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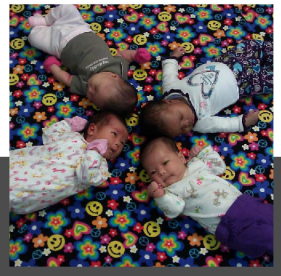
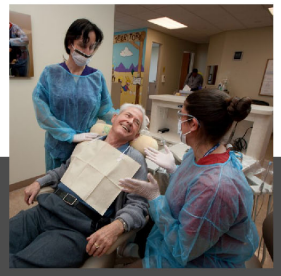
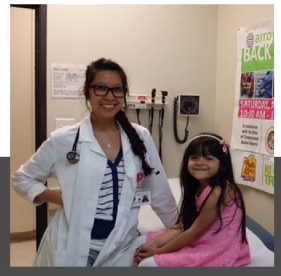


America's Voice for Community Health Care

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America's Voice for Community Health Care

The NACHC Mission

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

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Is PACE in Your Health Center's Future of Caring for Aging Populations

Tuesday May 3, 2021

1pm-2pm EDT

@NACHC

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TODAY'S GOALS

- Understand of the national landscape of the PACE program
  - Current legislative environment
  - PACE 2.0 and Growth Outlook
  - Impact of COVID-19 on PACE
- Understand how a PACE Program Operates Locally
  - Piedmont Health SeniorCare (Chapel Hill, NC)
- Understand how COVID-19 impacted PACE nationally

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TODAY'S SPEAKERS

Anita McClendon
VP, Data Management and Business Intelligence
National PACE Association
AnitaM@npaonline.org

Anita Gibson
Sr Director, Project Management and Policy Communications
National PACE Association
AnitaG@npaonline.org

Marianne Ratcliffe
Executive Director, Piedmont Health SeniorCare
RatclifM@piedmonthealth.org

Jason Patnosh (moderator)
Associate VP, Development and Innovation
Natl. Assoc. of Community Health Centers
Jpatnosh@nachc.org

@NACHC

PACE Growth

PACE 2.0

Presented to NACHC on May 4, 2021

The PACE 2.0 Initiative is supported by: The John A. Hartford Foundation, West Health, and The Harry and Jeanette Weinberg Foundation

Support. Innovate. Lead.

Programs for All-Inclusive Care for the Elderly (PACE)

- Snapshot of PACE
- Current Legislative Environment
- PACE 2.0 Initiative & PACE Growth

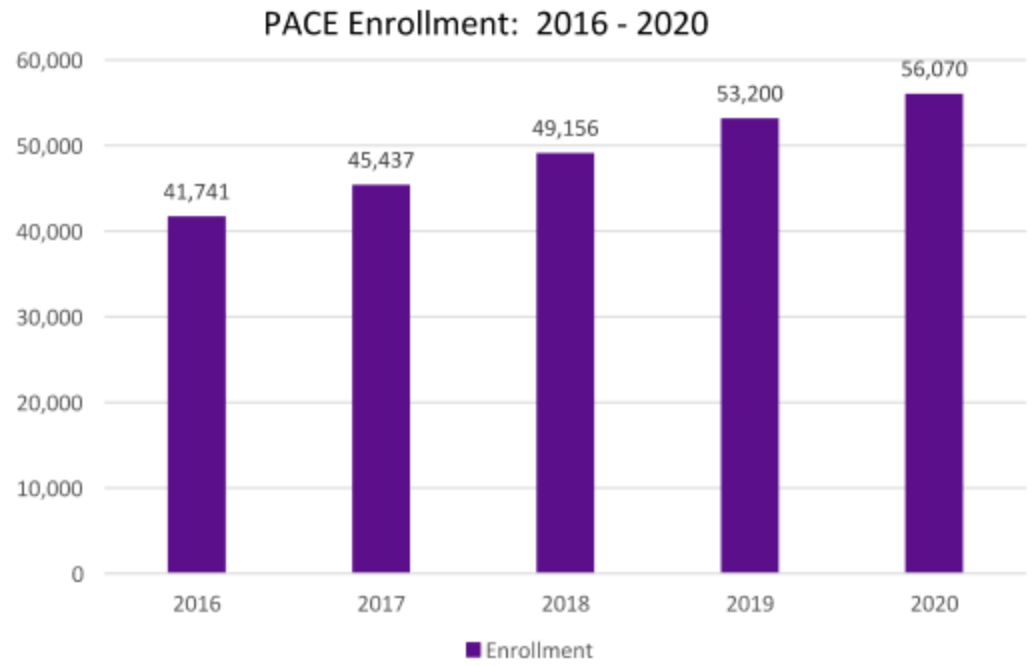
Snapshot of PACE

Who Does PACE Serve?

