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The Field Guide to Managed Care: A Primer

The past, present, and future of community-based organizations

How to form partnerships and prepare a service model

Helping hands: how foundations and government support CBOs on the path to managed care

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The Field Guide to Managed Care: A Primer

Introduction

Managed Care: The Business of Providing Quality Supports and Services to Older Adults

Aging services providers have always addressed the needs of the populations they serve with a "mission-driven, humanistic, and customer-service orientation," says The SCAN Foundation's Gretchen Alkema in the opening article of this supplemental issue of *Generations*. But as funding for the Older Americans Act has flattened out, these same providers must find a way to become more self-sustaining. A way forward is through seeking and building business partnerships with healthcare delivery systems and providers to offer integrated, or managed, care.

'As we . . . prepare for our own aging, health systems can help by focusing on what people want and need as they pursue the highest quality and care value.'

This is a long road—one with challenging twists and turns—for community-based providers moving toward fully integrated care. And there are many secrets to success—among them, collaboration, experimentation, and open-minded persistence—as shown in the articles and case studies in this supplement, "The Field Guide to Managed Care: A Primer."

The American Society on Aging (ASA) is pleased to offer this supplement to its regular quarterly publication of *Generations* journal. The Field Guide has been supported by a collaboration of The SCAN Foundation, The John A. Harford Foundation, the Administration for Community Living (ACL), the Gary and Mary West Foundation, the Marin Community Foundation, and the Colorado Health Foundation. All partners have united to fund a three-year grant to develop and establish the Aging and Disabilities Business Institute, which is housed within the National Association of Area Agencies on Aging (n4a); aging anddisabilitybusnessinstitute.org. Two future field guides will build upon the information we now have, providing new insights and more resources.

This Field Guide parses the landscape of managed care: what it is, why it is necessary, and how community-based organizations (CBO) and healthcare entities are partnering to effect it. As well, real-life case studies share lessons CBOs have learned in their journeys to managed care, and offer thoughts on what the future of managed care might hold.

This primer is divided into three sections that walk readers through this "new" managed care terrain. The content of Section One, "The World of Quality Care: History, Landscape, Outlook," was guided by Gretchen Alkema, vice president of Policy and Communications at The SCAN Foundation, who in addition to this advisory role contributed an overview of the aging services network, past, present, and future (see her article on page 5).

"Older Americans today are living dramatically longer than their parents

did, often complicated by multiple chronic conditions and daily functional challenges," says Alkema.

"As we—individuals, families, and society as a whole—prepare for our own aging, health systems can help by focusing on what people want and need as they pursue the highest quality at the best value. This approach includes putting the person needing support in the middle of the care experience, and building more connected systems of personalized support using the right mix of medical and non-medical providers."

Erin Westphal, program officer at The SCAN Foundation, helped shape Section Two, "Next Steps and Challenges: Identifying and Building Competencies for High-Value Partnerships." This section covers the specifics of how to develop models, set pricing, and implement and manage relationships within integrated care collaborations.

"Various policy actions have changed the landscape for delivering services to older adults and people with disabilities, creating new opportunities for high-value partnerships and making it imperative that we foster competencies across groups and develop the infrastructure for smooth integration of services," says Westphal.

"The Linkage Lab (www.thescanfoundation/linkage-lab-initiative), Care Excellence (https://careexcellence.org), and other programs exist to prepare CBOs, care managers, and others to successfully manage collaborations that are becoming more common and important."

For Section Three, "Managed Care Models in Action," Brenda Schmitthenner, program officer, Successful Aging, for the Gary and Mary West Foundation, found stellar case studies showing how CBOs and Area Agencies on Aging have progressed through the managed care process. Also included are articles that enumerate philanthropic support for organizations shifting to managed care, how the federal ACL is lending support, and one foundation's reflection on what lies ahead for the future of community-based services.

"The healthcare landscape in this country has changed dramatically in recent years, with more states looking to Managed Care Organizations (MCO) to control Medicaid expenditures for a growing population of older adults and persons with disabilities who require long-term services and supports [LTSS]," says Schmitthenner.

'Various policy actions have changed the landscape for delivering services to older adults and people with disabilities, creating new opportunities for high-value partnerships.'

"Many trailblazing CBOs have seized the opportunity to deliver services like care transitions, care management, and nutrition to high-risk health plan members by executing contracts with MCOs. Their experiences provide valuable learnings and opportunities for replication to sustain essential LTSS."

As June Simmons, founding partner and CEO of Partners in Care Foundation, says in her closing article (see page 65), "Integrating healthcare and social services around the needs, goals, and preferences of people with chronic conditions is closer to being achieved than ever before."

Community-Based Organizations, from Past to Present to Future

By Gretchen E. Alkema

Aging network service providers now must become business-minded entities that foster sustainable partnerships and forge successful outcomes.

It was the summer of 1965. President Lyndon B. Johnson was making headway on his War on Poverty, with the development and passage of Medicare and Medicaid, creating more affordable and accessible healthcare coverage for older and low-income Americans. But another law was emerging that set a monumental vision to champion the dignity and independence of our aging nation: The Older Americans Act (OAA).

Many CBOs emerged or greatly expanded as the OAA created a dedicated and predictable funding stream for their services.

The OAA was developed after policy makers expressed intense concern about a lack of community social services for older people. In the 1950s and early 1960s, policy makers and advocates increasingly recognized that older Americans were a growing proportion of the population and that their needs were not being addressed through existing programs. The OAA articulated ambitious goals to promote the well-being of individuals ages 60 and older through retirement security, healthy living, stable housing, meaningful community engagement, and more.

On July 14, 1965, upon signing the OAA, which passed with substantial bipartisan support, President Johnson said the law would provide:

> *. . . an orderly, intelligent, and constructive program to help us meet the new dimensions of responsibilities which lie ahead in the remaining years of this century. Under this program every state and every community can now move toward a coordinated program of services and opportunities for our older citizens* (Johnson, 1965).

How could this be accomplished while honoring the heterogeneous nature of older Americans and the communities where they resided? Using federalism as its guide, the OAA created a federal-state administrative architecture that fostered planning and program implementation based on local-level needs and a

→ABSTRACT The aging network, developed and initially sustained through the Older Americans Act, is a major vehicle for organizing and delivering services to help older adults receive the support they need to live well in their homes and communities. Policy and regulatory changes have created challenges and opportunities for the aging network. New opportunities for innovation and revenue generation include partnerships with the healthcare sector, which suggests it is time for the network to transform toward business-minded operations, while maintaining its charitable heart. **| key words**: *aging network, community-based organizations, managed care, healthcare, transformation*

variety of services. The Administration on Aging (part of the Administration for Community Living, or ACL, within the Department of Health and Human Services [HHS]) is the federal focal point for implementing the law and considering health-related matters affecting older adults (National Health Policy Forum, 2012).

Fifty-six states and territories receive OAA funds for community planning and social services, research and development projects, and workforce training. These dollars are passed down to more than 600 area agencies on aging and 200 tribal organizations that partner with nearly 20,000 providers for myriad community-oriented services—caregiver support, elder abuse prevention, home-delivered and congregate meals, job training, medication management, preventive health services, transportation, and more (ACL, 2015). This "aging network" is a major vehicle for organizing and delivering services that help older adults with daily living needs receive the support they need to live well in their homes and communities.

While some community-based organizations (CBO) have existed for nearly 100 years (e.g., Easterseals, Jewish Family Services, Volunteers of America), many others emerged or greatly expanded as the OAA created a dedicated and predictable funding stream for their service platform. Since the early 2000s, OAA funding has remained stagnant relative to the growing demographic of older Americans. (Fox-Grage and Ujvari, 2014).

Currently, the OAA budget ($1.9 billion) is comparable to about one day's worth of Medicare spending (HHS, 2016). Additionally, the OAA budget is granted unevenly across states through a congressionally defined formula, which has been a point of contention during the last few reauthorizations (Napili and Collelo, 2012). The widening differential between modest OAA funding levels over time and anticipated need for services as the population ages have led to various policy and operational responses, as follows: targeting only the highest need individuals; greater reliance on philanthropic support; and active consideration of alternative funding sources.

Benefits and Challenges of the 21st Century Aging Network

While CBOs in the aging network range in depth of expertise, service platforms, staffing types and levels, as well as in community integration, the network as a whole has developed strength throughout its tenure. Service providers are generally from nonprofit organizations that fill a unique role in their communities. They often balance a service portfolio addressing the needs of various populations through a localized approach with a mission-driven, humanistic, and customer-service orientation. Rooted in communities, these providers are sensitive to local context and nuances across population segments, and often have built a solid trust and engagement. OAA funding and its associated service delivery requirements have created the basic service structure for these organizations, yet each takes its own approach on how services are delivered. Some work in partnership with health, housing,

and city service providers, with staff from more sophisticated organizations being able to break through service impasses to help clients get needs met (e.g., they may have back-channel access to county social services staff to help expedite a review for Medicaid eligibility).

Leading organizations have also implemented evidence-based programs to decrease depression, mitigate falls, better manage chronic health conditions, and address medication-related problems—all of which show promise in the network's ability to directly improve functional outcomes for older adults (National Council on Aging, 2016).

