CMS and DHCS~~.

CMS applications submitted January through June of a given calendar year may begin operations no sooner than July 1 of the subsequent calendar year, pending final DHCS and CMS approval of the new PACE Organization or Existing PO Expansion application.

CMS applications submitted July through December of a given calendar year may begin operations no sooner than January 1 of the calendar year that follows the subsequent calendar year (i.e., a December 31, 2018 submission would be eligible for a January 1, 2020 start date), pending final DHCS and CMS approval of the new PACE Organization or Service Area Expansion application.

Prospective PO's and expansion applicants requiring new rate development should take the available start dates into consideration when preparing to submit an application. Any delays in the application submission or review process may result in the program start getting pushed back to the next available program start date of either January 1 or July 1.

Applicants should also account for the time frame requirements of other public licensing entities when considering the overall application timeline process.

**Initial Application Submission Components**

Letter of Intent

All applicants must submit a Letter of Intent (LOI) to DHCS indicating their plans to submit a PACE application. The LOI should identify the following:

- The applicant
- The proposed service area, including a listing of proposed zip codes and a service area map~~; and the proposed site location~~
- The address for the applicant's PACE center and the anticipated operational date of the center (subject to DHCS approval) based on DHCS program start date guidelines above

New applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can refer to the DHCS PACE website for a listing of all zip codes by county that PO's currently operate in at: http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx. Pending applications for new or expansion PO's are also posted to the DHCS website.

CMS application submission deadlines can be found under the application training guide here: https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html. The LOI to DHCS must be submitted at least 90 days prior to the proposed CMS submission date, and the initial application must be submitted at least 60 days prior to the proposed CMS submission date. Applications submitted to DHCS after these dates are not guaranteed to be reviewed in time to meet the proposed CMS submission deadline.

Letters of Support

All PACE applicants must submit letters of support from local entities in the area that the applicant proposes to serve. These may include but are not limited to County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-Cal managed care health plans (MCPs), Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), local Multipurpose Senior Services Program (MSSP) Waiver sites, etc. Letters of support should be attached to

the LOI. ~~The minimum requirements for letters of support in County Organized Health System counties is provided below.~~

Market Feasibility Study

All PACE applicants, including Service Area Expansions, must submit a market feasibility study of the area that they propose to serve. The feasibility study should include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership
- Identify all competitive factors impacting the market, such as:
    - Existing PO's
    - MCPs
    - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
    - Medi-Cal Waiver Programs
    - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
    - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve / deny an application.

State Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment III): Please refer to DHCS website "PACE Orientation Package & Approved Templates" for resource and templates.

| **New PACE Application** | **Service Area Expansion (Existing and New County)** |
|---|---|
| • 3.1 – Service Area<br>• 3.2 – Legal Entity and Organization Structure<br>• 3.3 – Governing Body<br>• 3.4 – Fiscal Soundness<br>• 3.5 – Marketing<br>• 3.13 – Contracted Services<br>• 3.23 – Transportation Services | • 3.1 – Service Area<br>• 3.4 – Fiscal Soundness<br>• 3.5 – Marketing<br>• 3.13 – Contracted Services<br>• 3.23 – Transportation Services |

In addition to the attestations and documents required in the PACE application, DHCS requires a detailed narrative in each of these sections to better understand the organizational background and financial standing of the applicant. Applicants should

refer to the Attachments in this document as well as the documents on the DHCS PACE website under PACE Orientation Package & Approved Templates.

**Additional Considerations and Limitations**

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify any existing and/or pending PO's of the new applicant's intent, and the existing and/or pending PO(s) will have an opportunity to submit their own market feasibility study in response. The counter-feasibility study must be submitted to DHCS by the initial application submission date. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county and a new or expansion application is requesting a zip code not in the PO's service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market feasibility study.

DHCS will conduct its own market feasibility study using Medi-Cal data to verify the market feasibility studies that applicants/PO's submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing PO's.

