NATIONAL ASSOCIATION OF Community Health Centers®

The Building Blocks of Care Coordination: Basics, Billing, and Looking Beyond to PACE

Part III: Starting or Contracting with a PACE Organization

January 8, 2026

Housekeeping

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Welcome!

This three-part webinar series equips CHCs with foundational and practical knowledge to strengthen care coordination for Medicare patients. This session will focus on key considerations for CHCs interested in starting a PACE program or contracting with an existing PACE organization, including operational requirements, partnership models, and implications for serving dually eligible Medicare and Medicaid patients.

Objective: Participants will have a clear understanding of the PACE model and the strategic, operational, and financial factors involved in launching or partnering with a PACE program to better support older adults with complex care needs.

Today's Speakers

Peter Fitzgerald

Chief Strategy Officer, *National PACE Association*

Vernita Todd, MBA, FACHE

Vice President, Senior Health Services, *San Diego PACE*

Brian Toomey, MSW

Former CEO, *Piedmont Health Services*

Elizabeth Linderbaum, MPP

Director of Regulatory Affairs, *NACHC*

Care Coordination Connection to PACE

Joint Medicare-Medicaid program that covers all medical and social needs for participants
Goal of allowing participants to live in their homes safely for as long as possible

Patient Eligibility

At least 55 years old

Must live in a service area of a PACE organization

Certified to need nursing home level care but cleared to live in a community safely (with support)

Services Provided

- Adult day care
- Recreational therapy
- Home care and nursing home care
- Transportation to appts and the PACE center
- Hospital care and emergency services
- Prescription drugs
- Medical, dental, vision & hearing care

Care Coordination

Personalized care plan development

Doctors, nurses, social workers, therapists, social worker, dieticians etc all working together

Program of All-Inclusive Care for the Elderly (PACE)

Peter Fitzgerald
Chief Strategy Officer
National PACE Association
January 8, 2026

The PACE Model Philosophy

The PACE Model of Care is centered on the belief that it is better for the well-being of frail elders with chronic care needs and their families to be served in the community whenever possible.

"What I witnessed here is a true miracle… It's a different way of looking at how you can age in America."

"What they're really doing is giving you agency over your future."

Dr. Oz's Visit to On Lok PACE

Why PACE? "A Consistently 'High Performer'"

Study: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning, Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care

- PACE participants significantly less likely
  - to be hospitalized,
  - to visit the ED, or
  - be institutionalized

Why PACE: Caregiver and Participant Satisfaction

- Family caregivers are highly satisfied with the support they receive
- High participant satisfaction
- Low disenrollment rate

Sources: https://www.npaonline.org/sites/default/files/PDFs/infographic/NPA_infographic_may2023-combined.pdf

Who Do We Serve?

PACE Participants

80.5%
are dually eligible for Medicaid & Medicare

19.1%
are Medicaid-only

0.4%
pay a premium (Medicare-only or other)

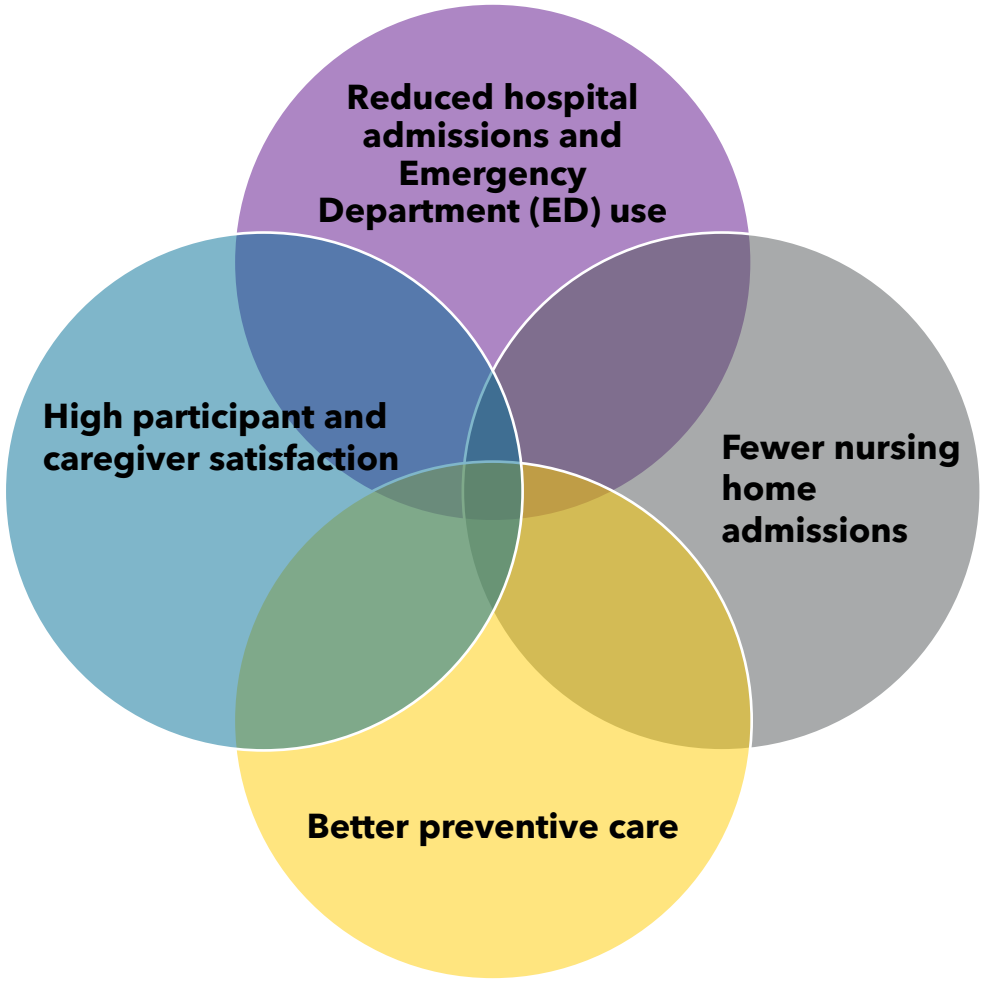
- Participants are eligible to join PACE if they are…
  - 55 years of age or older
  - Live in a PACE service area
  - Certified as needing nursing home care
  - Able to live safely in the community with the services of the PACE program at the time of enrollment