- 55 and older
- At nursing home level of care
- Able to live in the community at the time of enrollment – with support of PACE
- Live in PACE service area
- 90% Dual-Eligibles
  - All Medicare benefits
  - All Medicaid benefits
  - Capitated Monthly Rate

NATIONAL PACE ASSOCIATION

National Overview



138 Organizations

268 Centers

31 States

CHC Sponsored PACE Organizations

PACE Organization	City	State
Altamed	Los Angeles	CA
Central Valley PACE	Modesto	CA
Family Health Center for Older Adults	San Diego	CA
Northeast Medical Services	San Francisco	CA
San Diego PACE/San Ysidro Health	San Diego	CA
Element Care*	Lynn	MA
Harbor Health Elder Service Plan	Dorchester	MA

PACE Organization	City	State
Neighborhood PACE	East Boston	MA
Uphams PACE	Boston	MA
Piedmont Health SeniorCare	Carrboro	NC
PACE of Southern Piedmont*	Charlotte	NC
Senior Total Life Care*	Gastonia	NC
International Community Health Services	Seattle	WA

*Joint venture between a community health center and another organization (e.g. AAA, LTSS)

Current Legislative Environment

The American Rescue Plan (P.L. 117-2)

- Passed in House and Senate
- Signed by President Biden
- Enhanced 10% federal match for HCBS, incl. PACE
- For increased or expanded services
- One year (4/1/21 – 3/31/22)
- CMS yet to issue guidance to states

HCBS: Home and Community Based Services

The PACE Plus Act, S. 1162

- Expanding access and affordability
  - Grants for rural and medically underserved areas
  - Medicare beneficiary access in states without PACE
  - Health status adjusted rates for Medicare-only
  - State option to expand eligibility
- Reducing administrative barriers
  - Grants for state administering agencies
  - Continuous enrollment throughout the month
  - Expedited application reviews
  - CMS coordinated oversight (FCHCO)
- PACE Pilots

The Ensuring Parity in MA and PACE for Audio-only Telehealth Act, H.R. 2166/S. 150

- Senate sponsors
  - Catherine Cortez Masto (D-NV)
  - Tim Scott (R-SC)
- House sponsors
  - Terri Sewell (D-AL7)
  - Gus Bilirakis (R-FL12)
- Requires acceptance of audio-only telehealth encounters for risk adjustment purposes in 2020 and 2021
- Guardrails
  - Diagnoses must relate to a chronic disease/condition
  - Provider must have treated participant within the last 3 years

PACE Part D Choice – Coming Soon

Champions

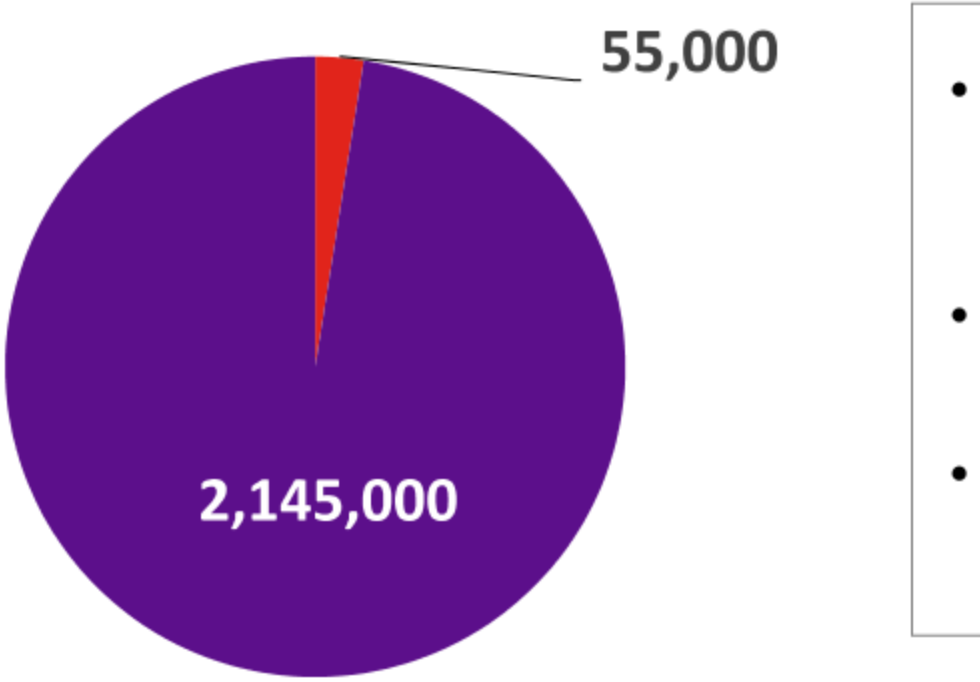
- Senate
  - Tom Carper (D-DE)
  - Pat Toomey (R-PA)
- House
  - Earl Blumenauer (D-OR3)
  - Jackie Walorski (R-IN2)

Overview

- Medicare-only option
- Standalone Part D plan
- PACE and Part D plan coordination requirements
- PACE Part D premiums are 20x more costly ($843.88 x month v $41 x month)

