

The Opportunity of PACE as a Model of Care within the Community Health Center Setting

CalPACE Overview

CPCA Annual Conference

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Chief Executive Officer, CalPACE



California PACE Association (CalPACE)



- Formed in 2007 as a 501(c)(6) association
- First state association of Program of All-inclusive Care for the Elderly (PACE) providers
- Through education and advocacy, CalPACE strives to support and expand the PACE model and promote high-quality health care services to California's seniors

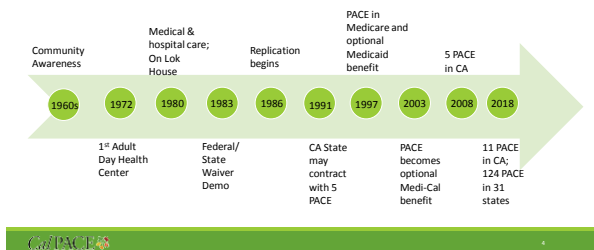


What is PACE?

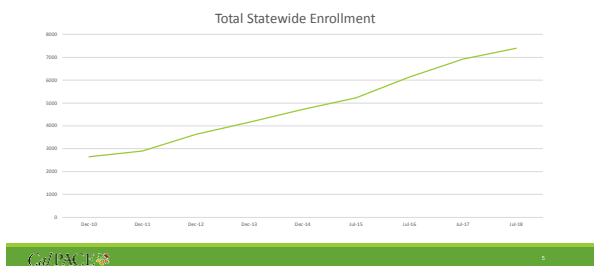
- Program of All-inclusive Care for the Elderly (PACE®)
- A fully integrated care program for adults age 55 or older living with chronic illnesses or disabilities
- Coordinates and provides comprehensive services to enable seniors to live independently at home or in the community for as long as possible
- Provides all care and services covered by Medicare and Medi-Cal as well as other services that are necessary to enable persons to live safely in the community
- Fully capitated and at risk for providing all services



History of PACE



PACE Enrollment Growth - California



CA Counties Served by PACE



PACE is in twelve counties throughout California.

- Alameda
- Contra Costa
- Fresno
- Humboldt
- Los Angeles
- Orange
- Riverside
- Sacramento
- San Bernardino
- San Diego
- San Francisco
- Santa Clara



CalPACE Providers

Presently, there are 11 PACE provider organizations in California.



PACE Participant Profile



- Average age: 76 years
- Percent dually eligible: 75%
- Percent with Alzheimer's, dementia: 39%
- Average number of ADLs: 3.5
- Average number of medical diagnoses: 18
- Average Medicare risk score: 2.1
- Percent Residing in Community: 97%



Who Can Benefit from PACE?

Older adults and seniors who are unstable due to chronic conditions or cognitive impairments	Transportation and logistical challenges making it difficult to maintain medical appointments	High rates of hospitalization and ER use
Unable to perform activities of daily living (average of 3.5)	Nursing home eligible	Family is considering nursing home placement



PACE Outcomes

97 percent of beneficiaries are able to live in the community as opposed to NFs

94 percent report that they are very satisfied with the care they receive

94 percent say they would recommend PACE to a close friend

Rates of hospitalization are commensurate with the general Medicare population

31 percent lower risk of long-term nursing home admission than comparable beneficiaries in HCBS waiver programs



Special Features of PACE

Specialized transportation

Dental and vision care

Restorative and maintenance therapy

Home delivered meals

Home Modifications



Why is interest in PACE growing?

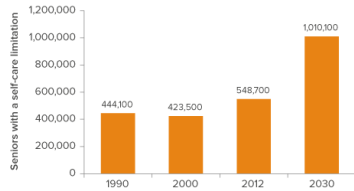
Need for community based care solutions for older populations in Medi-Cal

Disproportionate costs of serving higher need populations in Medi-Cal

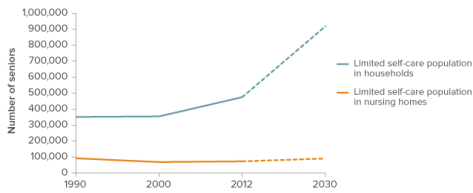
Supportive state and federal policy environment