Source: https://www.npaonline.org/docs/default-source/uploadedfiles/pdfs/infographic-pdf/npa-infographic-oct-2025.pdf?sfvrsn=bbd09118_1

What is PACE?

Program of All-Inclusive Care for the Elderly

- Fully capitated alternative to nursing home care
- Helps older adults with complex medical needs live safely in the community
- Integrated system of care for seniors that is:
  - Community-based
  - Comprehensive
  - Capitated
  - Coordinated



Source: https://www.npaonline.org/sites/default/files/11341-PACE.pdf

Data sources specified in Appendix

Staffing

- **Plan Management**
- **Compliance**
- **Marketing**
- **Intake**
- **HR/Training**

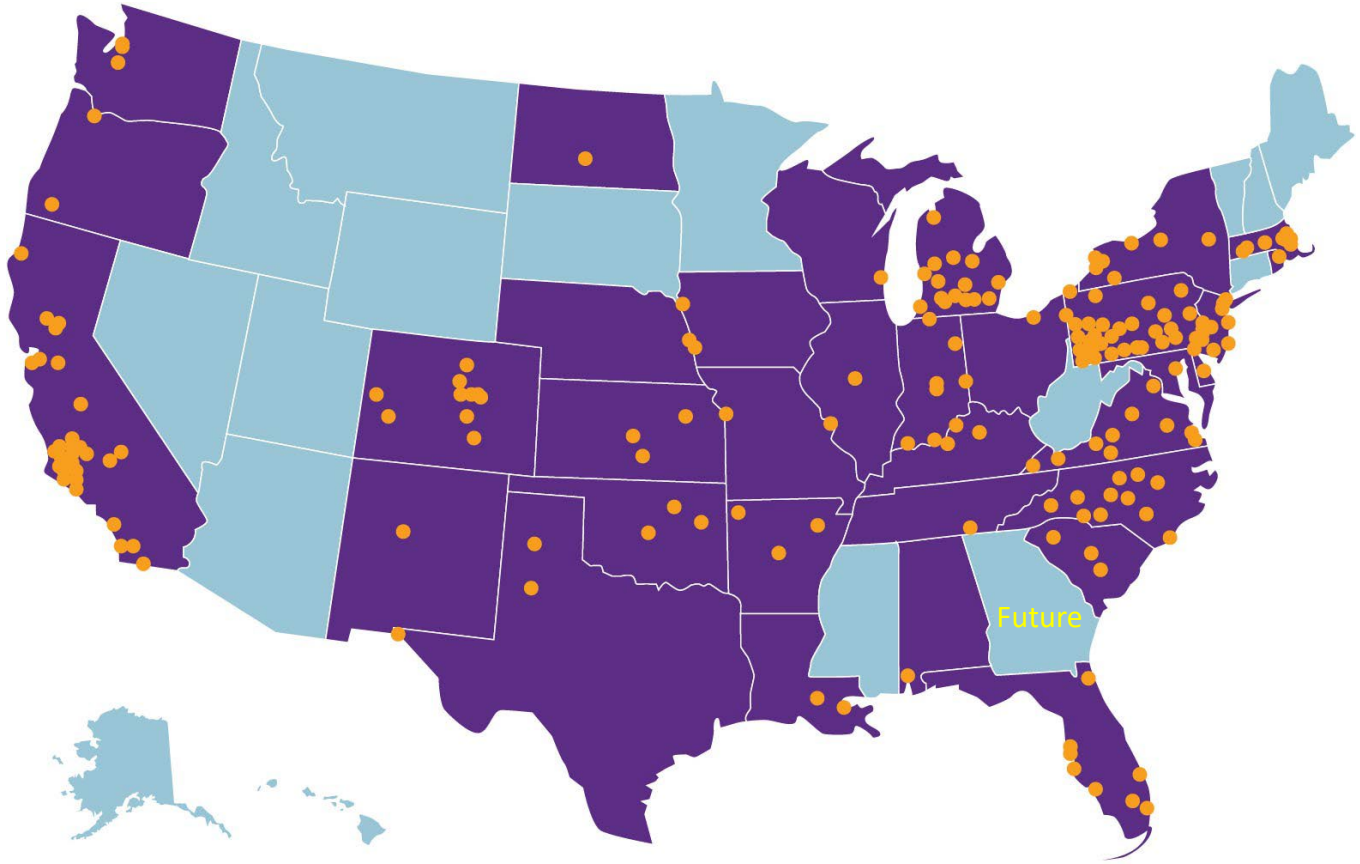
Monthly Capitation Rate Example: Dual Eligible

