Department of Health Care Services
Proposed Trailer Bill Language [608]

Modernization of the Program of All-Inclusive Care for the Elderly

FACT SHEET

Issue Title:
Legislative change is necessary to enable modernization of the Program for All-Inclusive Care for the Elderly (PACE) as current statute includes limitations which create barriers for the Department of Health Care Services (DHCS) to efficiently administer and oversee the program. The proposed legislative changes would ameliorate these limitations:

- Rate Setting: Standardizing rate-setting will allow DHCS to determine comparability of cost and experience between PACE and like population subsets served through Long-Term Services and Supports (LTSS) integration into managed care health plans under the Coordinated Care Initiative. Statutory change is necessary as DHCS is currently required to use a Fee-for-Service (FFS) equivalent cost/upper payment limit methodology to set capitation rates for PACE Organizations.
- Cap on the Number of PACE Organizations: Removal of existing statutory language that caps the number of PACE Organizations with which DHCS can contract.
- Not-for-Profit Requirement: Removal of existing statutory language to align with updated PACE federal rules and regulations.
- PACE Flexibilities: Addition of new statutory language enabling DHCS to seek flexibility from the Centers for Medicare and Medicaid Services (CMS) on several issues including the composition of the PACE interdisciplinary team (IDT), the frequency of IDT meetings, use of alternative care settings, use of community-based physicians, marketing practices, and development of a streamlined PACE waiver process.

Background:
PACE enrollment in the State is voluntary for Medi-Cal beneficiaries. Federal regulations (Title 42, Code of Federal Regulations, Section 460.162) specify that a PACE participant may voluntarily disenroll from the program without cause at any time. Participants must be at least 55 years old, live in the PACE organization's designated service area, be certified as eligible for nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment. The PACE program becomes the sole source of Medicare and Medi-Cal services for PACE participants.

The PACE model of care provides a comprehensive medical/social service delivery system using an IDT approach that provides and coordinates all needed preventive, primary, acute and LTSS. Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model affords eligible individuals to remain independent and in their homes for as long as possible. The PACE plan receives a monthly Medicaid and/or Medicare capitation payment for each enrolled participant and retains full risk for the cost of all Medicare and Medi-Cal services as well as any additional services determined necessary by the PACE IDT.

The PACE population is comprised predominantly of beneficiaries dually eligible for Medicare and Medi-Cal, and the Seniors and Persons with Disabilities (SPD) Medi-Cal only population. These populations have been transitioned to the Medi-Cal managed care delivery system over the past five years under California's Bridge to Reform Section 1115 Medicaid Waiver. As a result, the enrollment base for PACE Organizations has changed from a majority FFS population to a managed care population over the last four years.

Justification for the Change:
Rate Setting: The PACE FFS rate methodology does not take into account plan-specific experience and utilization when setting PACE rates. Pursuant to subdivision (e)(1) of Welfare and Institution (W&I) Code Section 14593, DHCS is required to "establish capitation rates paid to each PACE organization at no less than 95 percent of the FFS equivalent cost, including DHCS's cost of administration, that DHCS estimates would be payable for all services covered under the PACE Organization contract if all those services were to be furnished to Medi-Cal beneficiaries." However, there is an erosion of FFS data as Medi-Cal transitions to a managed care delivery system creating a fundamental issue with the current FFS equivalent PACE rate methodology DHCS is required to use to set rates. In December 2015, CMS issued guidance updating rate setting criteria for PACE Medicaid capitation rates. As part of this guidance, CMS has stated that new managed care rates must be based on data no older than three years. The current rate methodology needs to change to address any future data credibility issue(s) regardless of what type of new methodology is established.

Legislation is required to move away from the traditional FFS equivalent rate methodology to set capitation rates for the PACE Organizations and instead implement actuarially sound rates based on plan-specific cost, service utilization, quality and performance based measures utilized for other managed care health plan models contracting with DHCS. The FFS equivalent rate methodology specified in state statute is not in alignment with the plan-specific cost and experience-based rate methodology that is utilized for other managed care health plans contracting with DHCS. The scope of the rate methodology utilized for managed care health plans is defined in W&I Code Section 14301.1. A change to the current rate calculation methodology is necessary and alignment of rate methodologies between PACE and managed care health plans is appropriate. Standardizing rate-setting will allow DHCS to determine comparability of cost and experience between PACE and like population subsets served through managed care health plans that provide care to similar populations.

Cap on the Number of PACE Organizations: Removal of the existing cap on the number of PACE Organizations with which DHCS can contract, as proposed, will promote better alignment with DHCS's Strategic Plan initiative 2.1 to support integrated linkages between systems of care. Removing the PACE Organization cap will allow continuing expansion of PACE in California, which aligns with ongoing DHCS efforts to transition to a statewide managed care delivery system. Currently, there are eleven PACE Organizations that are in operation with three additional interested applicants.

To achieve this goal, a statutory change is necessary as DHCS is currently limited by subdivision (a)(2) of W&I Code Section 14593 to contracting with no more than 15 PACE Organizations (language removing the cap will be contingent upon federal approval of the experience-based rate methodology).

Not-for-Profit Requirement: Removal of the existing specification that DHCS enter into contracts only with nonprofit organizations for the purpose of implementing PACE aligns with recently released federal guidance permitting for-profit entities to apply as PACE Organizations. Removal of the nonprofit specification will also align with ongoing DHCS efforts to transition to a statewide managed care delivery system by further enabling continuing expansion of PACE in California.

To achieve this goal, a statutory change is necessary as DHCS is currently limited by subdivision (a)(1) of W&I Code Section 14593 to contracting with public or private "nonprofit" organizations for implementation of the PACE program. A related change in W&I Code Section 14592 that would modify the reference to federal law is intended to assure that an outdated federal regulation will not be a barrier to this clarification.

PACE Flexibilities: PACE continues to grow at a rate much faster than anticipated, expanding and evolving with the advent of newer health care delivery practices and methods, much unlike the rules governing PACE. Federal PACE regulations do not provide any flexibility in requirements of the composition of the PACE IDT and frequency of IDT meetings, use of alternative care settings, use of community-based physicians, marketing practices, and the PACE waiver process. The lack of flexibility in the PACE regulations hinders PACE Organizations from keeping up with current best practices and as a result disservices California participants that may benefit from newer methods. Enabling DHCS to seek flexibility in the federal PACE regulations allows for continued modernization of the program in addition to assisting PACE Organizations in their efforts to provide the highest quality of care to Californians.

Summary of Arguments in Support:
DHCS has been working with CalPACE (California Association of PACE organizations) to define the non-UPL methodology and there is general agreement on moving to a different rate method; however, the details of the methodology are still under discussion.

BCP or Estimate Issue # and Title: Estimate Base PC 114

Additional Information:
DHCS initiated an actuarial workgroup with PACE Organizations to define specific criteria for the new PACE rate-setting methodology. In order to project the fiscal impact of this proposal, DHCS trended actual Medi-Cal line of business cost experience and PACE member month information forward to CY 2016. The fiscal analysis indicates that transition to an actuarial, experience-based rate methodology is estimated to be budget neutral.

Removal of the cap on PACE Organizations is also estimated to be budget neutral as the transition to an experience-based rate methodology will allow for alignment with experience-based rate-setting used for other integrated managed care plan models serving like populations.

- There is no discernible fiscal impact on other state departments at this time.
- Additional state operations funding is not needed to change the rate methodology structure or carry out the proposal.