The aging network faces several interrelated challenges that have hampered its ability to manage and lead change in the current political, policy, and fiscal climates. First is the network's long-standing dependence on OAA grants for core operational sustainability, coupled with a 1970s accountability framework, requiring that organizations report the number of services provided instead of outcomes achieved. As OAA funds stagnated in each federal budget cycle, organizations initially spent significant time seeking new funding to backfill needs, as well as making hard decisions to not serve older adults in need, to stop some services, and, in extreme cases, to close their doors.

Aging services providers must illustrate the value of their services in reducing costs elsewhere in the larger healthcare system.

The persistence of flat OAA funding has forced organizations to choose between trying to continue "business as usual" or become a more business-focused entity—both of which risk significant financial instability. Some are beginning to embrace the concept of "no margin, no mission," yet struggle with having the time, financial stability, and expertise to engage in introspection about who and what they are as an organization and translate that into transformation. Transforming such organizations is a significant challenge. It involves rethinking leadership and management approaches, as well as staffing needs and patterns, clarifying and communicating about services offered, reaching out to new customer bases for diverse revenue sources, and defining quality and outcome thresholds for services.

Last, much of the transformation needed depends upon a new, evolving resource—a robust and protected technological infrastructure. The number of meals served, rides provided, or care management visits delivered no longer defines success. Instead, aging services providers must now illustrate the value of their services in reducing costs elsewhere in the larger healthcare system. As a result, there is increased importance placed on providers' ability to maintain client records, complete billing to third-party payers, assess and monitor quality measures, and communicate seamlessly with other providers.

New Opportunities for the Aging Network

A core tenet of the 2010 Patient Protection and Affordable Care Act (ACA) was to transform how Medicare- and Medicaid-funded services are delivered to achieve better care quality, while at the same time reducing overall care costs. Its premise was to change payment models for care, shifting from a "volume of services" mentality to focusing on the value health plans and systems provide. Value-based care for hospitals and health systems was initially defined as a reduction in inappropriate hospital admissions and emergency room visits, particularly thirty-day readmissions rates for the same health condition.

The ACA created the Innovation Center within the Centers for Medicare & Medicaid Services, which has been the incubator and funding source for most of the value-based payment models and delivery system arrangements, such as integrated care demonstrations for those with dual eligibility, the bundled

payment initiative between hospitals and post-acute care, and various care management–based demonstrations across the states. Concurrently, several states have asked for federal approval to reconfigure operations of their Medicaid program. Many states have contracted with managed care companies to accept operational and fiscal responsibility for Medicaid services—both for healthcare and long-term services and supports (LTSS). Currently, Medicaid-managed LTSS is the primary vehicle that delivers daily living support for low-income older adults with functional needs.

All of these policy and regulatory changes have created substantial opportunities for the aging network because of their established presence, depth of knowledge, and enduring commitment to local-oriented services with a primary goal of helping individuals in need live well in community. Beyond the necessity of quality care, health plans and systems (such as Accountable Care Organizations) also have a financial incentive to ensure their members are thriving in the community, especially after a major medical intervention. Health plans involved in the integration of Medicare and Medicaid services are particularly responsible for the total set of health and functional outcomes of their members. Innovative health plans and systems are fostering partnerships with CBOs that help members with the transition from hospital to home, provide follow-up care management and family caregiving support, arrange for personal care and home modifications where necessary, and help identify functional decline before this becomes an emergency situation.

Leading and managing change will be the core of the aging network's success.

For health plans and systems to use the aging network well, they need to better understand what services the network offers to support older adults with chronic health conditions and daily living needs, and how to best contract with these providers. The aging network must assess the needs of the healthcare sector and demonstrate the value they bring in providing localized

services to meet well-defined health and functional outcomes. In addition, the network needs to be ready for this new kind of partnership, which requires a different kind of operational model for success. Several new initiatives, including the National Aging and Disability Business Institute (aginganddisabilitybusinessinstitute.org), provide trainings, an ongoing webinar series, and technical assistance to aging network organizations to help them create and renovate their business models to become effective partners with healthcare entities.

Looking Forward

The aging network is experiencing a fundamental transition—one in which leading and managing change will be the core of its success. It is time for the network to ramp up to a business-minded operational structure, while maintaining at its center a charitable heart. Partnerships with the healthcare sector give CBOs new opportunities for innovation and revenue generation. However, healthcare will not likely pay for the breadth of aging services that the network is accustomed to providing through OAA funding. This transition to new business models and payment structures will be difficult, and not all organizations in the network will survive. It will take strong leadership, a dedicated sense of mission, adaptability, creativity, collaboration, persistence, patience, and a willingness to continually experiment.

The good news is that the organizations that comprise the aging network—that form its heart and soul—have the fortitude and determination to accept this challenge. During one of her final speaking engagements, Assistant Secretary for Aging Kathy Greenlee talked about what the network carries as it marches into a new future:

> *We are an amazing group of talented, caring people. We have each other's backs. We share ideas and inspiration. We give hugs and pep talks. We brainstorm and vent. We laugh together . . . and sometimes we cry. . . . We pick ourselves up and try. We have attitude, dignity, and leadership* (Greenlee, 2016).

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References

Administration for Community Living (ACL). 2015. *The Older Americans Act: Aging Well Since 1965*. http://acl.gov/NewsRoom/Observances/OAA50/docs/OAA-Brief-Final.pdf. Retrieved September 30, 2016.

Fox-Grage, W., and Ujvari, K. 2014. *Insight on the Issues: The Older Americans Act*. AARP Public Policy Institute. www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2014/the-older-americans-act-AARP-ppi-health.pdf. Retrieved October 9, 2016.

Greenlee, K. 2016. "Leaving a Legacy: Forging New Partnerships Beyond the Aging Network." Keynote remarks, "Answers on Aging Conference," from the National Association of Area Agencies on Aging, San Diego, CA, July 26.

Johnson, L. B. 1965. *Public Papers of the Presidents of the United States: Lyndon B. Johnson, 1965*. Vol. 2. U.S. Government Printing Office. 1963–1969. www.presidency.ucsb.edu/ws/index.php?pid=27079. Retrieved October 9, 2016.

Napili, A., and Collelo, K. J. 2012. *Funding for the Older Americans Act and Other Administration on Aging Programs*. Washington, DC: Congressional Research Service.

National Council on Aging. 2016. *Center for Healthy Aging*. NCOA. www.ncoa.org/center-for-healthy-aging/. Retrieved October 9, 2016.

National Health Policy Forum. 2012. "The Basics: Older Americans Act of 1965." www.nhpf.org/library/the-basics/Basics_OlderAmericansAct_02-23-12.pdf. Retrieved October 9, 2016

U.S. Department of Health and Human Services (HHS). 2016. *HHS FY2016 Budget in Brief. Centers for Medicare & Medicaid Services*. www.hhs.gov/about/budget/budget-in-brief/cms/medicare/index.html. Retrieved October 9, 2016.

The Big Shift: What Is the Landscape and Potential of Managed Care?

By Stephen A. Somers and Nancy Archibald

Team-based, integrated care can be crucial for older adults with multiple chronic conditions, but CBOs need to build business skills before fully participating in this type of care.

Over the past two decades, Medicare and Medicaid—the primary insurers of healthcare and long-term services and supports (LTSS) for older Americans—have progressively shifted their payment arrangements from fee-for-service (FFS) to managed care. This shift has important implications not just for beneficiaries, but also for the providers and community-based organizations (CBO) that serve older adults; these organizations must adapt their business models to succeed in this new environment.

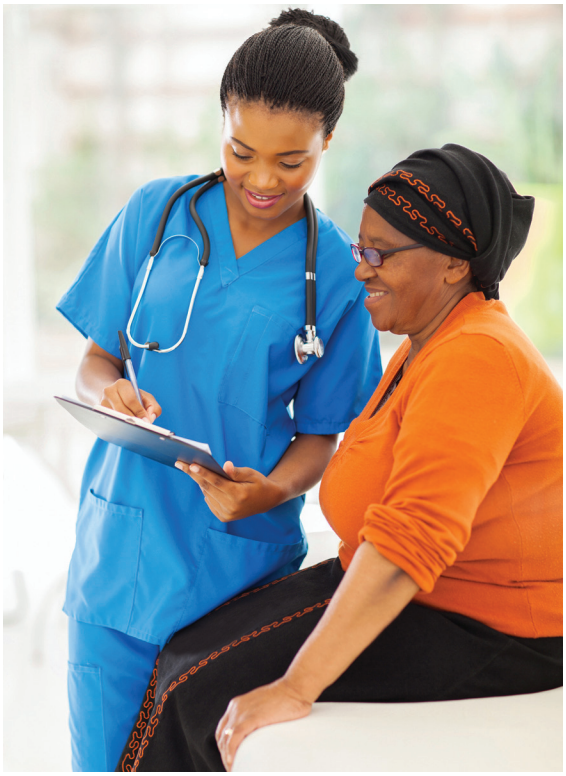
The goals of managed care have changed, too. Originally focused on managing service use, managed care is now oriented toward delivering integrated, team-based care. There is a growing recognition among Medicare and Medicaid purchasers and plans that individuals with complex care needs, including older adults with multiple chronic conditions and younger individuals with disabilities, can benefit from the integration of services a managed care program can provide. Consequently, the range of services provided by managed care organizations has expanded from primary and acute care to behavioral health and LTSS.