Payment Type	Amount
Medicare – Parts A&B	$ 3,103
Medicare – Part D	$ 876
Medicaid – Dual Eligible	$ 4,487
Total/Month	$ 8,466

Financing New PACE Organization

Planning and Predevelopment	Bridge Funding-	Site Acquisition	Start Up – Early Operations
Feasibility Assessment Business Plan RFP Response (state dependent) Provider Application/Service Area Expansion Application	Project staff Licensing, approvals Program Development (Policies, Procedures) Recruitment, Hiring, Training Outreach/Marketing development	Architectural and Engineering Plans Construction/Renovations Equipment Vans IT systems	Working capital
$115K - $245K	$300K - $600K	$300K - $700K + purchase/lease costs	$2.6M - $5.2M

PACE by the Numbers



PACE Programs currently exist in 33 States and the District of Columbia.

198 PACE Organizations

380 PACE Centers

While PACE is a permanent federal program, states must choose it as an option

Over 90,000 older adults enrolled

Source: NPA PACE by the Numbers, September 2025; NPA PACE in the States September 2025 Report (internal)

Federal Policy Context

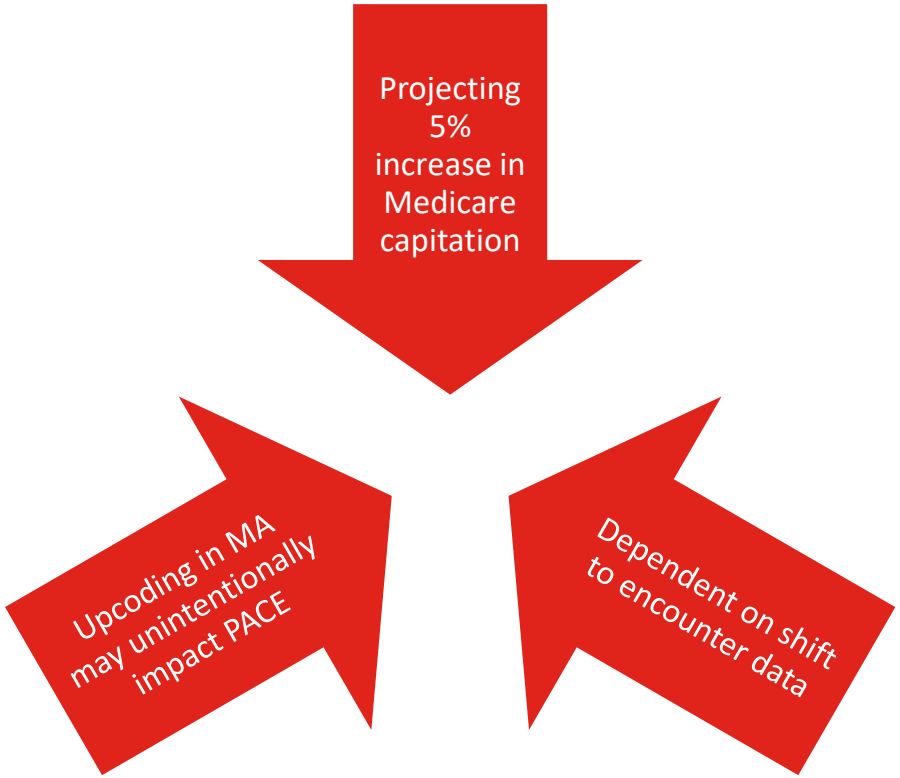
Regulatory red tape

Market competition

Quality and Value

Payment

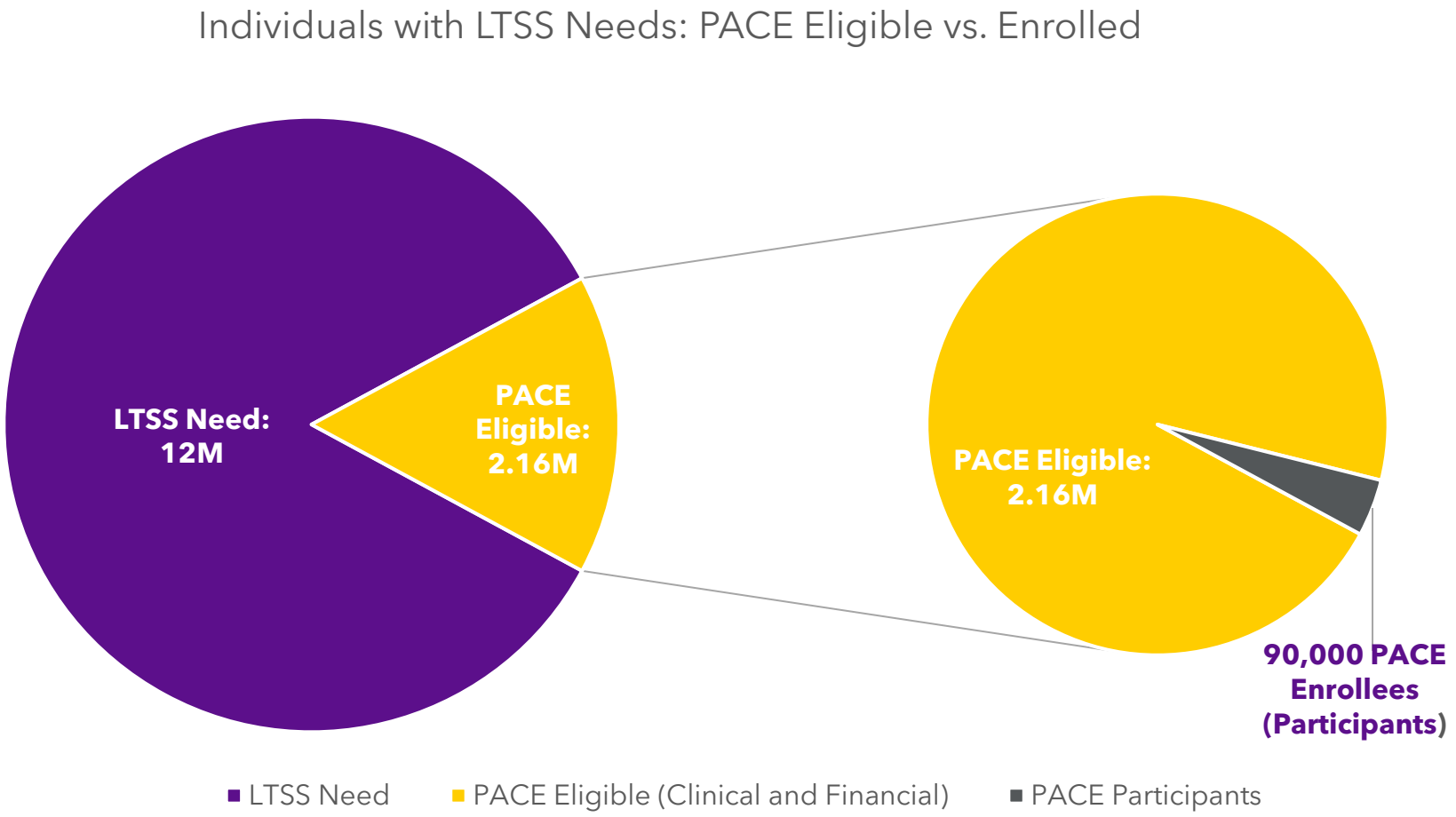
Medicare



Medicaid

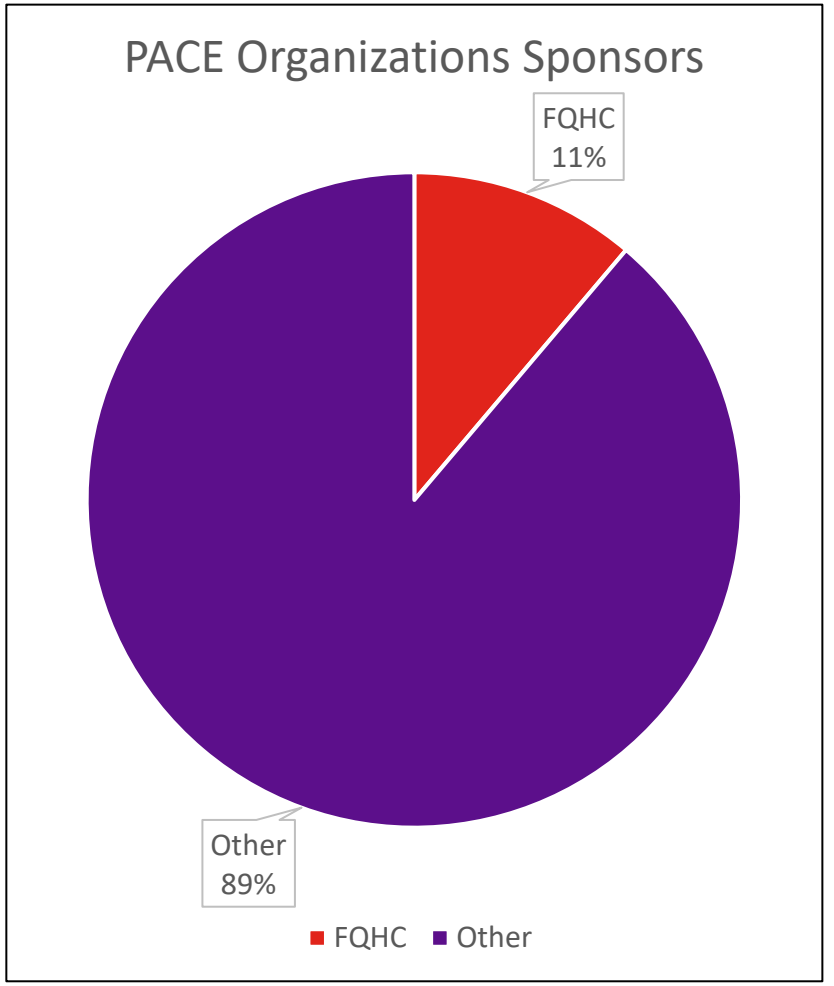
- HR1 budget threats to state Medicaid programs
- Comparisons to broader health plan options

PACE Opportunity



How Can PACE and CHCs Work Together

- Mutual Referrals
  - PACE eligible FQHC patients
  - Individuals needing primary care but not eligible for PACE
- Purchased Services, e.g.
  - Primary care
  - Behavioral health
- Development and Sponsorship - FQHCs
  - 20 PACE organizations are sponsored by an FQHC
  - Second largest PACE organizations (Altamed)
  - Fastest PACE organization growth rate (San Diego PACE)



A Look at San Diego PACE

Vernita Todd,