PACE 2.0 Initiative & PACE Growth

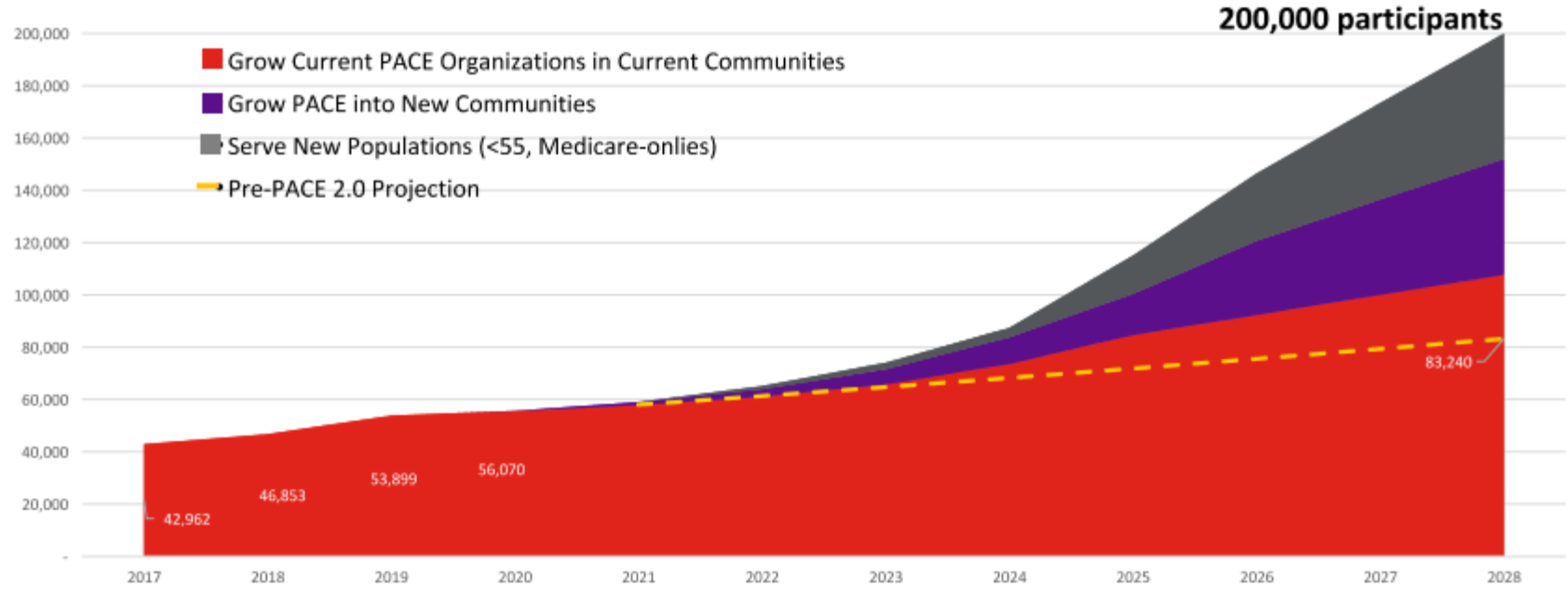
PACE Growth Needed



- **2.2M** - Number of low income, older adults, needing LTSS
- **~55K** - Number of older adults PACE serves
- **14%** - Percent of the 55K served by CHC/PACE

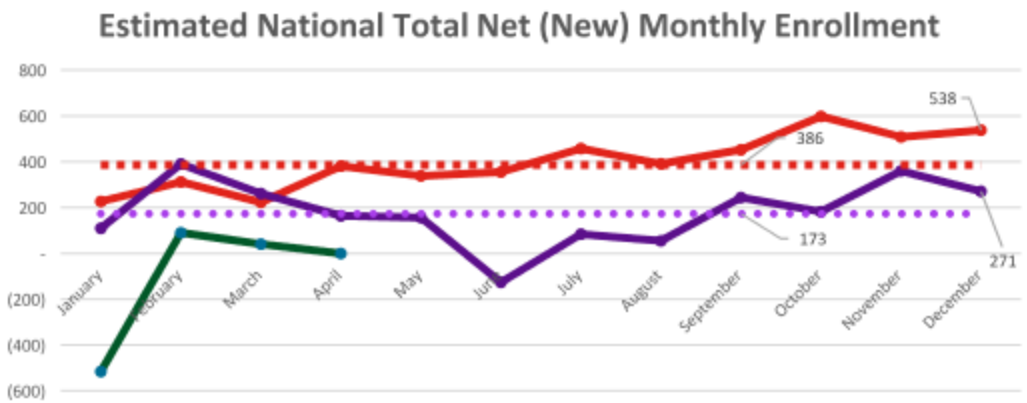
LTSS: Long-term services and supports; CHC: Community Healthcare Centers

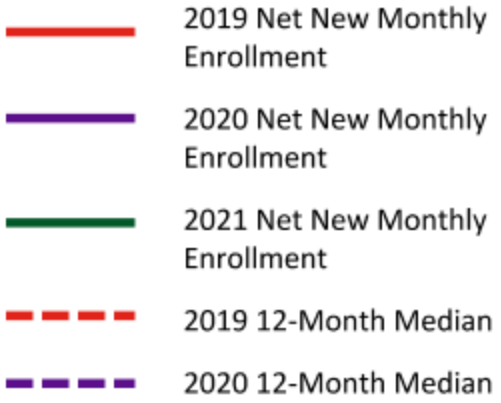
PACE 2.0 Initiative: 200,000 Enrollees by 2028



