Date of Hearing: April 20, 2021

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 540 (Petrie-Norris) – As Introduced February 10, 2021

SUBJECT: Program of All-Inclusive Care for the Elderly.

SUMMARY: Requires a Program of All-Inclusive Care for the Elderly (PACE) plan to be presented as an enrollment option in the same manner as other Medi-Cal managed care (MCMC) plan options, included in all enrollment materials, enrollment assistance programs, and outreach programs, and made available to beneficiaries whenever enrollment choices and options are presented. Prohibits persons meeting the age qualifications for PACE and who choose PACE from being assigned to a MCMC plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not to be eligible for a PACE plan. Specifically, **this bill**:

1) Requires, in areas where a PACE plan is available, the PACE plan to be presented as an enrollment option in the same manner as other MCMC plan options, included in all enrollment materials, enrollment assistance programs, and outreach programs, and made available to beneficiaries whenever enrollment choices and options are presented.

2) Requires outreach and enrollment materials to enable beneficiaries to understand what PACE provides, that, if eligible, they may be assessed for PACE eligibility and enroll in PACE, and how they can receive additional information and request to be assessed for PACE eligibility.

3) Prohibits persons meeting the age qualifications for PACE and who choose PACE from being assigned to a MCMC plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not to be eligible for a PACE plan.

4) Requires persons enrolled in a PACE plan to receive all Medicare and Medi-Cal services from the PACE program pursuant to the three-way agreement between the PACE program, the Department of Health Care Services (DHCS), and the federal Centers for Medicare and Medicaid Services (CMS).

5) Requires DHCS, as part of the MCMC enrollment process for dual eligible beneficiaries, seniors, and persons with disabilities, to establish an auto-referral system to refer to PACE organizations beneficiaries who appear to be eligible for PACE based on age, residence, and prior use of services.

6) Prohibits persons meeting the age qualifications for PACE who are auto referred to PACE from being assigned to a MCMC plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not be eligible for a PACE plan.

7) Requires health plan risk stratification and health risk assessment processes completed by MCMC plans to include criteria to identify and refer to PACE beneficiaries who appear to be eligible for PACE based on age, condition, functional impairment, and use of services.

8) Requires, in areas where a PACE plan is available, PACE to be identified and presented as a Medicare plan option in any mailings or notices to beneficiaries dually eligible for Medicare

and Medi-Cal regarding their options to enroll in a Medicare plan and to provide information about how they can receive additional information and be assessed for PACE eligibility.

EXISTING LAW:

1) Requires, subject to approval by CMS of a Medicaid State Plan amendment electing PACE as a state Medicaid option, PACE program services to be a covered benefit of the Medi-Cal program, subject to utilization controls and eligibility criteria that require that the beneficiary be certifiable for nursing facility services based on Medi-Cal criteria.

2) Requires the Director of DHCS to establish the 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 CMS, DHCS, and PACE organizations, meeting the requirements of the federal Balanced Budget Act of 1997 (Public Law 105-33) and any other applicable law or regulation.

3) Permits DHCS to enter into contracts with public or private organizations for implementation of the PACE program.

4) Requires, in the seven counties where the CalMediConnect (CMC) option is available (a CMC plan that integrates Medicare and Medi-Cal benefits) for individuals dually eligible for Medicare and Medi-Cal, the PACE plan to be presented as an enrollment option, included in all enrollment materials, enrollment assistance programs, and outreach programs related to the demonstration project, and made available to beneficiaries whenever enrollment choices and options are presented, in areas where a PACE plan is available.

5) Requires, in CMC counties, person meeting the age qualifications for PACE and who choose PACE to remain in the fee-for-service (FFS) Medi-Cal and Medicare programs, and not be assigned to a managed care health plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not to be eligible for a PACE plan.

6) Requires, in CMC counties, persons enrolled in a PACE plan to receive all Medicare and Medi-Cal services from the PACE program pursuant to the three-way agreement between the PACE program, DHCS, and CMS.

7) Requires DHCS or its enrollment contractors, except in counties with county organized health systems (COHS), to notify a beneficiary who is required to receive Medi-Cal long-term care services and supports through a MCMC plan and who is potentially eligible for PACE that they may alternatively request to be assessed for eligibility for PACE, and, if eligible, may enroll in PACE.

8) Prohibits DHCS or its enrollment contractor from enrolling enroll a beneficiary who requests to be assessed for PACE in a MCMC plan until the earlier of 60 days or the time that they are assessed and determined to be ineligible for a PACE plan, unless the beneficiary subsequently chooses to enroll in a MCMC plan. Requires, during the time that the beneficiary is being assessed, they are to remain in FFS Medi-Cal, or, if applicable, the MCMC plan in which they are enrolled.