Managed care's increasingly team-based focus and its extended array of covered services call for the involvement of a broad range of community-based providers, particularly in the LTSS arena. However, these providers may have little experience working in a managed care environment. This article presents an overview of the managed care landscape, how managed care serves older adults, and the future of managed care for this population, in an effort to help CBOs better position themselves within this shifting terrain.

The Current Landscape: Medicare and Medicaid Managed Care

In the Medicare program, Medicare Advantage (MA)—the managed care alternative to Original Medicare (i.e., FFS)—has become an increasingly popular choice for beneficiaries. Enrollment in

→ABSTRACT Older adults increasingly receive healthcare and other services through Medicare and Medicaid managed care delivery systems. The team-based, integrated care offered by managed care plans can be crucial to coordinating services for older adults, many of whom have multiple chronic conditions and needs for long-term services and supports. Community-based providers can play a key role in integrated care, but may have to build their breadth of knowledge and business skills before they can fully participate in managed care arrangements. **| key words**: *managed care, community-based providers, older adults*



MA plans grew from 9.7 million in 2008, or 22 percent of Medicare beneficiaries, to 17.6 million in 2016, or 31 percent of beneficiaries (Jacobson et al., 2016). MA offers beneficiaries a number of plan options, including some with low or no premiums (but with higher out-of-pocket costs). In addition, MA plans can offer supplemental benefits including vision, dental, hearing, and wellness coverage that may be attractive to older adults. MA also has a subtype of plans called Dual Eligible Special Needs plans, which enroll individuals with both Medicare and Medicaid; these are discussed below.

On the other side of the ledger, states have created a variety of Medicaid managed care programs providing comprehensive primary and acute care services, as well as specialty programs covering behavioral healthcare, dental, transportation, and LTSS. An emerging trend is for states to fold physical health, behavioral health, and LTSS into one managed care contract covering all of these services. Also, states have been adding new populations, including older adults and people with disabilities, into Medicaid managed care programs (Snyder and Rudowitz, 2016). In 2014, the most recent year for which data are available, there were forty-five states with comprehensive Medicaid managed care programs that enrolled 60 percent of Medicaid beneficiaries in the United States (Centers for Medicare & Medicaid Services [CMS], 2016a).

Types and features of managed care for all older adults

Older adults often enroll in managed care either through MA or state-based Medicaid managed LTSS (MLTSS) programs. For the most part, these Medicare and Medicaid managed care programs operate independently, cover different types of services, and have different requirements and standards.

Medicare Advantage

Medicare Advantage—otherwise known as Medicare Part C—is offered by private insurance plans and covers all of the services that Original Medicare covers under Medicare Parts A, B, and D: emergency department care; inpatient hospital care; home healthcare; and a limited number of days in a skilled nursing facility (all under Medicare Part A); physician visits, and other outpatient care (under Medicare Part B); and prescription drugs (under Medicare Part D).

Enrollment in Medicare Advantage (MA) plans grew from 9.7 million in 2008, to 17.6 million in 2016.

MA plans may contract with community-based providers to conduct the health risk assessments required of all new enrollees, or to provide services such as home healthcare.

MA enrollment is voluntary. Beneficiaries can sign up for a MA plan during the annual open enrollment period (October 15 through December 7) and can disenroll from their MA plan and return

to Original Medicare during the Medicare Advantage Disenrollment period (January 1 through February 14). Other than a few special circumstances, enrollees are locked in to their MA plan for the rest of the calendar year.

In addition to the beneficiary protections in Original Medicare, MA plans offer a number of other protections. To ensure access to care, plans must meet network adequacy standards for the numbers and types of providers in their plans, as well as standards for provider proximity to beneficiary residences. When a plan denies coverage of a service, it must explain the denial and what steps the beneficiary can take to appeal the decision. There is a five-level appeals process that begins within the health plan and extends up to federal district court. MA enrollees also have the right to file a grievance against their plan or specific providers.

To ensure access to care, MA plans must meet network adequacy standards for the numbers and types of providers in their plans.

Medicaid MLTSS programs

State-based Medicaid MLTSS programs are the other type of managed care program commonly serving older adults. An increasing number of states are using managed care for low-income older adults and people with disabilities who need LTSS, including institutional care and home- and community-based services (e.g., home health aide services, adult daycare programs, personal care services, non-emergency medical transportation). As noted above, some MLTSS programs integrate LTSS with primary, acute, and behavioral healthcare.

Enrollment in state Medicaid MLTSS programs may be voluntary (as in Massachusetts' Senior Care Options program) or mandatory (as in Tennessee's TennCare CHOICES program). MLTSS enrollees are usually locked in to their managed care plan for one year. All Medicaid MLTSS programs have network adequacy standards and a four-level appeals process, as well as other beneficiary rights and protections that vary by state. Last, states are required to develop care management requirements for person-centered needs assessments, service planning, and service coordination consistent with federal guidance and regulations.

Depending upon the state, the managed care organizations that participate in MLTSS programs may contract with a wide variety of CBOs to provide services, including eligibility screening, enrollment options counseling, in-home assessments, care planning, and care management and coordination. These providers are especially key given their role in addressing social determinants of health (e.g., poverty, unstable housing, food insecurity, low literacy) and, as a result, potentially improving overall health outcomes.

It is worth noting that Accountable Care Organizations (ACO), while not necessarily based on traditional capitated managed care arrangements, are another type of "managed" delivery structure that serves older adults. ACOs are provider-led models found predominantly in Medicare and, increasingly, in state Medicaid programs. ACOs seek to meet both quality and cost targets, and may be particularly useful in serving beneficiaries in areas with low rates of managed care penetration. States are interested in exploring how ACOs could partner with CBOs to provide care coordination and other supports to prevent hospital readmissions.

How Managed Care Serves Dually Eligible Beneficiaries

Close to 6 million individuals older than age 65 receive services from both the Medicare and Medicaid programs. For these dually eligible individuals, Medicare broadly covers primary and acute care services (including hospital and post-acute care) and prescription drugs. Medi-

caid generally covers LTSS, Medicare cost-sharing, and some wraparound services not covered by Medicare.

Historically, dually eligible beneficiaries were not included in Medicaid managed care programs because of their complex care needs and the lack of financial incentives for insurers to coordinate their care without having the ability to influence both Medicare and Medicaid service use (Kruse, 2014). Had state Medicaid agencies paid for expanded care coordination services and LTSS, any resulting savings would most likely have accrued to Medicare. The result for many dually eligible beneficiaries has been fragmented, uncoordinated care, which, in turn, often leads to reduced access to care, poor care quality, and high costs in the form of avoidable emergency department visits and inpatient stays.

Managed care's ability to provide team-based, integrated care now allows for more effective care coordination for dually eligible beneficiaries who often have complex medical, behavioral health, and LTSS needs. Dually eligible beneficiaries are being served through three special types of managed care programs, as outlined below.

Dual Eligible Special Needs Plans (D-SNP)

D-SNPs are a type of MA plan that provides a coordinated Medicare and Medicaid benefit package and offers a higher level of integration than regular MA plans or traditional Medicare fee-for-service. D-SNPs must contract with the Medicaid agencies in the states in which they operate, and in their contracts they must specify a process for coordinating enrollees' Medicare and Medicaid benefits. This function is important because it helps reduce the fragmentation and discontinuity of care often experienced by dually eligible individuals in the FFS system. Approximately 1.8 million dually eligible beneficiaries are enrolled in D-SNPs (CMS, 2016b).

Aligned D-SNP/MLTSS plans

States can also use their contracts with D-SNPs to provide Medicare and Medicaid benefits in-

cluding LTSS and-or behavioral health services. Some states even require that health plans offer a D-SNP in every service area in which they have an MLTSS plan, or vice versa. This potential for aligned enrollment can help to further integration because enrollees would receive all Medicare and Medicaid services from the same health plan.

Medicare-Medicaid Plans under the Medicare-Medicaid Financial Alignment Initiative

Through the Medicare-Medicaid Financial Alignment Initiative, twelve states are testing either managed fee-for-service or capitated models of integrated care. In the capitated model, a state, CMS, and a health plan enter a three-way contract under which the plan (known as a Medicare-Medicaid Plan) provides seamless and comprehensive coverage for integrated Medicare and Medicaid services in return for a combined prospective payment. Medicare-Medicaid Plans also must provide interdisciplinary care team management to beneficiaries with complex needs. The demonstration programs will run at least through 2018, and, thus far, they cover approximately 400,000 beneficiaries.

The Future of Managed Care

In the coming years, managed care programs will continue to grow. Enrollment in MA by 2026 is expected to reach 41 percent of Medicare beneficiaries (Jacobson et al., 2016). The enrollment of dually eligible beneficiaries into managed care arrangements is also likely to grow. Plus, the number of states with Medicaid MLTSS programs is increasing. In 2004, only eight states had MLTSS programs (Saucier et al., 2012), but as of 2016, nineteen states have MLTSS programs and two more plan to launch MLTSS programs in 2017 or 2018 (Kruse and Ensslin, 2016).