Supported by grants from The John A. Harford Foundation, West Health, and The Harry and Jeanette Weinberg Foundation

PACE Enrollment During COVID-19 PHE



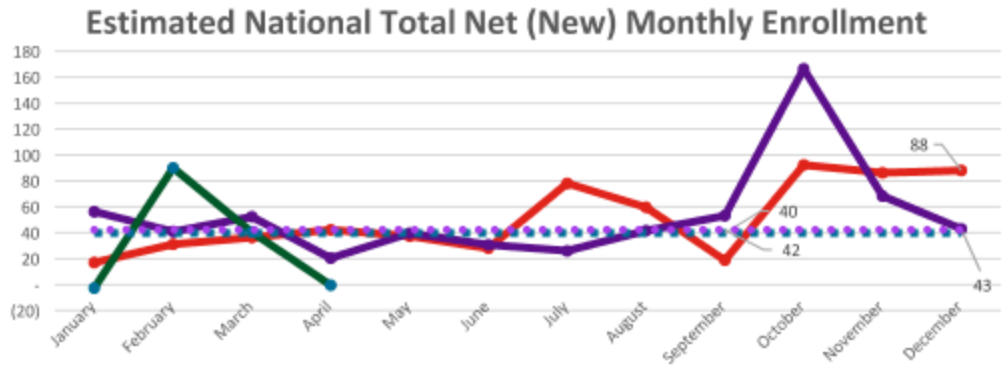


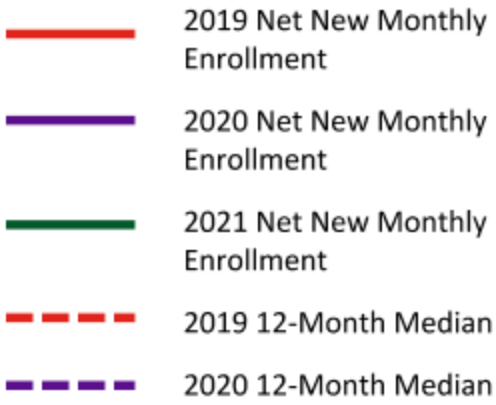
Estimated National Net Change in Monthly Enrollment												
Year	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
2019	227	312	223	381	338	355	458	391	452	598	508	538
2020	110	391	261	164	157	(126)	84	55	244	182	360	271
2021	(516)	90	40	(0)								

Data Sources:

- NPA analysis based on:
  - CMS monthly Medicare enrollment data
  - Self-reported annual Medicaid-only census percentages

CHC/PACE Growth During COVID-19 PHE





Estimated National Net Change in Monthly Enrollment												
Year	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
2019	17	31	36	42	37	28	78	60	19	92	86	88
2020	56	41	52	20	40	31	26	42	53	166	68	43
2021	(3)	90	40	(0)								

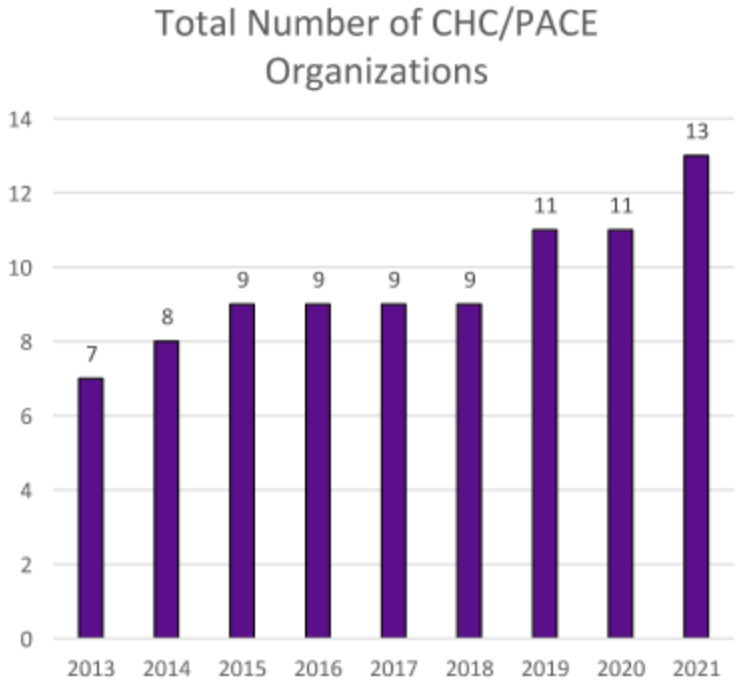
Data Sources:

- CMS monthly Medicare enrollment data
- Self-reported annual Medicaid-only census percentages

Note:

- Two new programs began enrolling in Q4 2019
- One new program contract in 2021 has not begun enrolling and one new program began enrolling in Q1 2021

CHC Are PACE Leaders



- Some CHC/PACE are leaders in:
  - Serving the largest number older adults in PACE
  - Growing PACE
  - Innovation

KEY TAKEAWAYS

- *Health centers are a pillar of PACE 2.0 and key partners to the program's growth*