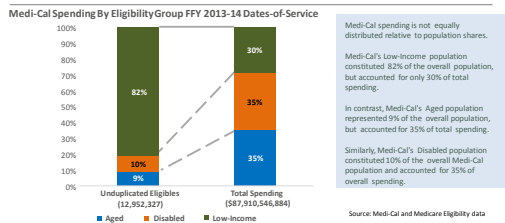
The number of seniors facing difficulties with self care will almost double by 2030



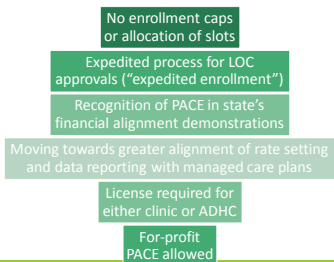
Most seniors with self-care difficulties will be living at home



Aged, Disabled Eligibility Groups Generate Disproportionate Spending



State Policy Environment for PACE - CA



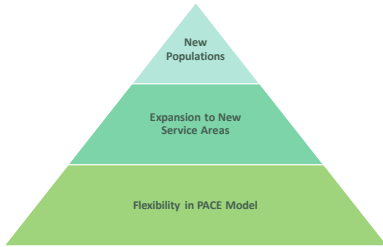
Federal Policy Environment

- Moving towards greater operational flexibility
- Authority for PACE pilots to test PACE model with new populations
- Provider interest in being able to more readily serve Medicare only population

Challenges for PACE Providers

- Cumbersome application process
- Regulatory requirements
- Increasing competition among providers
- Rate methodology that reflects unique features

Opportunities for PACE Expansion



“PACE is a glimpse into the future.”

- Andy Slavitt, Former Acting CMS Administrator



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Program of All Inclusive Care for the Elderly: SYHealth's Commitment to our Community's Senior Population

Kevin Mattson
President and CEO



Overview of SYHealth

SYHealth was founded in 1969 by a group of 7 women with a mission of helping their community find affordable and culturally appropriate health care. Today, SYHealth has 14 medical clinics, 6 dental clinics, 3 school-based clinics, 3 mobile units, 1 retail clinic, 2 HIV sites and 5 WIC sites, 1 PACE program. Served a total of 91,315 unduplicated patients in 2016.

Users by Age					Users by Gender		
Age	0-18	19-34	35-54	55 and Over	Gender	Female	Male
Percentage	37.14%	19.17%	21.74%	21.95%	Percentage	58.53%	41.47%

Users by Ethnicity				Users by Type of Medical Insurance				
Ethnicity	Hispanic or Latino	Non-Latino	Unreported	Insurance	None/Uninsured	Regular Medicaid	Medicare	Private Insurance
Percentage	77.08%	20.45%	2.47%	Percentage	30.27%	56.49%	9.04%	4.19%



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Why PACE?

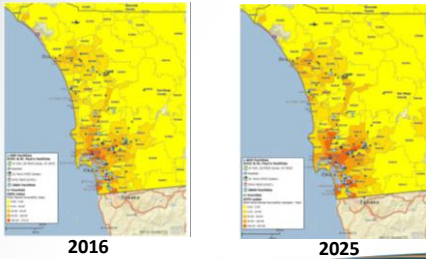
SYHealth opened San Diego PACE on April 1, 2015. The following is a list of contributing factors that encouraged SYHealth to open a PACE program:

- SYHealth Board commitment to culturally appropriate care for seniors in our community. SYHealth has over 20,000 senior patients in care and a large percentage are PACE eligible.
- SYHealth has been serving this community for over 48 years and developed trust among the senior population.
- SYHealth opened an Adult Day Health Center (ADHC) in mid 2010. By early 2011 state budget cuts eliminated cost based reimbursement causing the ADHC to no longer be a financially viable program.
- Given SYHealth's initial investment in senior services, PACE became a viable option and an opportunity to maintain as well as expand senior services in our community



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PACE Market Favorability Index