Zip Code Overlap Review Tool

DHCS, in consultation with other State Administering Agencies, uses a review tool to assist in considering prospective PO applications and the overlapping service area they propose to enter. The review tool is included as Attachment II (Service Area Overlap Review Criteria) to this letter. Rather than using a certain formula or "threshold number," DHCS will ~~take~~consider all factors ~~into consideration~~and available data and ultimately decide whether to move forward with signing the State Assurance page.

Restrictions on Delegation

DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as "grandfathered" in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department's prior written approval.

Please note that DHCS' prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant's home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

<u>POs in County Organized Health System Counties</u>

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a third party PO in a COHS county if the applicant includes a letter of support from the COHS that includes the following:

- A statement that the COHS supports the establishment of the independent PO in the county, and
- A statement that the COHS request DHCS to submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in that COHS county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and

CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a) Bridge to Reform Demonstration Waiver effective March 19, 2014.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. PO's must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. ~~Assembly bills 847 (Chapter 315~~Health & Safety Code section 100315 allows CDPH, DHCS, the Department ~~of 2005)~~Social Services and ~~577 (Chapter 456~~the California Department ~~of 2009) established the authority for CDPH/DHCS~~Aging to authorize exemptions to a PO from specific licensing ~~and regulatory~~ requirements for clinics, adult day health care centers, Community Care Licensing facilities, and home health agencies~~. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic~~ that are duplicative, conflicting, or ~~ADHC) for each PACE Center.~~ inconsistent with PO requirements. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements and anticipated time lines.

For-profit entities applying to become a PO do not qualify to be licensed as a Primary Care Clinic as defined under Health and Safety Code (HSC §1204). A for-profit designation also means that CDPH is unable to approve an exemption from Primary Care Clinic licensure. In this situation, DHCS has developed an exemption and monitoring process for PACE Center Primary Care Clinics. DHCS will conduct an onsite and desk review of exemption requests received which will simultaneous occur during the State Readiness Review of PACE building. For-profit entities wishing to apply for a Primary Care Clinic exemption may do so by contacting their DHCS contract managers.

CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx .

Replacement PACE Centers

Existing PO's may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a Service Area Expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan, notification to participants, and details of any changes in staffing, policies and procedures, etc.

PO's seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition. Replacement Centers are not subject to the January 1 or July 1 start dates.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care PACE Manager.

Sincerely,

Evelyn Schaeffer, Division Chief
Integrated System of Care Division

Enclosures

Attachment I
Attachment II
Attachment III

## Attachment I - PACE Application Required Attestations and Uploads

| Attestation Topic | Section # | Initial | SAE | Upload Required (Initial) | Upload Required (SAE) |
|---|---|---|---|---|---|
| Service Area | 3.1 | X | X | X | X |
| Legal Entity and Organizational | 3.2 | X | X | X | X |
| Governing Body | 3.3 | X | X | X | X |
| Fiscal Soundness | 3.4 | X | X | X | X |
| Marketing | 3.5 | X | X | X | X |
| Explanation of Rights | 3.6 | X | X | X | X |
| Grievance | 3.7 | X | X | X | X |
| Appeals | 3.8 | X | X | X | X |
| Enrollment | 3.9 | X | X | X | X |
| Disenrollment | 3.10 | X | X | X | X |
| Personnel Compliance | 3.11 | X | X | | |
| Program Integrity | 3.12 | X | X | | |
| Contracted Services | 3.13 | X | X | | |
| Required Services | 3.14 | X | X | | |
| Service Delivery | 3.15 | X | X | | |
| Infection Control | 3.16 | X | X | | |
| Interdisciplinary Team | 3.17 | X | X | | |
| Participant Assessment | 3.18 | X | X | | |
| Plan of Care | 3.19 | X | X | | |
| Restraints | 3.20 | X | X | | |
| Physical Environment | 3.21 | X | X | | |
| Emergency and Disaster | 3.22 | X | X | | |
| Transportation Services | 3.23 | X | X | | |
| Dietary Services | 3.24 | X | X | | |
| Termination | 3.25 | X | X | X | X |
| Maintenance of Records & | 3.26 | X | X | | |
| Medical Records | 3.27 | X | X | | |
| Quality Assessment Performance Improvement | 3.28 | X | X | X | X |
| State Attestations | 3.29 | X | X | X | X |
| Waivers | 3.30 | X | X | X (as applicable) | |
| Application Attestations | 3.31 | X | X | X | X |
| State Readiness Review | 3.32 | X | X (as applicable) | X | X (as applicable) |

## Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors it determines appropriate to fully assess the application. DHCS will consider all factors and ultimately decide whether to move forward with signing the State Assurance page.

| Category | Subcategory | Criteria |
|---|---|---|
| Service Area Overlap with Existing PACE Operator | Service Area Overlap | Overlap includes less than 25% of potential participants in existing service area |
| | | Overlap includes between 25% and 50% of potential participants in existing service area |
| | | Overlap includes between 50% and 75% of potential participants in existing service area |
| | | Overlap includes over 75% of potential participants in existing service area |
| | Facility Overlap | Proposed service area includes existing PACE facility or alternative care setting |
| | | Proposed service area does not include existing PACE facility or alternative care setting |
| Level of Success & Investment of Existing PACE Operators/ Applicants | Market Penetration of Existing Operators in Proposed Service Area | Market penetration under 10% |
| | | Market penetration between 10% and 30% |
| | | Market penetration over 30% |
| | Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area | Facility investment over $5M in the past year |
| | | Facility investment over $5M between 1 and 2 years |
| | | Facility investment over $5M between 2 and 3 years |
| | | No facility investments over $5M in last 3 years |
| Local Support | Local Government Support | Formal vote of city council or comparable body in support of new applicant |
| | | Letter of support from city council member or comparable official |
| | | No written support from local government official |
| | Local Service Provider Involvement | Lead applicant is a services provider in proposed service area |
| | | Supporting applicant is a services provider in proposed service area |
| | | No part of applying entity is services provider in proposed service area |

# Attachment III: Documentation Requirements for DHCS Initial Submission Review of New PACE Application

Additional information on required documents

| Attestation Topic | Section # | Documents required to upload in HPMS |
|---|---|---|
| Service Area | 3.1 | ☐ Detailed map, with location of PACE center clearly marked<br>☐ Map to include a scale of the complete geographic service area that includes county, zip code, street boundaries, census tract or block or tribal jurisdiction and main traffic arteries, physical barriers such as mountains and rivers and location of the PACE center, hospital providers, ambulatory and institutional services sites.<br>☐ Map to depict the mean travel time from the farthest points on the geographic boundaries to the nearest ambulatory and institutional service sites. If the geographic service area includes an area covered by another PACE organization, identify the duplicate area.<br>o Note: The map must be developed in accordance with 42 CFR §460.22, §460.70, and §460.98. |
| Legal Entity and Organizational Structure | 3.2 | ☐ Description of the organizational structure of the PACE organization, including the relationship to, at a minimum, the governing body, owner, program director, medical director, and to any parent, affiliate or subsidiary entity.<br>☐ Evidence of non-profit or for-profit corporation status |
| Governing Body | 3.3 | ☐ List of the members of the Board of Directors and their titles. Indicate which, if any, members are consumer representative. Include the name and phone number of a contact for the governing body and the name and phone number of the PACE Program director responsible for oversight and administration as described in 42 CFR §460.62(a). |
| Fiscal Soundness | 3.4 | ☐ Description of any reserve requirements and other financial requirements set by the State and supporting documentation to demonstrate how the applicant meets these requirements.<br><br>☐ Independently audited financial statement for the three most recent fiscal year periods or, if operational for a shorter period of time, for each operational fiscal year.<br>o Note: If a PACE program is a line of business of the applicant, it should provide audited statements relating to the legal entity. Audits provided in the |