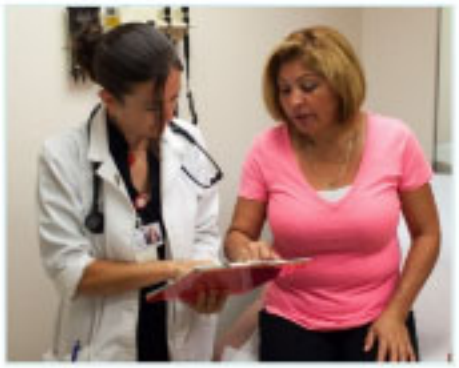
- *Several pieces of legislation could help to enhance, grow, and offer new opportunities for health centers*

Transition to Piedmont slides







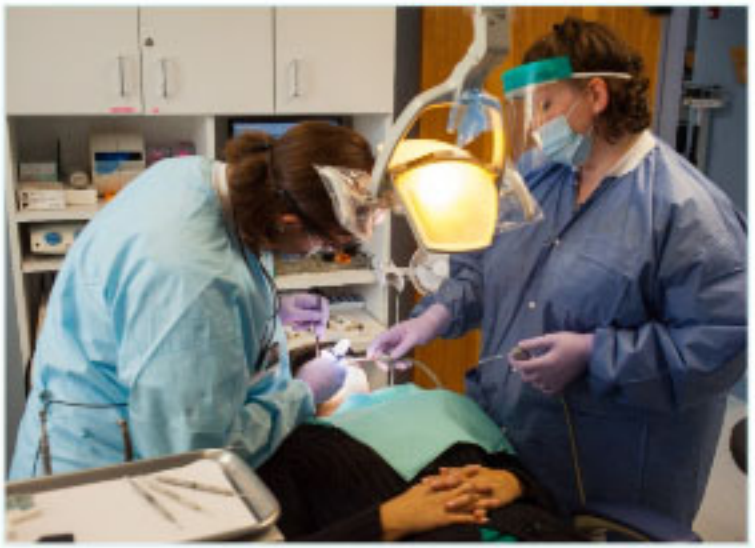
Welcome to Piedmont Health

Our Mission

We are driven every day by our belief that **all people deserve access to timely, high-quality, and affordable health care, regardless of their circumstance**.

We serve people of all ages and from all walks of life, and we want each person to feel comfortable and confident in their health care team.

We value our relationships with those we serve, and are proud and honored to be both **serving the 5th generation of some families,** while also **welcoming thousands of newcomers each year**.



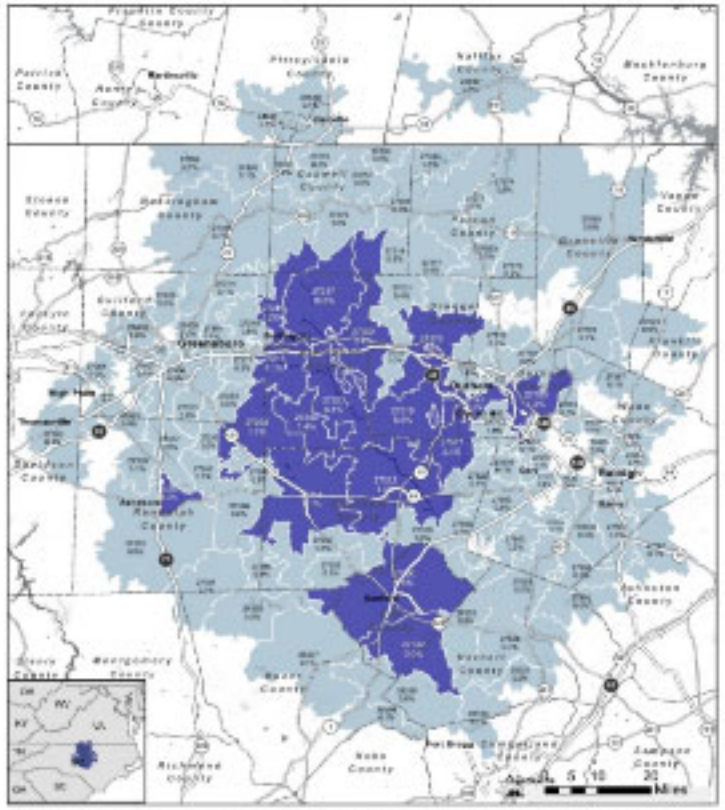
Our Impact

Piedmont Health Partners

From humble beginnings, Piedmont Health has grown into an organization making a regional impact on health care access and health disparities in North Carolina.

We now operate **ten community health centers** and **two adult day health centers** with a staff of more than 500 health professionals.

Our high-quality primary care medical home model is recognized by **The Joint Commission** and the **National Committee for Quality Assurance**.



shading represents where 75% of Piedmont Health patients hail from

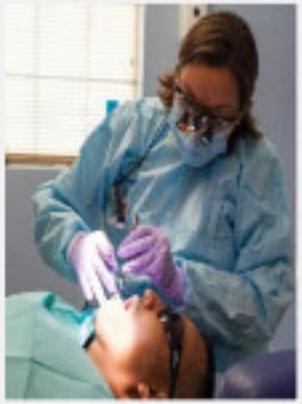
shading represents where the remainder of Piedmont Health patients hail from

The Piedmont Health service area is more than 3400 square miles – larger than the state of Delaware.