Several related trends are emerging that support managed care's aim to improve quality and reduce costs compared to the fee-for-service system, as follows:

Rebalancing the Provision of LTSS from Insti-tutional to Community-Based Settings. The growth of MLTSS programs will likely strengthen efforts to rebalance the provision of LTSS from institutional to community-based settings. MLTSS program payment rates can be structured to stimulate care delivery in community settings (Musumeci, 2015).

Addressing Social Determinants of Health. Managed care programs increasingly are recognizing the connection between social determinants and health outcomes. While Medicaid programs have typically only paid for direct medical care or services that foster access to care, (including care coordination, interpretation, and transportation), some states are implementing innovative programs that allow Medicaid to pay for a broader range of supportive services, which

Building Business Acumen Among Community-Based Providers

Community-based providers may be unfamiliar with how to package and price their services in a way that allows them to contract with managed care plans, health systems, or ACOs. As enrollment of older adults and other higher-need populations into managed care arrangements grows, the U.S. Department of Health and Human Services' Administration for Community Living has developed a program to help aging and disability community-based networks to strengthen their partnerships with the healthcare sector. Through the Business Acumen for Community Based Organizations (goo.gl/6ehRPD) program, eleven networks of community-based aging and disability organizations are participating in a learning collaborative and receiving targeted technical assistance to build their business acumen. Lessons from the learning collaborative will assist other CBOs as they position themselves to enter into agreements with managed care organizations.

include housing-related services and environmental modifications. CBOs can play a key role in ensuring that beneficiaries' non-medical needs are identified and adequately met.

Adopting Value-Based Purchasing Strategies. Adopting value-based purchasing (VBP) stra-tegies that tie payments to performance on quality measures is a major trend in both Medicare and Medicaid, including within their respective managed care programs. VBP arrangements include the following: performance incentives or penalties; shared savings and-or risk against quality and cost targets; episode-based or bundled payments; and global payment programs. Both Medicare and state Medicaid programs will continue to rely on VBP to improve the quality of care provided and will turn to managed care organizations to create VBP arrangements with their providers.

Conclusion

The major shift toward managed care in Medicare and Medicaid is having a profound impact on care delivery for older adults. Larger and larger numbers of individuals with more complex care needs will be enrolling in managed care programs. The focus of these programs on providing integrated, team-based care is pushing the development of new service delivery models. The shift to managed care also represents a cultural shift for many community-based providers who may feel as if they are entering unfamiliar territory. The good news is that the skills and mission-driven focus of these providers will be a valuable addition to managed delivery systems. The challenge is for CBOs to adapt to this culture and develop the business skills to successfully transition into this new environment.

Some states are implementing innovative programs that allow Medicaid to pay for a broader range of supportive services.

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References

Centers for Medicare & Medicaid Services (CMS). 2016a. *Medicaid Managed Care Enrollment and Program Characteristics, 2014*. Baltimore, MD: CMS.

CMS. 2016b. *SNP Comprehensive Report: October 2016*. Baltimore, MD: CMS.

Jacobson, G., et al. 2016. *Medicare Advantage 2016 Spotlight: Enrollment Market Update*. Menlo Park, CA: Kaiser Family Foundation.

Kruse, A. 2014. *Strategies to Facilitate Managed Care Implementation for Medicare-Medicaid Enrollees*. Hamilton, NJ: Center for Health Care Strategies.

Kruse, A., and Ensslin, B. 2016. *State Trends in the Delivery of Medicaid Long-Term Services and Supports*. Hamilton, NJ: Center for Health Care Strategies.

Musumeci, M. 2015. *Rebalancing in Capitated Medicaid Managed Long-Term Services and Supports Programs: Key Issues from a Roundtable Discussion on Measuring Performance*. Menlo Park, CA: Kaiser Family Foundation.

Saucier, P., et al. 2012. *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update*. Baltimore, MD: CMS.

Snyder, L., and Rudowitz, R. 2016. *Trends in State Medicaid Programs: Looking Back and Looking Ahead*. Menlo Park, CA: Kaiser Family Foundation.

Who Cares? Implications of Managed Care for Organizations and the Communities They Serve

By Jennifer Dexter

A more coordinated system will work well, as long as its development includes the voices of people with disabilities, older adults, and providers.

Medicaid, the primary funding source for the majority of long-term services and supports (LTSS) for people with disabilities and older adults, is changing significantly. Those individuals covered by Medicaid and the service providers supporting them must adjust to ensure that people with disabilities and older adults continue to have access to needed services and supports, including the protection of their entitled rights. The increase in the numbers of people with disabilities and older adults covered by managed care is a critical issue for organizations providing services to these populations. This new demographic is resulting in a restructuring and reconsidering of business practices, service-delivery models, partnerships, and infrastructure.

Learning to change thinking and structures to align with MCO needs is a significant issue for providers.

One of the greatest transformations happening now is that states are rapidly evolving their Medicaid programs to address both increasing need for services and fiscal constraints. Reasons for this evolution are myriad, but the primary drivers are states seeking to have a more managed and predictable Medicaid budget and increased incentives to do a better job of providing home- and community-based services under Medicaid. This evolution includes integrating LTSS with basic healthcare services under a managed care model.

According to the National Association of States United for Aging and Disabilities' (NASUAD) *State Medicaid Tracker* as of August 2016, twenty-one states are implementing managed long-term services and supports (MLTSS) programs and requiring people with disabilities and older adults to go through a managed

→ABSTRACT States are rapidly evolving their Medicaid programs to address the increasing need for services and fiscal constraints. This transition to managed care in Medicaid, particularly in managed long-term services and supports (MLTSS), requires community-based organizations to have record-keeping and financial systems that can interact with multiple managed care organizations. There will need to be a greater emphasis on partnerships. The LTSS system will also transform to a less specialized approach. And, there will be a continued and increasing focus on cost containment. **| key words**: *Medicaid, managed care, managed long-term services and supports, community-based organizations*

care organization (MCO) to receive services (NASUAD, 2016). Because they remain under the Medicaid umbrella, most of these waivers require MCOs to deliver a comprehensive set of benefits.

While this article will focus primarily on the transition to managed care in Medicaid, and particularly MLTSS, there are many ways people with disabilities and older adults might be covered by managed care. These include Medicare Special Needs Plans, demonstration programs for individuals dually eligible for Medicare and Medicaid, and Accountable Care Organizations. Many of the opportunities and challenges that the transition to MLTSS offers apply to these other models.

MLTSS models, while relatively untested to date, offer opportunities for improving care coordination, and-or expanding access to LTSS. The following is an overview of some of the effects of transitioning to MLTSS.

Transitioning to MLTSS

One of the bigger shifts when working under managed care is the relationship between the funder and the service provider. Under traditional models, providers negotiate a rate and provide a unit of service. This negotiation happens once and may be revisited regularly, based on budgets, but it is a fairly straightforward process.

In a managed care model, ideally there is a partnership between the MCO, the provider, and the individual to coordinate and maximize care, while minimizing costs. This means a need for more regular communication about progress and ongoing needs.

MCOs coordinate more aspects of care, and may be looking for partners to provide a complete suite of services instead of having to develop multiple contracts with specialist provider organizations to create that full array of services. Learning to change thinking and structures to align with MCO needs is a significant issue for providers.

Teaching MCOs about providers' experience and practices is equally important. The experience of organizations like Easterseals is deep—we have a long history of working with people with disabilities and older adults. Taking the knowledge we have about populations we serve and infusing it within the business acumen that MCOs possess can make for a powerful partnership. We are known and trusted by the people we serve, and we can help individuals navigate the transition to MLTSS. There is much to be learned from each other.

Organizations such as Easterseals understand the impact on outcomes of access to value-added services such as transportation, recreation, respite, employment, and

caregiver supports. While increasing access to these critical services can be difficult to achieve in tight fiscal times, the partnership between MCOs and provider organizations can work to increase access to those services. MCOs are motivated to include these services as preventive measures that will avoid more costly services later. Traditional Medicaid does not offer those incentives.

What the Transition Means for Clients

For individuals covered by MCOs, the best-case scenario is that the change is relatively transparent to them. Comparable services to what was available under traditional Medicaid should be available under managed care, with the addition of better care coordination. While this has happened for many, other individuals continue to face challenges accessing care. In actuality, experience is showing that the barriers to accessing needed services are comparable, but slightly different, under managed care. People still face uphill battles to get coverage for everything they need, and MCO administration can be difficult to navigate when seeking redress for an issue.

There will be a continued and increasing focus on cost containment that will require constant vigilance by individuals and providers.

One of the most difficult issues for providers may be interacting with MCO infrastructures. The transition to MLTSS requires community-based organizations (CBO) to have record-keeping and financial systems that can interact with multiple MCOs. While healthcare entities providing acute care have undergone a tremendous transition to electronic health records, a similar transition has not happened for LTSS providers. Providers will need financial and technical assistance to create infrastructure that will work in a managed care environment. MCOs are usually supportive in this transition, but in some cases, it can be financially prohibitive for the provider. If there is not some funding for CBOs to support infrastructure improvements, the system may not be as efficient or as comprehensive as it needs to be and some providers may not be able to provide needed services.

There is tremendous opportunity to improve services for people with disabilities and older adults under managed care. With adequate infrastructure and service reimbursement, there can be a true partnership between the individual, the provider, and the MCO. And if the system can shift to support new models of service, people will have access to more holistic and coordinated care. Time is of the essence, though, and MCOs, providers, and individuals must work together to assure all these "ifs" become reality.