VP, Senior Health Services

January 8, 2026

San Diego PACE
Program of All-Inclusive Care for the Elderly
SAN YSIDRO HEALTH

San Ysidro Health TODAY

Why San Ysidro Health

At San Ysidro Health, *patient-centered* is our way of saying that patients are our top priority.

www.syhealth.org

Patients

162,000 served!
54 Clinics and Program Sites

PCMH

National Committee for Quality Assurance

Workforce

Internal Medicine Residency
Family Medicine Continuity Clinic
Pediatric Dentistry Residency
AT Stills Medical School

Network

20th largest FQHC in the Nation based on patients served *(n=1,370)*

2nd largest by budget

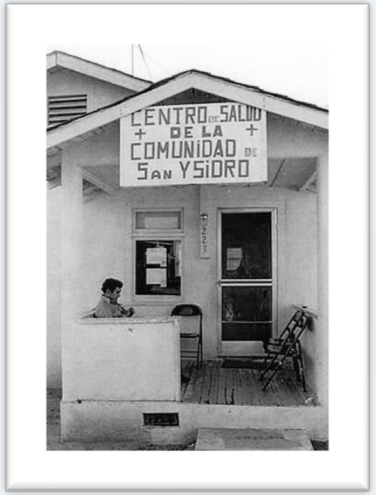
Team

3,100+ Employees
250+ Provider Staff
MDs, Dentists, Psychologists, Nurse Practitioners

The Connection to Our Federally Qualified Health Center

SAN YSIDRO HEALTH

Since 1969



Mission to improve the health and well-being of the community with access for all!