Community Health Centers Core Services

Medical

Medical teams provide full-spectrum primary care to people of all ages, including check-ups, prenatal care and family planning, sick care, and chronic illness management including medical nutrition support.



Dental

Six dental practices provide dental services for children and adults, including cleanings, sealants, fillings and extractions, and prosthodontic services, with onsite x-ray.

Primary Care Behavioral Health

Licensed behavioral health care consultants are a part of our clinical care teams and address the emotional health, substance use, and chronic illness management concerns of patients as they are identified.

Care Support

Care managers, language interpreters, WIC, outreach, eligibility and referral staff ensure whole-person, coordinated care both within Piedmont Health and with the larger health care system.

Pharmacy

Eight on-site pharmacies ensure access to medication for our patients, offering a consistent, comprehensive formulary of affordable medications.

PACE Core Services

Healthcare

PACE participants receive all medically necessary care, including primary medical, dental and specialty care, medication and durable medical equipment, and hospitalization and skilled nursing placement as needed.

Rehabilitation

Physical, occupational, and speech therapy services according to the individual care plan are delivered at the PACE Center.

Home care

Participants receive assistance with home care needs as needed.

Home away from Home

PACE Centers provide participants with meals and social activities in addition to clinical services.

Transportation

Medical transportation to our PACE centers and community providers is offered to all participants.

PACE vs FQHC

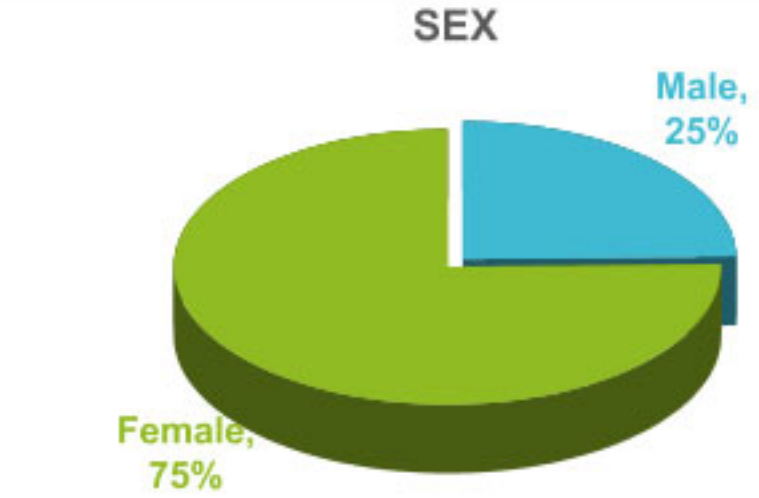
- Both work with limited funds, but PACE is responsible for more services.
- Both operate where there is a need, but PACE requires a feasibility study.
- Both monitor and report on quality and demographics, but PACE also monitors and reports on utilization of services.

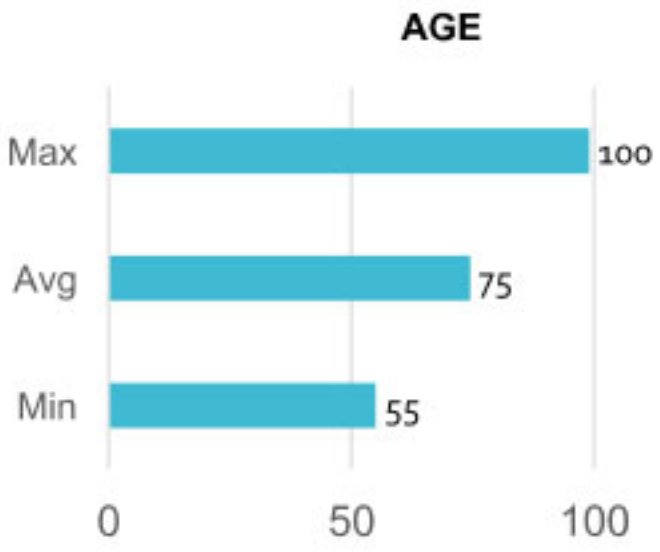
- Capitated vs Fee for service

PACE Development

- 2004 – NC General Assembly approved 2 pilot PACE sites, one of which was PHS
- Sept 2006 – 1 of 15 CMS Rural PACE grants
- Dec 2008 – 1st site (Burlington) opened
- Jan 2014 – 2nd site (Pittsboro) opened
- Census 5/1/21: 304
- >800 served

PHSC Demographics





Willie, 72 yrs

Participant Profile

- Avg. risk score 2.6 (B) and 2.7 (P)
  - Multiple chronic diseases & co-morbidities
- Additional risk factors:
  - Caregiver support
  - Compliance – medication & other
  - Housing and environmental issues
  - Substance abuse & behavioral health

Participant Profile

Average of 8 diagnoses – e.g:

