Date of Hearing: April 8, 2026

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 1672 (Solache) – As Amended March 26, 2026

Policy Committee: Health Vote: 16 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill requires the Department of Health Care Services (DHCS) to negotiate with a Program of All-Inclusive Care for the Elderly (PACE) to develop capitation rates for care of dually enrolled Medi-Cal and Medicare beneficiaries. The bill also establishes rules and timelines in the rate development process.

FISCAL EFFECT:

Costs of an unknown, but likely minor and absorbable, amount for DHCS to increase communication to enable negotiation with the existing 40 PACE organizations. DHCS had not provided a fiscal estimate when this analysis was prepared.

COMMENTS:

1) **Purpose.** This bill is sponsored by the California PACE Association (CalPACE). According to the author:

> PACE organizations provide comprehensive care to our older residents, who deserve our best efforts to ensure their well-being. [This bill] seeks to establish clear, reasonable expectations for transparency and meaningful engagement in PACE rate development. This improved transparency supports responsible planning, program stability, and continued access to care for vulnerable older adults.

2) **Background.** ***PACE.*** The PACE program is a benefit that offers a comprehensive service delivery system, primarily to certain dually eligible Medi-Cal and Medicare beneficiaries. PACE is designed to provide preventive, primary, acute, and long-term care services to older individuals with significant health needs, to enable them to continue living in the community and avoid hospitalization and skilled nursing facility (SNF) services. A PACE organization enters a three-way contract with DHCS and the federal Centers for Medicare and Medicaid Services (CMS) to deliver all Medicare and Medicaid services. According to CalPACE, PACE programs serve over 30,000 participants in 28 counties across California.

   The number of PACE organizations has grown dramatically in recent years, with over 20 new PACE organizations commencing operations between July 2025 and January 2027. DHCS's November 2025 Local Assistance Estimate assumes PACE expenditures of $2.4

billion ($1.3 billion General Fund) in 2025-26 and $3.3 billion ($1.7 billion General Fund) in 2026-27. Because of this rapid growth, DHCS instituted a moratorium on applications for new PACE organizations on November 17, 2025.

Rate-Setting for PACE. Federal regulations require the monthly capitation amount to be negotiated between the PACE organization and state Medicaid agency (DHCS). PACE rates must be less than the "amount that would have otherwise been paid" (AWOP) under the Medicaid state plan if the individual was not enrolled in PACE. PACE rates also take into account comparative frailty of participants.

DHCS states it develops actuarial rate ranges that apply to each PACE organization, in accordance with generally accepted actuarial principles and practices, and using an experience-based rate approach that leverages PACE organizations' historical cost experience to project reasonable, appropriate, and attainable future costs. DHCS selects and pays each PACE organization capitation rates within the actuarial rate ranges. Beginning January 1, 2027, DHCS will cap payments to PACE organizations such that actual payment rates are not less than the lower bound and not greater than the midpoint.

PACE Organizations' Complaints about Current Process. According to CalPACE, when final rates are released, PACE organizations are asked to comment on the prospective rates without access to the underlying data, assumptions, or calculations used to develop those rates. Without visibility into the actual data and methodologies used, PACE organizations argue providers are unable to meaningfully assess or respond to proposed rates. CalPACE also points out the rate-setting process creates significant operational uncertainty, making it difficult to responsibly plan for staffing, services, and growth when they do not understand how rates are calculated or why rates change from year to year.

3) **Prior Legislation.** SB 833 (Committee on Budget and Fiscal Review), Chapter 30, Statutes of 2016, modified the rate setting methodology for PACE by using the rate-setting methodology used for managed care organizations while addressing unique features of PACE programs and high cost treatments, among other changes regarding PACE payment rates; eliminated the cap on the number of PACE programs; clarified that PACE programs may be for-profit organizations; and authorized DHCS to seek federal approval to allow for administrative flexibilities within the operations of PACE programs.

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