San Diego PACE

Program of All-Inclusive Care for the Elderly

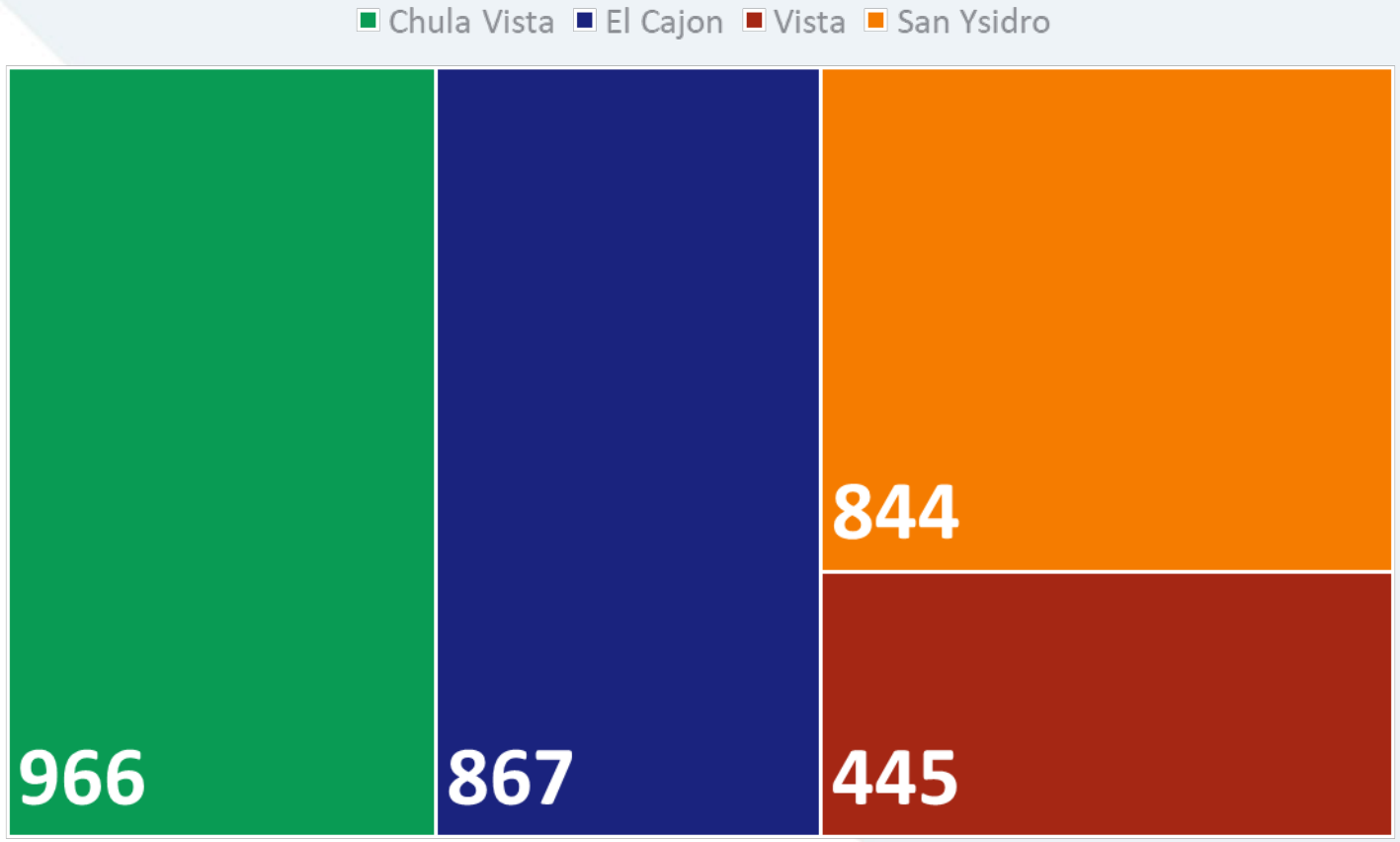
SAN YSIDRO HEALTH

Since 2015

- Enhanced commitment to seniors
- ADHC model was no longer viable
- PACE became our path forward… now we're 10!