- Heart Disease: 58%
- Chronic Renal Disease: 42%
- Chronic Lung: 26%
- Diabetes: 53%
- Depression: 45%
- Stroke: 28%
- BMI>=40: 11%
- Cognitive Impairment: 41%
- Smoker: 19%
- High risk of falling (per PT): 42%

- Average 4 ADLs limitations & 4 IADLs
- 40% choose DNR
- Deaths: Home 62%, SNF 8%, Hospice Home 15%, and Hospital 15%

Performance Indicators

- ER
- hospitalizations
- Readmissions
- SNF placements
- Falls
- Infections
- Wounds/pressure ulcers
- Diabetes HbA1c <= 9
- Advanced directives
- Level of function (ADLs)
- Depression (GDS)
- Cognitive function (SLUMS)
- Disenrollment & Enrollment rates
- Caregiver and participant satisfaction
- Health plan compliance
- Risk Score
- Claims adjudication

How We Started

- Piedmont's highest risk patients were seniors whose needs could not be met in 20 min encounter. Staff and board began exploring alternative models
- Educated ourselves & Board ~1 year
- Joined National PACE Association
- Developed a timeline and critical decision points.
  - Market analysis show that there are enough dually-eligible people in the service area?
  - Feasibility study & proforma?
  - Partners to help with the Capital outlay and the operational start-up cost?
  - What is the risk to our existing organization? How can it be mitigated?
  - How can we refer within our existing organization to leverage existing resources?

Break even – Year 2

Years in Operation	census	revenue	expenses	net revenues
ØSTART UP			579,753	-579,753
ØYEAR ONE	4	1,447,244	1,809,971	-362,727
ØYEAR TWO	59	3,866,295	3,175,402	690,893
ØYEAR THREE	88	5,839,741	4,754,505	1,085,236
ØYEAR FOUR	117	7,199,661	6,790,510	409,151
ØYEAR FIVE	126	8,310,237	8,322,702	-12,465

ØThe census is the average for the year.
ØExcludes Capital Outlay of $2,400,000 for the facility and $350,000 for vehicles.
ØYear Five was the startup year for our Second site.

Capitation 2020

PMPM	PMPM
Avg revenue	$ 6,877
Avg expenses	$ 6,140
Net	$ 737

~4,100 MM / year

Revenue	$26,422,560	
Expenses	$23,183,068	


Thank you!!

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KEY TAKEAWAYS

- *Know your state requirements for going forward with PACE (i.e., legislation needed, state Medicaid office support, etc).*
- *While health centers and PACE both monitor/report on quality indicators and demographics—PACE must also monitor/report on utilization of services.*
- *Be ready for an all-hands on deck education and information sharing of administration, providers, and the Board.*

Transition to NPA-COVID 19 Impact Slides

PACE COVID-19 DATA

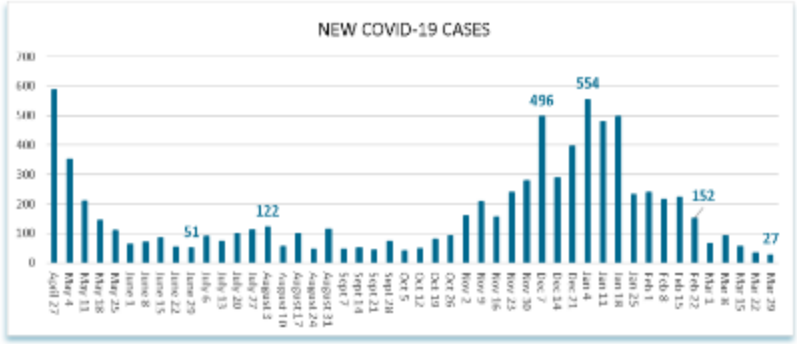
PACE COVID-19 DATA

- Weekly COVID-19 data collection since April 2020
- Cumulative as well as New for reporting period
  - Confirmed cases including where likely contracted
  - Hospitalized including when diagnosed
  - Deaths including place of death and living situation at time of death
- Submitted data represents:
  - Over 90% of NPA member organizations
  - All 28 states where member organizations are, or were, located
  - 80% of total PACE census
- Most programs submit regularly with occasional missed weeks

PARTICIPANT COVID-19 DATA UPDATE	New this Period	Cumulative to Date
# CONFIRMED COVID-19 cases		
#Confirmed cases contracted in SNF		
#Confirmed cases contracted in other congregate setting (e.g., ALF, Grp Home)		
#Confirmed cases contracted in community		
# HOSPITALIZED due to COVID-19		
# COVID-19 confirmed prior to hospitalization		
# COVID-19 confirmed during hospitalization		
# DEATHS due to COVID-19		
#Place of death - SNF		
#Place of death - Other congregate living (e.g., ALF, Grp Home, etc.)		
#Place of death - Home		
#Place of death - Hospital		
#Living situation at time of death – SNF		
#Living situation at time of death – Other congregate living (e.g., ALF, Grp Home)		
#Living situation at time of death - Home		