9) Requires, in areas specified by the director for expansion of the MCMC program under particular MCMC plan models where DHCS is contracting with a prepaid health plan that is

contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority, a Medi-Cal applicant or beneficiary to be informed of the health care options available regarding methods of receiving Medi-Cal benefits. (This process is referred to as the "Health Care Options" process.)

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, PACE allows older adults to remain in their home and near their loved ones, while still guaranteeing their wellbeing and safety as they age. This bill will help more seniors remain in their homes and communities by improving beneficiary awareness of and access to the PACE. This author concludes this bill is a common sense measure that ensures seniors have access to all their options, including PACE, when choosing a plan that is best for them.

2) **PACE**. PACE is a capitated benefit provided primarily to certain Medi-Cal and Medicare beneficiaries that offers a comprehensive service delivery system that integrates Medicare and Medicaid financing. The program was modeled after the acute and long-term care services of On Lok Senior Health Services in San Francisco. To be eligible for PACE, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment. Enrollment in PACE is voluntary. An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services). The PACE service package must include all Medicare and Medicaid covered services and other services determined necessary by the interdisciplinary team for the care of the PACE participant. PACE plans assume full financial risk for participants' care without limits on amount, duration, or scope of services. DHCS has 19 contracts with PACE organizations for risk-based capitated lifetime care for the frail elderly. PACE rates are developed using actuarial principles, including actual experience of the PACE population. The DHCS Budget assumes PACE expenditures of $803.2 million ($401.6 million General Fund) in 2020-21 and $948.4 million ($474.2 million General Fund) in 2021-22. PACE is projected to have an average monthly enrollment of 11,380 in 2020-21 increasing to 13,062 in 2021-22. The PACE organizations, counties and operational dates (as shown in the DHCS Medi-Cal Estimate) is shown below:

PACE Organization	County	Operational
On Lok Lifeways	San Francisco	November 1, 1983
	Alameda	July 1, 2002
	Santa Clara	January 1, 2009
Centers for Elders' Independence	Alameda	June 1, 1992
	Contra Costa	June 1, 1992
Sutter Senior Care	Sacramento	August 1, 1992
AltaMed Senior BuenaCare	Los Angeles	January 1, 1996
	Orange	July 1, 2021
St. Paul's PACE	San Diego	February 1, 2008
Los Angeles Jewish Home (Brandman)	Los Angeles	February 1, 2013
CalOptima PACE	Orange	September 1, 2013

PACE Organization	County	Operational
InnovAge	San Bernardino	April 1, 2014
	Riverside	April 1, 2014
Innovative Integrated Health	Fresno	August 1, 2014
	Kern	January 1, 2020
	Tulare	January 1, 2020
	Orange	July 1, 2021
Redwood Coast	Humboldt	September 1, 2014
San Ysidro	San Diego	April 1, 2015
Stockton PACE	San Joaquin	January 1, 2019
	Stanislaus	January 1, 2019
Gary & Mary West	San Diego	July 1, 2019
Family Health Centers of San Diego	San Diego	July 1, 2019
Pacific PACE	Los Angeles	July 1, 2019
Sequoia	Fresno	July 1, 2020
	Kings	July 1, 2020
	Madera	July 1, 2020
	Tulare	July 1, 2020
InnovAge – Sacramento	Sacramento	July 1, 2020
	Placer	July 1, 2020
	Sutter	July 1, 2020
	Yuba	July 1, 2020
	El Dorado	July 1, 2020
	San Joaquin	July 1, 2020
LA Coast	Los Angeles	January 1, 2020
Central Valley	San Joaquin	July 1, 2020
	Stanislaus	July 1, 2020
North East Medical Services (NEMS)	San Francisco	January 1, 2021
Neighborhood Health	Riverside	July 1, 2021
	San Bernardino	July 1, 2021

3) **MCMC PLAN ENROLLMENT PROCESS**. In counties with a choice of MCMC plans, beneficiaries must choose a MCMC plan within 30 days. The choice process involves a Health Care Options process through Maximus, DHCS' contracted enrollment vendor. If a beneficiary does not choose a plan within 30 days, they are defaulted into a MCMC plan.

   In COHS counties, there is not a choice process as beneficiaries are automatically assigned to the COHS plan effective the following month, with a cut-off date at the end of the month that varies from month-to-month that would result in the person being enrolled the following month. Maximus only provides services in non-COHS counties. In Coordinated Care Initiative (CCI) counties only, DHCS includes PACE on the choice form for zip codes where PACE operates, as well as includes PACE information in the Enrollment Packet, the CCI Resource Guide, and Maximus links to PACE from the Health Care Options website. If a beneficiary chooses PACE on the choice form in CCI counties, Maximus sends that choice information to PACE. PACE reviews for eligibility and then processes the enrollment through a direct enrollment file submitted to DHCS. If PACE finds the beneficiary meets PACE eligibility criteria, Maximus then receives that enrollment information on a normal

daily file that they receive from Medi-Cal Eligibility Data System for all beneficiaries in all plans including PACE. Maximus then updates their enrollment system to record that the beneficiary is enrolled in PACE.