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Who we serve

- San Diego PACE Demographic Data
 - ✓ 93% Latinos/as, 5% White, 2% other
 - ✓ 70% Females and 30% Males
 - ✓ Average age is 74 / Age range is from 55 to 96
 - ✓ 70% are duals (Medi-Medi) and 30% are Medi-Cal Only
- Top diagnosis
 - ✓ Dementia (Alzheimer's Type)
 - ✓ Diabetes (All types)
 - ✓ Hypertension
 - ✓ Depression other Behavioral health diagnoses



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PACE: Pros and Cons

- **PROS**
 - Coordinated and Comprehensive Care to meet the needs of frail elderly
 - Team Approach to Care (PCMH on steroids)
 - Transportation, Meals and Day Services
 - 24/7 care
 - Assistance with nursing home placement if/when needed
 - Follow up after hospitalizations
 - Caregiver involved in the plan and care of PACE participants
- **CONS**
 - Participants must agree to give up their current provider and potentially their specialist(s)
 - Must discontinue current In-Home Support Services (IHSS) hours



Infrastructure

- SDP has one PACE Center and looking to expand in 2019
- ~24,000 SF facility that currently houses ~ 90 staff and serve an average of 130 participants per day
- Current census is 345 participants (capacity is 350-400 participants)
- Different EHR – NextGen for FQHC, TruChart for PACE
- Contracted transportation services – 16 transportation vehicles: 9 route buses (day center) and 7 appointment vans
- Contracted food service provider and other services such as claims payment and adjudication



Challenges

- Transition from ADHC to PACE
- Steep learning curve
 - ◊ Limited knowledge of the PACE regulation and reporting requirements
 - ◊ Staff not experienced in the team approached to care or care planning as a team
 - ◊ New PACE specific EHR
 - ◊ Several trainings required to understand PACE and serving the geriatric population
- Different line of business – managed care plan versus primary care provider
- Enrollments – patients don't want to leave their PCP
- Human Resources - Limited pool of geriatric providers and RNs
- Finance
 - ◊ Accurate budgeting for census growth and related third party claim expenses
 - ◊ Medicaid payment follow-up and tracking by participant is difficult due to Medi-Cal 820 Reports being issued so long after the month of payment and accurately projecting and estimating IBNR expense.
- Different line of business – managed care plan versus primary care provider
- Contracting
 - ◊ Limited negotiating power when setting up the program which resulted in high contracted rates
 - ◊ Contractors confusing SD PACE with the only other PACE program in the county and did not want to enter in contractual agreements



SD PACE Key Data - 2017

- SD PACE Referrals and Enrollments - 2017

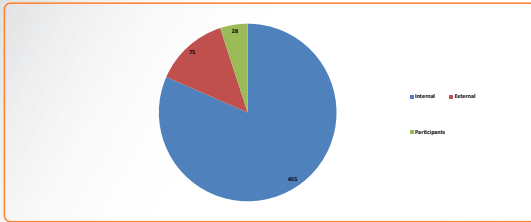
PACE Conversion and Enrollment Data - 2017					
	Referred	Enrolled	Conversion Rate	Disenrolled	Net Enrollment
YTD	558	121	21.7%	43	78
Ave/Month	46.5	10.1	21.7%	3.7	6.5

- Primary reasons for not enrolling or disenrolling in PACE in 2017
 - **Not enrolling:** Preference for their PCP – 38%
 - **Disenrolling:** Moving out of the service area 50%



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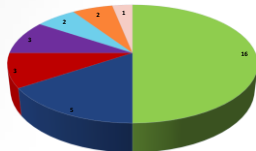
REFERRALS – BY SOURCE (Year 2017)



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Disenrollment reason Comparison

- Moving out of service area
- Feels PACE not appropriate for them
- Unhappy with PACE Services
- Unable to meet payment responsibilities
- Keep Previous PCP/Caregiver
- Keep Previous Health Plan
- Wants to stay at SNF



*Disenrollments does not include deaths (11)

TOTAL - 32



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Advice for other considering PACE

- Hire Technical Assistance/Consulting services that know and understand PACE to help set it up
- Conducting a market analysis to determine competitors, community need and PACE eligibles in their area
- Significant investment required
- Challenges to enrollment
- Be patient



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Questions?