PACE COVID-19 DATA

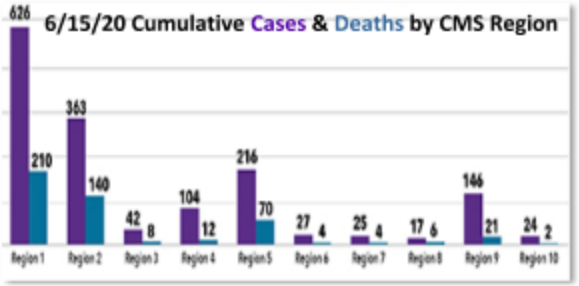
- **8,303** cumulative cases and **1,582** cumulative deaths as of 4/26/21
- Pattern of infection and mortality among POs mimicked the national pattern
  - High cases & deaths last spring, slowed in summer, rapid increase during fall/winter surge

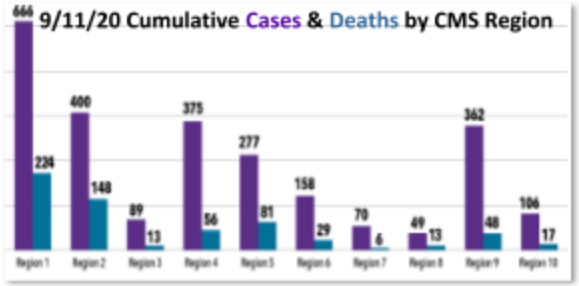


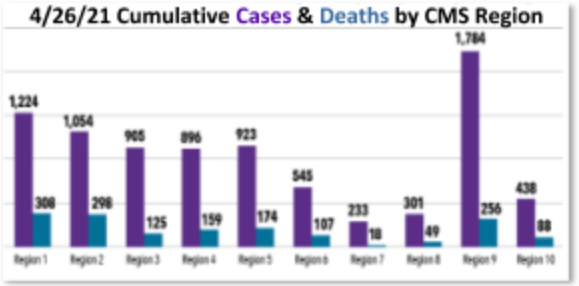
- 58% of infections and 49% of all deaths accrued early Nov. thru mid-Feb.
- New cases & deaths have decreased at least 85% from January peak

PACE COVID-19 DATA

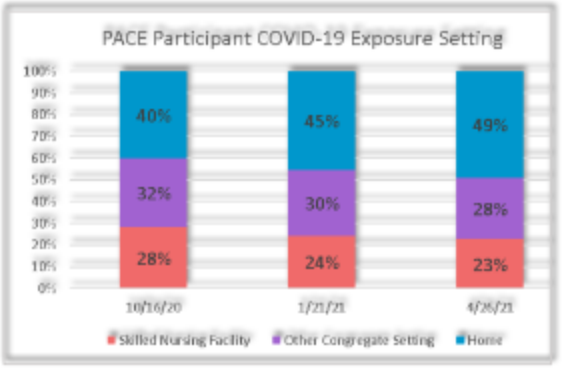
- Outcome variance closely related to Location and Population rather than entity type







- While most infections were contracted in congregate settings, the distribution of congregate vs home shifted during the winter surge.



PACE COVID-19 DATA

- PACE participants are at 1/3 the risk of Nursing Home residents for contracting or dying from COVID-19

NPA Member Organization Data: 4/12/2021					
Cumulative Confirmed Cases	Cumulative COVID-19 Deaths	AVG Total Participating PO Census	**PACE Confirmed Cases Rate**	**PACE Deaths Rate**	PACE Deaths as % of Confirmed Cases
8,187	1,556	42,048	**19.5%**	**3.7%**	19.01%

Data.CMS.gov COVID-19 Nursing Home Data: 4/11/2021					
Total Confirmed Cases	Total COVID-19 Deaths	AVG Total Occupied Beds	**NH Confirmed Cases Rate**	**NH Deaths Rate**	NH Deaths as % of Confirmed Cases
647,754	131,926	1,117,488	**58.0%**	**11.8%**	20.37%

- Participants receiving at least the first dose of a vaccine rose by more than 500% from February to April 2021
  - Approximately half of all PACE participants have been vaccinated (1st or both doses)

	PACE PARTICIPANTS		
	# Vaccinated	% of Participating PO Census	**% of Total PACE Census**
02/01/21 Cumulative	**3,856**	**15%**	**7%**
04/05/21 Cumulative	**26,514**	**68%**	**49%**

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KEY TAKEAWAYS

- *Key survey data indicates the pattern of COVID-19 infection and mortality among PACE Organizations mimicked the national patterns.*

- *PACE participants are at 1/3 the risk of nursing home residents for contracting or dying from COVID-19*

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UPCOMING WEBINARS

Ready to Take the Lead on a PACE Program

- Thursday June 3, 2021, 2pm-3pm EDT

Ready to Partner – Community Based Partnership Models in PACE

- Thursday July 22, 2021, 2pm-3pm EDT

Subject to change based on speaker availability

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THANK YOU and Contact information

- Questions
- Please complete the follow-up survey after the call.

Follow-up

- Jason Patnosh, NACHC (Jpatnosh@nachc.org)
- Anita McClendon, NPA (AnitaM@npaonline.org)
- Anita Gibson, NPA (AnitaG@npaonline.org)
- Marianne Ratcliffe, Piedmont Health SeniorCare (RatclifM@piedmonthealth.org)

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