There also is great risk for people with disabilities and older adults. At the end of the day, the ultimate goal of moving to managed care is to control costs. People with disabilities and older adults often need higher levels of service than the general population. Without protections, services for people with disabilities and older adults may be limited to manage costs. Education will be critical in this area.

An MCO without experience in early intervention services might not understand that physical therapy for a child with a disability who is working on learning to sit is different than an adult working on the same goal after an injury. For the child, that therapy may result in their ability to sit within several years time, while it might be months for an adult. If an MCO sets a cutoff for funding therapy when a goal (like sitting independently) is not achieved after a few months, the child could be denied needed services. This may be due to a lack of understanding about the needs of a specific population or indivi-

dual, and can result in that individual needing more intensive, higher cost services later. State Medicaid systems, providers, and MCOs need to work together to avoid such situations during this time of change.

One of the other areas of concern is the lack of political leverage that transitioning Medicaid to managed care means for people with disabilities and older adults. When states move to managed care, private MCOs are responsible for prioritizing services, instead of the state. There will be less political leverage for providers and consumers to fight for specific services and programs. From a state legislator's point of view, they have budgeted for the program and it is then up to the MCO to allocate those funds appropriately, with guidance from the state. If a state decides to cut funding for a specific Medicaid program that serves older adults with dementia, providers and families can work together to advocate at the state legislature to change that decision. If an MCO decided to limit the same therapy, the discussion will be between families and a private organization that may or may not act on their entreaties. We need to make sure that the system remains responsive to advocacy and input from the public about real needs and experiences.

Outcomes, Going Forward

Going forward, several outcomes seem likely. The first is a greater emphasis on partnerships. This will include partnerships between MCOs and providers, individuals and providers, acute care and LTSS providers, and among LTSS providers. The LTSS system as a whole will also transform to a less specialized approach to care. This can take many forms, from working together to develop creative models of comprehensive care to improving communication and business relationships to present a united front to MCOs. Finally, there will no doubt be a continued and increasing focus on cost containment that will require constant vigilance by individuals and providers.

The opportunities presented by a more coordinated approach to care will not come to pass if we do not include the voice of people with disabilities, older adults, and providers in both system development and in ongoing administration of services. Efforts like intensive community engagement during the transition to MLTSS, provider advisory groups working with MCOs during plan development, and other strategies will help achieve the best systems possible.

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References

National Association of States United for Aging and Disabilities (NASUAD). 2016. *State Medicaid Integration Tracker*. www.nasuad.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker. Retrieved October 18, 2016.

The Case for Building a Mindset of Change: Not Just Business as Usual

By Bradley Gilbert

> A successful managed care organization will have a mission focused on doing the right thing for its members.

Today, more than 35 million Americans are ages 65 or older, with that number expected to reach 70 million by the year 2032 (National Institute on Aging, 2007). And while advances in technology, lifestyle, and access to medical care mean many older adults are living longer and often healthier lives, the National Council on Aging (2016) estimates that 80 percent of older adults have at least one chronic disease, and 68 percent have at least two.

Managed care organizations should support providers' use of technology to enhance care coordination.

Additionally, an estimated 20.4 percent of adults ages 65 and older meet criteria for a behavioral health disorder, most commonly anxiety, cognitive impairment, and mood disorders such as depression or bipolar disorder (Karel, Gatz, and Smyer, 2012). Older adults with depression visit the doctor and emergency room more often, use more medications, incur higher outpatient charges, and stay longer in the hospital (Centers for Disease Control and Prevention [CDC] and National Association of Chronic Disease Directors, 2008).

A significant number of older adults is also of low income; six out of ten Americans (5.5 million) who are enrolled in both Medicare and Medicaid are ages 65 or older (American Hospital Association [AHA], 2011). At Inland Empire Health Plan (IEHP), which serves more than 1.2 million low-income members in California's Inland Empire—one of the largest and fastest-growing metropolitan areas in the nation—more than 55,000 members are low-income older adults. Most have a disability or one or more chronic illnesses. Many struggle with both.

Successfully serving this complex, high-need, and potentially high-cost population in the managed care market requires flexibility, openness, and an out-of-the-box mindset, combined

→ABSTRACT Successfully serving the needs of older adults in a managed care setting requires flexibility, openness, and innovation. A care management focus encompassing holistic health, and meeting older adults' health and psychosocial issues, along with immediate medical needs, is critical. Equally important are partnerships with community-based organizations that provide social support, transportation, and housing, all of which have a significant impact on overall health. Also key is a strong provider network in which the health plan and physicians align to meet patients' needs, while creating shared value. **| key words**: *managed care, community-based organizations, chronic disease, behavioral health, social determinants of health*

with effective care management and collaboration among providers, payers, and community-based organizations (CBO).

The Importance of Care Management

Effective care management is the backbone of any successful managed care model, and is even more important when caring for older adults with chronic health and behavioral health needs. It goes beyond meeting immediate healthcare needs to incorporate treatment of underlying health issues, including behavioral issues, as well as lifestyle and psychosocial support. This represents a sweeping culture shift in the healthcare industry. Doctors, hospitals, and payers have traditionally focused on treating the patient's chief complaint, rather than addressing root causes (Rich et al., 2012). Today we must embrace a model of holistic health.

The most successful care management models incorporate many of the same characteristics, as follows:

- **Comprehensive health assessments and personalized care plans that ensure care is provided in the most appropriate setting, including home-based care.** A thorough health assessment will identify which services the person needs, including non-medical needs, and identify community-based resources and government programs for which the member might qualify.
- **An infrastructure that supports the seamless transition of patients between care settings.** For example, an older adult should receive appropriate follow-up from their primary care provider after discharge from a hospital stay. Studies show that such follow-up visits decrease hospital readmissions and emergency room visits, particularly for patients with chronic conditions (Society of Hospital Medicine, 2014). Good care management uses appointment scheduling and reminders, assists with transportation issues, and addresses other barriers to ensure older adults receive the follow-up care they need.
- **Resources for addressing behavioral health and psychosocial issues, and providing social support, housing, and other needs.**

Mental health problems are two to three times more common in patients with chronic medical illnesses (Croghan and Brown, 2010). Older adults with depression visit the doctor and emergency room more often, use more medication, incur higher outpatient charges, and stay longer in the hospital (CDC and National Association of Chronic Disease Directors, 2008). Research also shows that social isolation among older adults is as detrimental to health as smoking or inactivity (Knickman and Snell, 2002). A good care management program will address behavioral health needs, as well as issues such as loneliness, isolation, declines in hearing, sight, taste, and smell, and other psychosocial factors that affect overall health.

'An estimated 20.4 percent of adults ages 65 and older meet criteria for a behavioral health disorder.'

- **Care managers who build rapport with patients through frequent interactions and who coordinate communications among multiple providers.** The care manager understands the individual's medical, cultural, and psychosocial needs, and provides a single point of contact between the member and the health plan. The care manager also helps solve problems the member may have in understanding medication or treatment recommendations—confusion often caused by conflicting information provided by multiple doctors, along with other issues.
- **A strong medication management component.** Many older adults, especially those with multiple chronic conditions, fail to take their medications correctly, or are on medications that conflict with one another. This can happen for multiple reasons: they can't afford the proper medications, they can't get to the pharmacy, they don't understand how the medications work, they have vision problems that prevent them from reading the medication label—or they simply forget. Telephone support and home visits with medication review and education, when needed, should be part of all care management models.
- **A patient education component to ensure adherence to medication and treatment recommendations.** Education encourages older adults to participate more actively in managing their own care, and can improve overall health outcomes, particularly among individuals with multiple chronic conditions (Dreeben-Irimia, 2010).
- **Use of technology that ensures care is coordinated, whether the patient receives care in a doctor's office, hospital, rehabilitation center, at home, or in another care setting.** Many doctors traditionally work in silos, a fragmented approach to care in which a primary care physician may not know what treatment or medication a specialist is prescribing and vice versa (Molden, Brown, and Griffith, 2013). It is important for managed care organizations to support providers' use of technology to enhance care coordination.

IEHP offers a secure online provider portal allowing physicians to view their patients' health records, lab results, health risk assessments, and other key information. Physicians can receive alerts when their patients access certain health services (which may indicate the need for follow-up care), and when patients are due for immunizations and preventive care.

Community Collaboration Is Key

Community partnerships are essential to meeting older adults' comprehensive health, behavioral health, and psychosocial needs. CBOs and agencies are an important resource for addressing older adults' housing needs and providing social support, in-home assistive services, transportation, meal services, legal aid, and other assistance. Engaging CBOs in collaborative partnerships has been shown to improve care delivery and access, enhance care coordina-

tion, and build healthier communities overall (Silow-Carroll and Rodin, 2013).

IEHP has spearheaded the development of several such collaboratives. In 2006, IEHP brought together more than 300 organizations in the region serving people with disabilities, many of whom were older adults. The resulting Inland Empire Disabilities Collaborative has successfully shared resources and worked together to meet the full scope of health and social service needs of elders in the Inland Empire.

'Successful managed care organizations will develop programs tailored to meet their members' specific needs.'