| Attestation Topic | Section # | Documents required to upload in HPMS |
|---|---|---|
| | | Documents section of the application, are to include:<br>o Opinion of a certified public accountant;<br>o Statement of revenues and expense;<br>o Balance sheet;<br>o Statement of cash flows;<br>o Explanatory notes; and<br>o Statements of changes in net worth.<br><br>☐ The most recent year-to-date unaudited financial statement of the entity and independently audited financial statements of guarantors and lenders (e.g. organizations providing loans, letters of credit or other similar financing arrangements, excluding banks)<br><br>☐ Financial Projections<br>o Note: Provide financial projections beginning with program commencement through one year beyond break-even. (Financial projections should be prepared using the accrual method of accounting in conformity with generally accepted accounting principles (GAAP). Prepare projections using the pro-forma financial statement methodology. For a line of business, assumptions need only be submitted to support the projections of the line.) Projections must include:<br><br>o Opening and annual balance sheet<br>• Quarterly statements of revenues and expenses for legal entity<br>• Give projections in gross dollars and include year-end totals. (In cases where the plan is a line of business, the applicant should also complete a statement of revenue and expenses for the line of business).<br><br>o Statement and justification of assumptions;<br>• State major assumptions in sufficient detail to allow an independent financial analyst to reconstruct projected figures using only the stated assumptions;<br>• Include operating and capital budget breakdowns;<br>• Stated assumptions should address all periods for which |

| Attestation Topic | Section # | Documents required to upload in HPMS |
|---|---|---|
| | | projections are made and include inflation assumptions<br>• Justify assumptions to the extent that an independent financial analyst would be convinced that they are reasonable; and<br>• Base justification on such factors as the applicant's experience and the experience of other PACE organizations.<br><br>☐ Evidence of applicant's financing arrangements for any projected deficit.<br><br>☐ Insolvency Plan:<br>o Documents that demonstrate you can, in the event it becomes insolvent, cover expenses of at least the sum of one month's total capitation revenue to cover expenses the month prior to insolvency and one month's average payment to all contractors, based on the prior quarter's average payment, to cover expenses the month after the date insolvency is declared or operations cease. (Arrangements to cover expenses may include, but are not limited to, insolvency insurance or reinsurance, hold harmless arrangements, letters of credit, guarantees, net worth, restricted state reserves or State law provisions.)<br><br>☐ Attestation on your subordinated debt arrangements<br>o Note: The agreement must include the amount (whether it changes or not) and the account name under which the subordinate debt falls. (Subordinated debt is unsecured debt, which refers to any type of debt or general obligation that is not collateralized by a lien on specific assets of the borrower in the case of bankruptcy, liquidation or failure to meet the terms for repayment, whose repayment to its parent company or another lending entity ranks after all other debts have been paid when the subsidiary files for bankruptcy. It can also be defined as a loan that ranks below all other loans with regard to claims on assets or earnings).<br><br>☐ A copy of the applicant's most recent Insurance Protection table to summarize insurance or other arrangements for major types of loss and liability in accordance with 42 CFR §460.80. |

| Attestation Topic | Section # | Documents required to upload in HPMS |
|---|---|---|
| | | |

**Cottie Petrie-Norris**
ASSEMBLYWOMAN, SEVENTY-FOURTH DISTRICT

# Assembly Bill 1128

**Program of All-Inclusive Care for the Elderly (PACE) Administration**

## SUMMARY

This bill will help keep more seniors in their homes by streamlining the licensing for new or expanded Program for All-Inclusive Care for the Elderly (PACE) facilities. AB 1128 transfers, by January 1, 2021, the PACE clinical licensing functions from the Department of Public Health (DPH) to the Department of Health Care Services (DHCS), which currently administers all other PACE-related functions and issues.

## BACKGROUND

PACE is designed to provide care for California's frail population as an alternative to institutionalization. PACE programs coordinate and deliver preventive, primary, acute, and long-term care services to older adults who would otherwise be in nursing homes so they can continue to live in the community.

When PACE was established in California and recognized in the Welfare & Institutions Code in the 1980s (starting in Section 14591), it began as a federal program with 10 demonstration projects led by PACE operators (POs). Due to the success of the program, AB 574 (Lowenthal), Chapter 367, Statutes of 2011, increased the maximum number of organizations that could operate PACE programs from 10 to 15.