San Diego PACE Program of All-Inclusive Care for the Elderly 10 YEARS

Census by Site



The San Diego Environment

NPA: PACE in the States – June 2025

4 PACE Organizations in San Diego County serving 5,602

San Diego Potentially Eligible Seniors 60+ = 63,000

- *San Diego PACE (2015) – **3,173** census
  - 4 sites
- St. Paul's PACE (2008) – 1,469 census
  - 3 sites
- Gary & Mary West PACE (2019) – 473census
  - 1 site
- *Family Health Centers of San Diego PACE (2019) –487 census
  - 2 sites

29 PACE Organizations in CA

– CA Seniors Served in PACE = ~**26,000**

– Estimated **$350M** AWOP savings

198 PACE Organizations in **USA**

89,688 = Total seniors served in **33 states and DC**

*Estimated more than **2 million seniors** are eligible for PACE*

Data as of November 2025

FQHC & PACE: Why The Model Works

TRUSTED PARTNERS

- FQHCs have robust and comprehensive care delivery systems already developed
- FQHCs take a population health focus to quality
- FQHCs understand the importance of SDOH on participant care
- FQHCs are known to the patients and community stakeholders

INTEGRATED CARE

- FQHCs have integrated care models and health records
- FQHCs are Patient Centered Medical Home *(critical for PACE)*

Retaining Our Aging Populations:
Importance of Care Coordination

Senior Needs are different and should be addressed accordingly to make seniors feel connected to their medical home:

1. Longer Appointments
2. More Medication Management
3. Caregiver Assistance
4. Coordination of Appointments
5. Socialization Needs
6. Quiet, Easy, Relaxing

There's room for you in PACE…

Services

- Transportation*
- Home Health
- Housing/Maintenance

Growth

- Hospitals
- Venture Capitalists
- Community Agencies
- Trade Associations*

Provider

- FQHCs*
- Specialists
- Tenured Community Physicians

Closing Thoughts

- PACE provides fully capitated, comprehensive and holistic care for nursing home eligible seniors
  - ***True Value-Based Care***

- FQHCs are a perfect pipeline for PACE though changing doctors to go to the PACE program can be a struggle, so don't assume high conversion from the beginning
  - ***More than 30 million served in FQHCs, less than 100,000 served in PACE***

- Most participants coming in from the FQHCs have very **low RAF scores** due to lack of comprehensive coding
  - Chance to help your CHC in multiple ways – **invest in coding for your providers** (internal and/or training) – prove that "sickest patient elevator speech!"
    - *RAF – Risk Adjustment Factors help determine the amount you are paid (lags one year)*

***California leads the nation in number of PACE programs, so if you don't start one – are there other things you can do to provide service* to PACE?**

San Diego PACE

Program of All-Inclusive Care for the Elderly

SAN YSIDRO HEALTH

10 YEARS

Thank you!

Vernita Todd: vernita.todd@syhealth.org

Celebrating 10 years of compassionate care and service for seniors...

PACE AND FQHC

Community and Organization Issues

Brian Toomey
Former CEO, Piedmont Health Services

Many FQHC's are Considering PACE – What are the considerations

- FQHC'S have existed since 1965 – look how we have grown
- Several FQHC'S developed PACE programs in 1990's
- Look at your Mission Vision and Values Statements – almost all will include meeting Community needs
- Are you addressing the needs of seniors – and keeping everyone in community?
- PACE is a natural extension of FQHC values and Mission

Background on Piedmont Health Services (PHS)

- PHS opened PACE December 2008, one of two NC pilots
- PHS was one of 15 Rural PACE grant recipients
- PHS was committed to our Mission, Vision and Values
- We took several years to evaluate if it was right for us
- From 2008 – 2023 (During my tenure at PHS) we had positive results
- Averaged 13% operating margins, contributing to the FQHC bottom line – allowing us to see 50% uninsured patients

Piedmont Health Services PACE Journey & Advice

- Steps we took: Talk to other FQHC's and get their experience – especially FQHC's similar to you
- Engage Board, Administration and Medical staff in the exploration
- Budget Feasibility funds for the exploration – including travel
- JOIN NPA as an exploratory member – this is an incredible organization that wants you to succeed
- Attend NPA conferences
- Meet with FQHC's at the NACHC – another incredible organization that wants you to succeed – and NETWORK