IEHP also has partnered with the local housing authority and a private foundation in another program that provides homeless members with a safe place to stay when they are discharged from the hospital. Individuals are given a clean place to sleep, daily meals, hygiene supplies, and access to laundry facilities for one to three weeks as they recover from an injury or illness. They receive medical care, wound care, medications, and transportation to follow-up appointments. They also get help applying for food stamps and other benefits, and are connected with supportive services to help them find long-term stable housing.

Another example of organizations working together is the Inland Empire Health Information Exchange, a regional collaborative of hospitals, clinics, physician practices, health plans, and other providers. The collaborative, in which IEHP participates, allows clinicians to securely access medical records of more than 5 million Inland Empire residents when they seek care, regardless of where the care was provided.

Building a Strong Provider Network

A strong provider network is critical to any successful managed care organization. Building and maintaining solid partnerships between health plans and physicians can be challenging, as the goals of physicians (better care) and health plans (better value) have sometimes diverged. Today, providers and health plans must align around the interests of patients, creating shared value by working together to improve quality and eliminate inefficiencies.

A successful provider network serving older adults must span the entire care continuum. It must include not only primary and specialty care physicians and hospitals, but also pharmacies, behavioral health providers, home health agencies, rehabilitation centers, social services, and vision-care providers. This comprehensive network approach is vital to providing timely care in the most appropriate care setting, including at home.

Identifying providers who are already serving older adults in a market and bringing them into the network is a key strategy. Older adults are more likely to join and remain in a managed care organization when they can keep a primary care physician they know and trust (Goold and Lipkin, 1999).

Innovation—A Critical Part of the Equation

Innovation is not a word often used to describe managed care health plans. But healthcare today is changing so rapidly that finding new approaches to working with members, providers, and community partners is critical.

Successful managed care organizations will develop programs tailored to meet their members' specific needs. In 2016, IEHP developed a program to provide in-home medical care and education for low-income older adults and persons with disabilities who have five or more chronic health conditions. This population is the most likely to miss medical appointments and fail to fully comply with recommended treatment plans. An interdisciplinary team of providers, including a social worker, gets to know the member's individual needs. Through house calls, phone support, and member access to the care team twenty-four hours a day, 365 days a year,

members' chronic health conditions are managed, while members learn to better understand and care for their own health.

Above all, a successful managed care organization will have a mission focused on doing the right thing for its members. The organization's leadership and its workforce must believe in their work and be committed to affecting people's lives in a meaningful way.

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References

American Hospital Association (AHA). 2011. "Caring for Vulnerable Populations." AHA Committee on Research. www.aha.org/research/cor/caring/index.shtml. Retrieved September 28, 2016.

Centers for Disease Control and Prevention, and National Association of Chronic Disease Directors. 2008. *The State of Mental Health and Aging in America Issue Brief 1: What Do the Data Tell Us?* National Association of Chronic Disease Directors. www.cdc.gov/aging/agingdata/data-portal/mental-health.html. Retrieved September 28, 2016.

Croghan, T. W., and Brown, J. D. 2010. "Integrating Mental Health Treatment into the Patient Centered Medical Home." Agency for Healthcare Research and Quality. https://pcmh.ahrq.gov/page/integrating-mental-health-treatment-patient-centered-medical-home#tocWh. Retrieved October 12, 2016.

Dreeben-Irimia, O. 2010. "Education in Rehabilitation." *Jones & Bartlett Learning* www.jblearning.com/samples/0763755443/55447_CH01_Dreeben.pdf. Retrieved October 11, 2016.

Goold, S. D., and Lipkin, M. 1999. "The Doctor–Patient Relationship: Challenges, Opportunities, and Strategies." *Journal of General Internal Medicine* 14(Suppl. 1): S26–S33.

Karel, M. J., Gatz, M., and Smyer, M. 2012. "Aging and Mental Health in the Decade Ahead: What Psychologists Need to Know." *American Psychologist* www.ncbi.nlm.nih.gov/pubmed/21942364. Retrieved September 28, 2016.

Knickman, J., and Snell, E. 2002. "The 2030 Problem: Caring for Aging Baby Boomers." Health Research and Education Trust. www.ncbi.nlm.nih.gov/pmc/articles/PMC1464018/. Retrieved October 11, 2016.

Molden, M., Brown, C., and Griffith, B. 2013. "At the Heart of Integration: Aligning Physicians and Administrators to Create New Value." *FRONTIERS of Health Services Management* www.ache.org/chapters/downloads/chapter_education/materials_template79A.pdf. Retrieved October 11, 2016.

National Council on Aging. 2016. "Chronic Disease Management." www.ncoa.org/healthy-aging/chronic-disease/. Retrieved September 28, 2016.

National Institute on Aging. 2007. "Living Long and Well in the 21st Century: Strategic Directions for Research on Aging." www.nia.nih.gov/about/living-long-well-21st-century-strategic-directions-research-aging. Retrieved September 28, 2016.

Rich, E., et al. 2012. "Coordinating Care for Adults with Complex Care Needs in the Patient-centered Medical Home: Challenges and Solutions." Agency for Healthcare Research and Quality. https://pcmh.ahrq.gov/page/coordinating-care-adults-complex-care-needs-patient-centered-medical-home-challenges-and#h. Retrieved October 11, 2016.

Silow-Carroll, S., and Rodin, D. 2013. *Issue Brief: Forging Community Partnerships to Improve Health Care: The Experience of Four Medicaid Managed Care Organizations.* The Commonwealth Fund. www.commonwealthfund.org/~/media/files/publications/issue-brief/2013/apr/1687_silowcarroll_forging_community_partnerships_medicaid_managed_care_ib.pdf. Retrieved October 12, 2016.

Society of Hospital Medicine. 2014. "Follow-up Appointments Project BOOST® Implementation Toolkit." www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality___Innovation/Implementation_Toolkit/Boost/BOOST_Intervention/Tools/Follow_Up_Appointments.aspx. Retrieved October 10, 2016.

Developing a Model Concept and Clientele, with Potential Partners and Services

By Erin Lockwood and Lori Peterson

A step-by-step primer for organizations wanting to prepare a service model and form a partnership with a healthcare entity.

Successful partnerships often exhibit a number of common attributes, including strong communication, trust, and value for all parties, but less recognized is the structure that allows for these successes—the model design. The key to designing a model is first to create a framework that lays out every aspect of the relationship, from oversight to day-to-day operations. This article explores areas to consider as an organization develops a model and secures partnerships to improve the health system in their community.

Though positioning for a partnership with the healthcare sector may require a shift in approach and mindset, it is important to realize an organization's extant potential. Assets and skills already present can be used and improved to make the organization more sustainable. Repositioning or repackaging the organization's services can lead to success, as can peer education. For example, the Institute on Aging in San Francisco repurposed and repackaged a nursing home diversion program they had run for years, and secured a multi-million-dollar, value-based contract with a healthcare payer. It is now replicating this model for additional payers.

One community organization secured a multi-million-dollar contract with a healthcare payer by repurposing and repackaging their longtime nursing home diversion program.

Preparing to Design the Model

Though it may be tempting to jump straight to a model, it is crucial to strategically prepare for engaging healthcare providers and payers, as there are a number of avenues a partnership might follow. It is highly recommended that the organization complete an internal and external assessment first, plus develop a value proposition. The key to securing new partnerships is for an organization to convince the partner that their services hold value, and that it is the best entity to deliver that value.

→ABSTRACT Successful partnerships often exhibit a number of common attributes, including strong communication, trust, and value for all parties, but less recognized is the structure that allows for these successes—the model design. The key to designing a model is first to create a framework that lays out every aspect of the relationship, from oversight to day-to-day operations. This article explores areas to consider as an organization develops a model and secures partnerships to improve the health system in their community. **| key words**: *healthcare partnership, internal and external assessments, value proposition, managed care model*

An internal assessment clarifies what it will take to build capacity, while pointing out strengths, capabilities, benefits, and features that set the organization apart from its competitors. An external assessment provides insight into the needs of and opportunities within the community, while identifying potential partners and competitors. After completing these two assessments, key findings can be used to develop a value proposition that embodies the objective of a potential partnership with a healthcare entity, by addressing its needs (for more information on completing these initial steps, see our article in the November–December 2016 issue of *Aging Today*; www.asaging.org/blog/making-successful-cbo-floundering-flourishing).

These assessments ensure the organization will navigate the process purposefully, rather than without a clear direction. They also provide the information necessary not only to capture the interest of potential partners, but also to develop a model design for success.

Identifying Partnership Opportunities

The completed external assessment provides preliminary groundwork to identify potential partners in the local market, but it is important to further strategize and identify the type of partner that best matches the organization's strengths and intent. Is the organization looking to partner with a local hospital or health system, or are they better positioned to approach the local payers in the market?

Once the partner type has been narrowed down, it is time to explore potential opportunities in this category of provider. Hospitals may be assuming risk under a bundled payment program, or local payers may need to reduce costs for long-term supports and services. As such opportunities become clear, also clarified

should be the organization's value and unique features, capabilities, and benefits.

Concurrently, the organization must start shaping its desired partnership structure. What will be the nature of the relationship? It might be a contractual relationship, a co-created pilot, or even a grant-funded program. Though this does not need to be finalized immediately, it is an important aspect to begin exploring.