PACE is unique in that it is the only provider-based model of care where a single entity is entirely responsible for the delivery, outcomes, and cost of care. Eligible beneficiaries receive all of their services through one-stop-shop PACE centers, while still residing in their home and/or community. Participants are age 55 or older, certified by the state to qualify for nursing home care, able to be cared for safely in their community, and live in a PACE service area. Currently, there are 12 PACE programs operating in 42 sites across California, serving nearly 8,000 frail seniors.

## NEED FOR THE BILL

In 2016, the PACE Modernization Act Trailer Bill (Section 31-36 of Senate Bill (SB) 833, Chapter 30, Statutes of 2016) made updates to the program that included the removal of the cap on the total number of POs that operate in the state (previously capped at 15), and the allowance of for-profit entities to participate in the PACE program. These changes accelerated program growth.

As a result of these changes, DHCS responded to the increased interest in PACE by issuing a policy letter in August 2018 to clarify its review process for new/expansion PACE applications. One of the policy requirements specifies that a new or expansion PO will only be able to begin operations on either January 1 or July 1 of each year. According to DHCS, these two approval windows are intended to coincide with state budget and financial rate-setting development processes.

However, requiring new or expanded PACE program start dates of either January 1 or July 1 presents a problem for the clinical side of PACE programs. Because they provide medical services to beneficiaries as part of their care, PACE programs must obtain a community clinic license from DPH under a separate and lengthy process. According to CalPACE, the statewide association representing PACE programs, it can take between 12 and 18 months for DPH to review the PO's license application. This process is separate from DHCS' review process and inconsistent with DHCS' new policy of approving either January or July 1 program start dates of each year.

## SOLUTION

Moving the PACE licensing function from DPH to DHCS will have the administration of PACE under one department, DHCS, to facilitate program growth and access while saving the state from paying higher costs associated with nursing home settings for the specific population of seniors that PACE programs serve.

## SUPPORT

CalPACE (sponsor)

## OPPOSITION

None on file

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# PACE Modernization Act Amendments
# Budget Trailer Bill Language
# Fact Sheet
# Updated 1/30/19

**Proposal**

**Adopt budget trailer bill language to make adjustments to the Medi-Cal rate methodology for Programs of all-Inclusive Care for the Elderly (PACE) to recognize higher capital costs and higher risk associated with the PACE model versus other managed care models, and to require that rates be no lower than 90 percent of the amount the state would otherwise pay for existing programs and 95 percent for new organizations.**

**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.

Research shows that the PACE model achieves high levels of outcomes for the beneficiaries it serves, including low rates of hospitalization, delays in or avoidance of extended admissions to nursing facilities, extended longevity, high rates of participant satisfaction, and savings for the state and federal governments. Based on research by CalPACE, expenditures on PACE in 2017 were $23 million less than what would have otherwise been paid for their beneficiaries to be cared for outside of PACE.

The PACE Modernization Act (PMA), adopted in 2016, adopted several changes to update the state's oversight and payment of PACE organizations. The changes included moving the payment methodology from a fee-for-service based methodology to an experience-based rate methodology, under which payments are more closely tied to each organization's costs, similar to the methodology uses for Medi-Cal managed care plans. The new rate methodology went into effect beginning with calendar year 2018 rates.

**Reason for Proposal**

Despite the fact that the DHCS has adjusted the payment methodology it uses to pay managed care plans to make payments to PACE plans, the methodology does not address several unique costs and risks that PACE plans face. The rate methodology does not recognize that PACE organizations must make significant capital expenditures to develop, operate, expand, and upgrade PACE centers. It also doesn't recognize that PACE organizations face inherently greater risk and volatility associated with serving a small, but exclusively high need population. Administrative costs necessary for PACE organizations to phase in managed care reporting requirements such as reporting of encounters are also

not explicitly provided for in the methodology. The current methodology also removes provisions under the old methodology that required rates to be no lower than 95 percent of the amount the state would otherwise pay to care for comparable beneficiaries.