Additional Key Takeaways

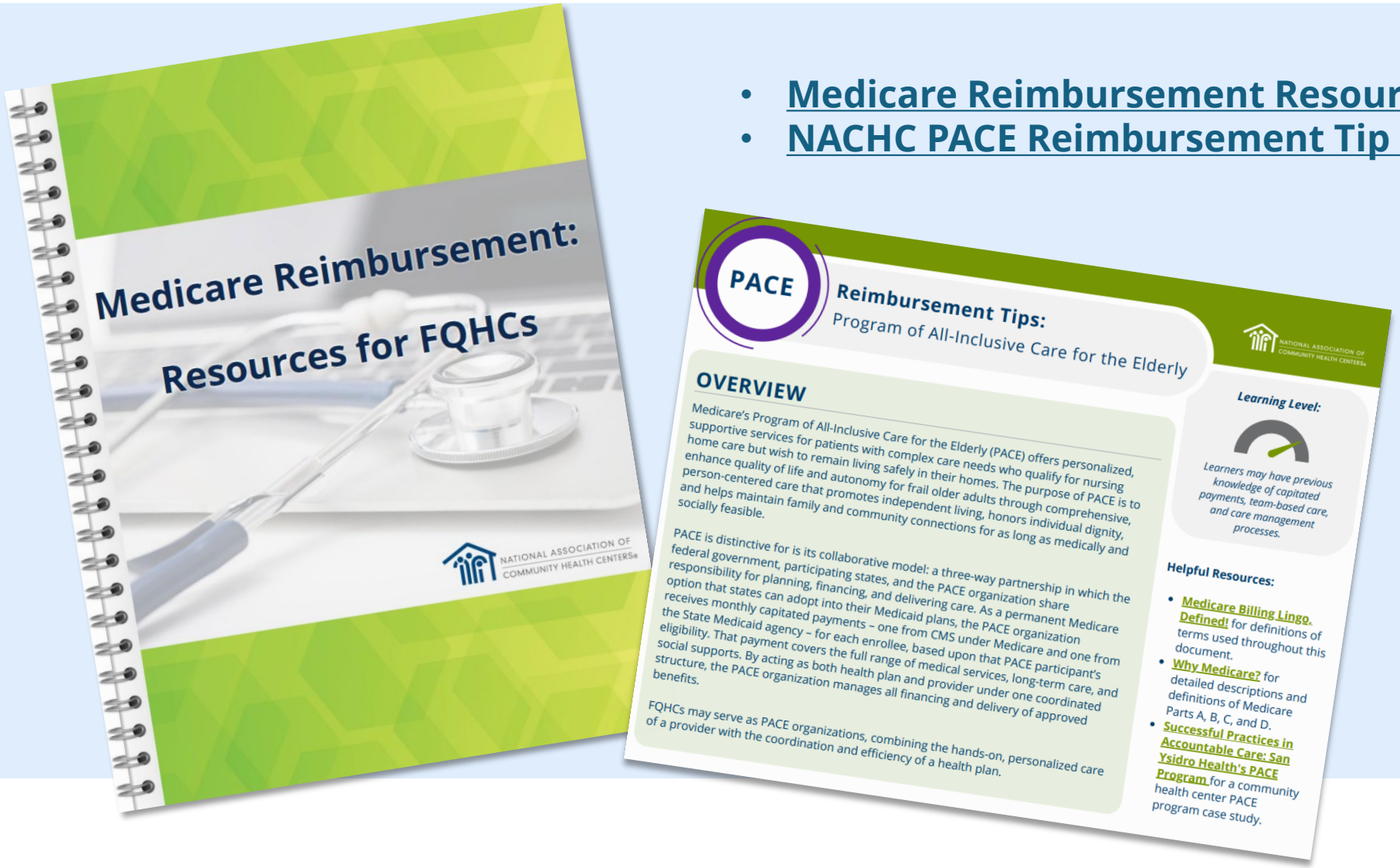
- Talk with FQHC's about who they used for their TA – you will need to have help for this
- Visit other PACE programs – including non-FQHC PACE programs
- The visits should include Board Admin, Clinical and Medical staff that are 'Senior Focused'
- Learn the pluses and minuses of doing a Fully Capitated Program – I think as an FQHC we are experienced as being innovative with less and thus are naturals for PACE

Summary

- PACE is the essence of what we do and who we are as an FQHC
- FQHC's have a history of leading – PACE is a natural fit
- Two Associations – NPA and NACHC have staff and members that can help you succeed.
- The next 15 - 20 years will be about seniors, cost containment, community-based solutions, innovation and quality outcomes
- FQHC'S AND PACE is the obvious solution

QUESTIONS & OPEN DISCUSSION

Resources



- [Medicare Reimbursement Resources for FQHCs]
- [NACHC PACE Reimbursement Tip Sheet]

Resources

- Assessment Tool for Determining Opportunity for PACE Development
- CHC Case Studies
- NPA website: www.npaonline.org
- APIQ website: www.apiqonline.org
- Peter Fitzgerald, NPA: peterf@npaonline.org

"Before I Found PACE" Testimonials

Khaadija Shabazz, PACE Southeast Michigan, has cared for her mother since she was diagnosed with dementia. Now her mother is enrolled in PACE Southeast Michigan, enabling Shabazz to keep her living independently in the community. To view the 90- second video, click here.

Thank you for participating in this webinar series!

All of the slides, recordings, and resources from this webinar series are posted on NACHC's website!

- **Missed Part I?** Review the recording and slides from our November 6th webinar on the basics of Medicare care coordination.
- **Missed Part II?** Review the recording and slides from our December 8th webinar on Medicare billing logistics.

Thank You!

Elizabeth Linderbaum

Director of Regulatory Affairs

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