Creating the Model Design

When it comes to designing a successful model, there are a number of key questions to ask: What services will be provided? Who is the target population? What might the pricing structure look like? How might data be used? What will the communication structure be?

Rather than take a broad approach to answering these questions, break them down into key sections and dedicate attention and time to each. The end product will probably be better if there is a strong discovery process during section development. Use various methods, such as informational interviews, extensive research, data analysis, observations, and even visualization and drawing to explore every potential.

Identifying the model's objective

The first step is to set the stage for the next steps by understanding the big picture. What is the purpose of this model? In what way will it address partner, community, and organization concerns? What is the objective? The focus? To address these questions, think back to the value proposition. This statement might contain the answer to some of these questions, but now the organization must adapt it to conceptualize the model and drive the rest of the design process.

Determining what services to provide

When determining which services should be provided, it is most important to incorporate findings from the internal and external assessments. The organization might be interested in case management, transportation, meals, etc. For the services being considered, ask if there is a definite need for them in the community. Ask if competitors offer this service, in which case the organization will need to differentiate itself. Once the service offerings package is decided upon, then identify the resources necessary to carry them out, including staff, equipment, training, knowledge, and perhaps using the services of additional organizations.

Forging operations and service delivery

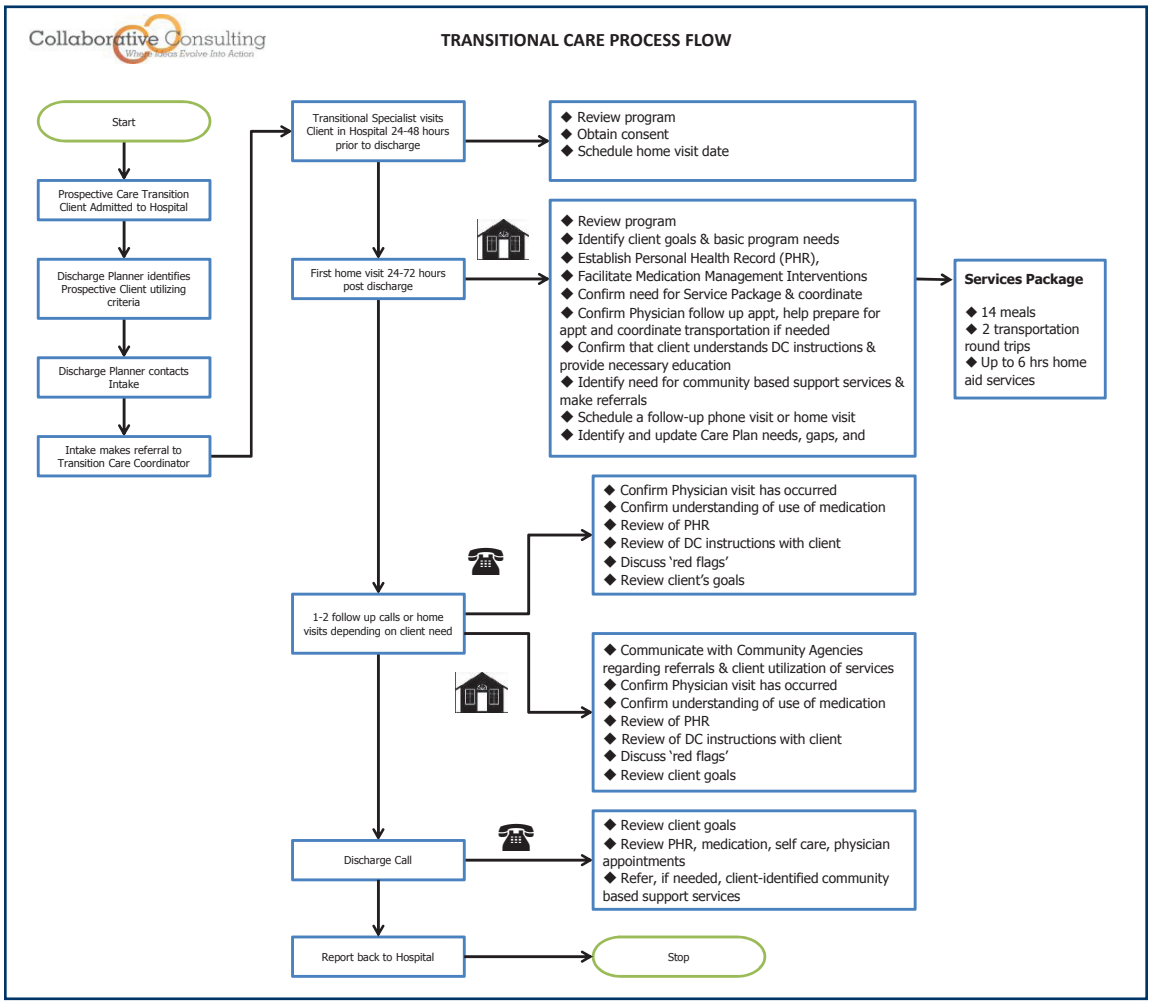
Once service offerings are finalized, begin work on the model structure. Create a walk-through of the service delivery, understand every aspect, including the communication and organizational structures, and the monitoring and evaluation processes. Crucial to successful operations is to identify and analyze every fine detail. A plan and model flow for each component is instrumental in achieving successful implementation, and provides a valuable visual reference moving forward. In designing the flow for each component, continually ask: What are next steps? Why? How? Be specific and, again, identify all necessary resources to achieve this—especially technology. How can using technology make the model better? What tools will help to achieve the goals and streamline the process?

When considering services to offer, ask if there is a definite need in the community for such services.

Understanding the finances

Finally, it is necessary to fully understand the finances. First, calculate the potential costs of this model. This should include fixed costs, variable costs, indirect costs, and any potential new costs, such as a technology platform to keep the operations running. Think of every possible detail, even down to handouts that might need to be developed and distributed, and be sure to overestimate, to leave room for negotiation. If a

Figure 1. Transitional Care Process



detailed flow chart was created in the previous step, it will be instrumental in determining costs (The SCAN Foundation has a number of valuable tools on this subject that can be found by visiting www.thescanfoundation.org/community-based-organizations).

Separate from costs is the need to determine pricing. The organization should consider the return on investment for itself and the partner. Also think about what it will take for the organization, and its model, to be sustainable. The organization also needs to ensure its pricing and offerings are competitive. Are there competitors that should be taken into account? And don't forget that a potential partner entity may want to build its own services.

Negotiation begins once a partner is secured and the model is being finalized. Imagine all possibilities, and be sure to incorporate these into the planning process. Ultimately, it may be necessary to refine the operation to meet the negotiated price, which might mean simplifying service offerings, reducing visits, or finding other cost-cutting measures. What is absolutely necessary for the model's viability? Where could the organization adjust? Extensive preparation in the planning phase leads to more confidence and success in these conversations.

The organization must also explore possible pricing structures and determine which will make the most sense. Should it be fee-for-service, a flat rate, or even a per-beneficiary, per-month fee? The type of partner, the services, the target population, and the model's scale will influence pricing structure. Last, when looking at finances, don't forget to explore alternative avenues of revenue, such as grants or Medicare and Medicaid reimbursements.

Measuring Success

As with any program, it is important to develop a monitoring and evaluation process—a method for measuring the program's success and determining what is and isn't working. In doing so, it is important to keep in mind the partner's expectations, as well as to remember the model's original objective. What measures need to be collected to assess whether these needs are being met? It could be readmission rates, adverse reactions, medication errors, etc., or a combination of several. Take into account the individuals invested in the models, as they are likely to measure success differently, and all forms of measurement will need to be addressed. Once necessary measures are identified, the organization needs to determine when and how measures will be collected, shared among organizations, and analyzed.

Moving Toward Implementation

Before engaging with a potential partner, think about running through the entire model design once or twice internally. Critically analyze the design and evaluate whether elements need to be changed or further examined. An outside perspective also can be valuable. Once confident in the proposed design, then approach the potential partner. At this point, a thorough model design should illustrate the organization's preparation and due diligence, but also show a willingness to build a lasting partnership and adjust the proposed design to achieve this.

Before engaging with a potential partner, consider testing the model design once or twice internally.

Understand that even with this preparation, a partnership is not guaranteed. It may take two or three attempts at identifying and reaching out to a potential partner before a partnership forms. Be patient and persevere. Remember also to be flexible in developing and finalizing any type of partnership. Though it may be tempting to seek immediate full implementation, realize there is value in first testing the concept, such as through enacting a small pilot.

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Pricing Strategies for LTSS Providers

By Victor Tabbush

How CBOs can—and should—set prices to maximize net revenues.

When pricing its long-term services and supports (LTSS) to a healthcare partner, a community-based organization (CBO) must decide upon more than the proper pricing. First, the CBO must specify the goal the price is designed to achieve. The goal might be to allow unfettered access to services—suggesting a low price; another might be to acquire business, even if means a short-term loss; yet another goal could be to maximize net revenues.

Second, the CBO must decide what *unit* is to be priced. The price could be for each unit of *service*—called fee-for-service; the CBO could also accept a certain amount per person, with the volume of services per person being unspecified. This is known as capitation. And as the final possibility, the CBO sets a price for each successful outcome. This is known as payment for value. The third decision is then what price to charge.

'The CBO must specify the goal the price is designed to achieve.'