Finally, the rate methodology does not recognize that new PACE organizations face inherently higher costs than more mature organizations. Under the current methodology, the cost experience of mature PACE organizations is used to establish new PACE organizations' rates, which forces them to sustain heavy losses in their initial years of operation.

**Arguments in Support**

- The rate methodology changes will better address unique costs and risks borne by PACE organizations that differentiate it from traditional managed care. DHCS has pointed to the capital intensive nature of PACE as a factor that is limiting more rapid PACE expansion. The proposed changes will enable PACE organizations to maintain reasonable reserves to manage the increased risk and volatility associated with serving exclusively beneficiaries with higher needs.

- The changes will ensure greater rate stability for PACE organizations by establishing a floor for rates of 90 percent of the amount the state would otherwise pay for comparable beneficiaries for existing programs and 95 percent for new organizations.

**Proposed Changes**

1. Requires the PACE rate methodology to be developed in accordance with generally accepted actuarial rate development principles and to provide for all reasonable, appropriate, and attainable costs for each PACE organization within each region.
2. Requires the rate methodology to explicitly recognize and provide specific funding percentages in the non-medical load rating component to cover capital costs sufficient to allow PACE organizations to operate and update facilities, and for risk and contingency to recognize the inherent volatility and fewer enrollees over which to spread risk compared to other managed care models.
3. Requires two percentage points to be added to each PACE organization's allowable administrative expenditures to enable them to meet the administrative standards applied to other managed care models for the first three years of the application of the rate methodology.
4. Sets a floor for PACE rates at 90 percent of the upper payment limit or amount that would otherwise be paid (AWOP) for comparable beneficiaries, and requires a detailed development of the department's calculation to be disclosed to each PACE organization.
5. For the first three years in which a new PACE organization begins operations or an existing PACE organization enters a previously unserved area, requires the rates to be no less than 95 percent of the amount that would otherwise be paid (AWOP), to reflect the lower enrollment and higher operating costs associated with new PACE organizations relative to PACE organizations with higher enrollment and more experience in providing managed care interventions to their beneficiaries.

**Sponsor: CalPACE**

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# 2019 Cal MediConnect Stakeholder Process
# CalPACE Recommendations

**Please describe your policy proposal for Cal MediConnect**

PACE organizations provide comprehensive health care and long-term services and supports to low-income seniors who qualify to be in nursing homes, to enable them to remain in the community for as long as possible. PACE organizations currently provide and coordinate services through over 40 care centers providing services in 14 counties in the state. By carefully coordinating and integrating services, PACE reduces utilization of hospital and ER services and delays the onset of extended nursing home stays, as well as improving the longevity and quality of life of frail seniors.

CalPACE supports the goals of the Cal MediConnect program of improving the coordination and integration of care for California's dual eligible population. We appreciate in particular the steps the state has taken to include PACE in the Cal MediConnect enrollment materials and outreach as means of informing dual beneficiaries that PACE is an alternative enrollment choice, and would strongly urge that the option to be assessed and to enroll in PACE be maintained in any new enrollment efforts or initiatives. We also appreciate the state's recognition of the growing interest in and expansion of PACE as a managed care alternative for older beneficiaries with higher needs. We believe this is consistent with the overall goals of enrolling duals in integrated care plans and continue presenting programs that can improve outcomes and reduce costs.

We think there are other things the state could do to better connect beneficiaries with higher needs with PACE which would further these goals. Surveys show, for example, that the state's enrollment broker has limited awareness of PACE and is not referring people to it who can benefit from it, which could be addressed through additional training on PACE. The LTSS screening questions developed by DHCS and stakeholders do not contain screening questions that can identify beneficiaries who may qualify for and benefit from PACE, which could be another area of opportunity. Potential referral of beneficiaries to PACE in Cal MediConnect is further limited by restrictions on the use of agents and brokers by PACE and in fact, PACE is handicapped in its use of brokers relative to Medicare Advantage and Cal MediConnect plans. The result of these missed opportunities is that the neediest dual beneficiaries, who can benefit from PACE the most, are often not aware of it, which puts them at risk of

experiencing extended nursing home stays and needing extensive medical interventions, which ultimately costs the state and federal government more than if they had enrolled in PACE.