In COHS counties, DHCS indicates it does not commission or require a form to be presented to beneficiaries regarding PACE options. PACE plans are responsible for marketing to advertise their availability as a specialty health plan option in COHS counties.

4) **CALIFORNIA ACCESSING AND INNOVATING MEDI-CAL (CALAIM).** DHCS' CalAIM trailer bill language (TBL) contains similar language to this bill on information on PACE enrollment. The TBL requires, in areas where a PACE plan is available:

   a) PACE to be presented as an enrollment option, included in all enrollment materials, enrollment assistance programs, and outreach programs, and made available to applicable beneficiaries whenever enrollment choices and options are presented;

   b) Persons meeting the age qualifications for PACE and who choose PACE are required to remain in the FFS Medi-Cal and Medicare programs, and are prohibited from being assigned to a MCMC plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not to be eligible for a PACE plan; and,

   c) Persons enrolled in a PACE plan are required to receive all Medicare and Medi-Cal services from the PACE program pursuant to the three-way agreement between the PACE program, DHCS, and the federal CMS.

5) **SUPPORT.** This bill is sponsored by CalPACE to help more seniors remain in their homes and communities by improving beneficiary awareness of and access to PACE. CalPACE states that, even though PACE is a model of care for seniors, many benefactors are unaware of PACE and how it may benefit them. Many seniors with higher needs could benefit from direct state engagement and referrals for PACE services. CalPACE argues this bill would improve beneficiary awareness and access to PACE by requiring: a) PACE to be offered as a Medi-Cal plan choice; b) PACE to be identified as a Medicare plan choice and included in all enrollment materials and information;, c) the DHCS services to establish an auto referral process to referral beneficiaries to PACE; d) assessment processes to include criteria to identify and provide for referral to PACE and, e) continuity of enrollment by exempting Medi-Cal beneficiaries who enrolled in PACE from mandatory or passive enrollment Medi-Cal managed care.

6) **DOUBLE REFERRAL.** This bill was heard in the Assembly Aging and Long-Term Care Committee on April 6, 2021 and passed on a 7-0 vote.

7) **RELATED LEGISLATION.** AB 523 (Nazarian) would require DHCS to make permanent the changes in PACE that DHCS instituted, on or before January 1, 2021, in response to the state of emergency caused by the 2019 novel coronavirus (COVID-19) by means of all-facility letters, or other similar instructions, which were taken without regulatory action. These would include telehealth, enrollment agreements, Adult Day Health Care Services provided in a beneficiary's home, involuntary disenrollments for being out of the service area, facility beds, marketing and discharge planning. AB 523 passed the Assembly Aging and Long-Term Care Committee on April 6, 2021 on a 6-0 vote.

8) **PREVIOUS LEGISLATION.** AB 2492 (Choi) would have required DHCS to authorize a PACE center to provide PACE services for the maximum number of individuals for which the PACE center is eligible to provide PACE services. Would have required DHCS' authorization to be in writing and to provide detailed reasons for the specific maximum number of individuals for which the PACE center is eligible to provide PACE services. Due to the shortened Legislative calendar brought on by the COVID-19 pandemic, this bill was not set for a hearing.

9) **PROPOSED AMENDMENTS.** Following discussions between the author's office, sponsor and, committee staff, the author is proposing to amend this bill to limit the prohibition on being assigned to a MCMC plan for the lessor of 60 days or until the person has been assessed for PACE eligibility to those individual who indicate an interest in being assessed for PACE eligibility and to areas of the state where there is a managed care plan options process. In addition, the proposed amendments differentiate how the outreach process would be conducted by whether there is a plan enrollment process for the county. Last, the author is proposing amendments to delete the requirement that MCMC plans (based on the risk stratification and health risk assessment) *refer* beneficiaries to PACE based on age, condition, function impairment, and use of services. Instead, the language would require MCMC plans to provide the person (who meets age, condition, functional impairment and use of service criteria) with the option to be assessed for PACE.

REGISTERED SUPPORT / OPPOSITION:

Support

CalPACE (sponsor)
AARP
Alta Med
Alzheimer's Greater Los Angeles
Alzheimer's Orange County
Alzheimer's San Diego
California Alliance for Retired Americans
California Association of Long Term Care Medicine
California Association of Public Authorities for IHSS
California Commission on Aging
Center for Elders Independence
Golden Valley Health Centers
Innovage
Innovative Integrated Health Inc.
LeadingAge California
On Lok Senior Health Services
San Ysidro Health
Welbehealth
Western Center on Law & Poverty, Inc

Opposition

None on file.

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