## Recommendations

1. We note that the proposed extension terms would impose a financial penalty on plans with high disenrollment rates. **We would recommend that transfers of beneficiaries from a Cal MediConnect plan to anther plan or program offering integrated care, including PACE, should be exempt from these penalties.** We think these types of transfers don't represent a failure of Cal MediConnect per se and in fact, may represent a better option for the affected beneficiaries. We think exempting these transfers from any penalty on the plans could also encourage plans and PACE to work together to jointly identify beneficiaries who are potentially eligible for PACE and, when appropriate, encourage their transfer to PACE.

2. As noted above, PACE organizations are disadvantaged relative to Medicare Advantage and Cal MediConnect plans in the use of brokers for referrals to PACE. There is additionally great confusion in the marketplace created by the use of brokers by multiple competing plan models. These factors limit the ability of PACE organizations to make beneficiaries aware of their programs. Medicare Advantage plans have historically been able to use independent brokers, subject to CMS guidelines. While Cal MediConnect plans were not allowed to use brokers during the initial years of the demonstration, recent CMS guidance now allows these plans to use independent brokers also, subject to CMS marketing guidelines. By contrast, PACE guidance strictly limits use of brokers by PACE organizations, by prohibiting PACE organizations from "contracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with the elderly to solicit enrollment." CMS' proposed PACE rule would put in place further restrictions by prohibiting "marketing by any individuals other than the employees of the PACE organization." **We recommend that as a means of levelling the playing field and increasing beneficiaries' awareness of PACE, DHCS and CMS provide flexibility by means of updated policy letters or use of PACE program waivers to allow PACE organizations to use independent brokers, subject to the same guidelines as apply to Medicare Advantage and Cal MediConnect plans.**

3. As noted above, secret shopper surveys of the enrollment broker and HICAP programs in California consistently show that consumers face a difficult time getting accurate and timely information about PACE when they contact these programs and in some cases, are not able to get any information. CalPACE has several times offered to conduct training for the enrollment broker staff but that offer has not been accepted by the state. While CalPACE did prepare a training guide on PACE in 2013, it is not clear that it has been widely utilized or referred to by enrollment broker staff in assisting beneficiaries with their enrollment choices. **We would strongly recommend, as a means of improving knowledge and awareness of PACE, that CalPACE and/or its members be allowed to conduct in-person training sessions with enrollment broker staff.**

4. DHCS has indicated that it has an interest in increasing enrollment in Cal MediConnect as a way of connecting more dual beneficiaries with models of integrated care. The current enrollment materials and outreach programs help do that by presenting PACE as an enrollment option and PACE has successfully shown that it can assess and enroll beneficiaries who are referred to PACE through this

process. Partly because of this process, awareness of and enrollment in PACE is growing, both in the CCI counties and non-CCI counties, and PACE has demonstrated its ability to achieve very high outcomes for beneficiaries who enroll in it. **For these reasons, we would strongly urge DHCS to continue to present beneficiaries with the option of being assessed for and enrolling in PACE in any new CCI or Cal MediConnect enrollment strategies or initiatives that it decides to undertake.**

### How will this proposal improve Cal MediConnect in a cost neutral way?

As noted above, PACE is a proven and highly effective integrated care program for older adults with higher needs. Expanding awareness of and opportunities to enroll in PACE via Cal MediConnect will enable the state and CMS to achieve their goals of enrolling more duals in models of integrated care that can improve outcomes and that are cost effective. Because PACE is paid using an experience based rate methodology, and because PACE rates have to be below the Amount that Would Otherwise be Paid (AWOP), there are savings to the state associated with increasing enrollment in PACE through our recommendations. We would note that the experience of managed care plans, including Cal MediConnect plans, is now factored into the calculation of the AWOP, indicating that PACE is cost-effective relative to managed care plans. The administrative costs of developing guidance or approving waivers to allow PACE to use brokers would be minimal and the costs of any training conducted for enrollment broker staff would be borne by PACE organizations.

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