This article provides useful pointers on how to set prices under these assumptions: fee-for-service has been decided upon, and the CBO wants to maximize net revenues. I will first distinguish among four potential scenarios or contexts for the CBO. Each scenario calls for unique pricing considerations. (These scenarios are illustrated in Figure 1, page 31.)

Think of a spectrum of control, with the CBO's degree of control over price-setting on the horizontal axis. The extreme left point corresponds to zero control for the CBO; here the buyer is in total control. I call that extreme case scenario **unilateral buyer control:** The **buyer** sets the price and the seller then must decide to accept or reject it.

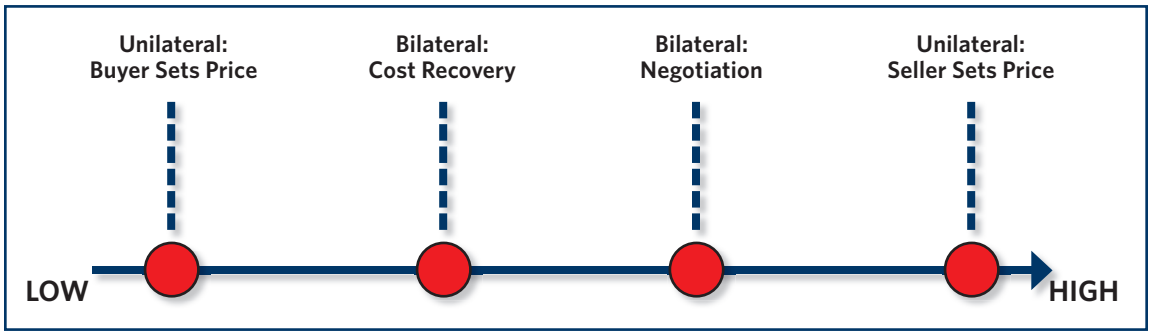
To the far right on the spectrum lies a scenario where the seller is in total control. I call this situation **unilateral seller control:** the **seller** sets the price, not the buyer. The buyer then accepts or rejects that price.

In between these extremes we have two intermediate scenarios where control over price setting is **shared** between parties. These contexts, cost-recovery pricing and pricing through negotiation, are ones in which control is bilateral or divided. It is crucial to understand the context for pricing because strategies and results differ substantially.

1. **Unilateral: Buyer.** The CBO has no discretion over price; instead, the medical partner dictates it. The CBO either takes it or leaves it.

→ABSTRACT This article provides specific strategies on how community-based organizations (CBO) should set prices in a fee-for-service system with healthcare partners. Four pricing scenarios are explained: unilateral buyer, in which the medical partner dictates pricing; bilateral cost recovery, in which the CBO charges a price that reasonably reflects its costs; bilateral negotiation, in which both parties negotiate pricing; and unilateral control, in which the seller sets the price. **| key words**: *CBOs, healthcare partners, fee-for-service pricing*

Figure 1: CBO Pricing Scenarios



Source: Victor Tabbush, September 23, 2016.

In this context, the CBO ought to perform breakeven analysis to decide whether or not to do business. The breakeven volume is that critical service volume resulting in neither profit nor loss. All costs, including those that are fixed, are covered at breakeven by revenues. The CBO must be reasonably certain that the service volume promised by the medical partner is sufficient; otherwise it is best to reject the contract.

2. **Bilateral: Cost Recovery.** The CBO can charge a particular price to the extent it can demonstrate to the medical partner that the price is a reasonable reflection of its costs. My advice is to use the **full cost recovery** (FCR) method to establish such a price. FCR covers the total cost of a service, including costs not directly related to delivering it. These indirect costs are, however, necessary to run the organization. FCR reduces the requested overhead percentage, a line item where it will meet resistance from the partner, and instead converts indirect costs into direct cost items through an allocation mechanism. The following example (and see Table 1, below) illustrates this method.

This example illustrates how FCR can yield a higher price for a seller. The service here is a 30-day post-discharge care coordination program offered by a CBO to a hospital for those patients most at risk for readmissions.

Table 1: Full Cost Recovery

Traditional Cost Accounting		FCR Accounting	
Payments to providers	$650	Payments to providers	$650
Provider IT equipment	$50	Provider IT equipment	$50
Mileage to/from clients	$100	Mileage to/from clients	$100
Client meals	$150	Client meals	$150
Client supplies	$50	Client supplies	$50
Total Direct Cost	$1,000	* Project management	$130
Indirect Cost (25%)	$250	* IT support	$5
		* Payroll taxes	$52
		* Payroll processing	$32
		Total Direct Cost	$1,219
		Indirect Cost (10%)	$122
Total	**$1,250**	**Total**	**$1,341**

* Represents cost item that was implicit in the traditional cost accounting method as embedded in the indirect cost allocation. Under FCR, the item appears as a direct cost.

Source: Victor Tabbush, September 23, 2016.

Notice how in traditional cost accounting, the overhead charge tends to be high—here, 25 percent of direct costs, a percentage imposed to cover those expenses that are difficult to allocate directly to the program. The CBO would then ask the hospital for $1,250 per client.

While difficult, it is not impossible to allocate indirect cost as shown in the column labeled "FCR Accounting." Here is how it works. Care providers report to and must be supervised by program managers and other administrative staff. Thus, an allowance for this necessary supervisory expense can be made, with the corresponding cost placed in the direct cost category. A possible basis for this allocation is the ratio of supervisory to direct provider salaries. Next, the care providers result in the CBO having to pay payroll taxes and also to incur payroll-processing charges to an outside vendor. Payroll taxes are at stipulated rates, posing no allocation challenges; payroll-processing charges can be allocated by dividing the entire CBO payroll by the pay of the providers required by this program.

Use the full cost recovery method to establish pricing that is a reasonable reflection of costs.

Finally, if providers are equipped with communication devices (iPads and iPhones, for example), they must be trained and supported by the CBO's information technology (IT) staff. Pro rata allowances for these expenses are straightforward. For example, IT expenses can be allocated on the basis of the number of devices operated by these care providers as a proportion of all devices used by the CBO.

These expenses, now labeled as direct costs, were previously incorporated into the indirect charge of 25 percent. The results of this full cost allocation scheme are twofold:

first, the overhead charge can be reduced (to 10 percent, in this case) because the rate no longer needs to cover so many indirect costs. Because partners are disinclined to accept high overhead rates, this is an advantage for the CBO. The second resulting advantage is less uncertain: the CBO can justifiably ask for a higher price—one that more accurately reflects its true costs. In this case, the requested fee rises from $1,250 to $1,341.

3. **Bilateral: Negotiation.** The price is negotiated between parties. The process must result in a mutually beneficial outcome. For the seller, the agreed upon price must exceed its costs; for the buyer, that price must be less than the maximum amount (value) it is prepared to pay. The CBO will achieve a more favorable price under these conditions: it creates a high value for the buyer; it faces little, if any, competition; and, it has information about its own costs, the value it delivers, and how that compares with the competition.
4. **Unilateral Control:** Seller sets the price. Here there is no need to justify price on the basis of

costs; nor is it a negotiation. The seller sets the price unilaterally. Now it is the buyer who must either take it or leave it! My advice in this case scenario is to price in accordance with value: the more money your services save for the medical partner, the higher the price you can charge. However, there is an important caveat: irrespective of that value, you cannot charge more than your competitors—unless, of course, you are delivering more value.

In some instances, a CBO may wish to consider a sliding-scale system.

A couple of considerations: first, suppose the population you are considering serving consists of individuals with differential risks for medical use—some being more costly than others for the partner to care for. If the overall population is segmented or stratified according to the degree of medical risk, the value weakens as the population expands to lower risk and lower use segments. A CBO may wish to consider a sliding-scale system. Here the medical partner would be charged progressively less per client, as the population served incorporates segments at less and less risk for medical utilization.

Second, if medical partners differ in the degree to which the CBO confers value upon them, the CBO may wish to consider price discrimination—charging different prices for the identical service. This pricing strategy would call for those medical partners with lower valuations on the service to be charged less than those who benefit more. However, in this instance, the CBO must take care that the pricing information is not shared. Either that, or it must create different versions of the services to hinder price comparisons. With a "versioning" strategy—meaning the creation of similar versions of the service—the CBO would need to add peripheral features into the core service when it offers it to a partner at a higher price. Otherwise, without these added benefits, the partner would demand the lower price being offered to other, more price-sensitive segments.

CBOs usually look to expanding programs or trimming expenses for sustained financial viability. There is a third way, which may involve considerably less organizational effort and turmoil; that is to systematically identify profit maximizing price(s) for its services. The guidance provided here has the potential to achieve the integration of its services with the medical sector, to further its organizational mission, and to accomplish both profitably.

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How to Develop the Infrastructure to Support and Implement the Managed Care Service Model

By Elaine Clark

What Meals on Wheels and Senior Outreach Services learned from its experience contracting with healthcare entities.

Meals on Wheels and Senior Outreach Services (MOWSOS) is a 48-year-old senior services organization that is re-envisioning its service and revenue models to meet the demands of a growing population of older adults, operating under a managed care service model. MOWSOS provides an array of services—home-delivered meals, congregant meals, care management, falls prevention services, and a friendly visitor program—that help keep older adults healthy, active, and independent for as long as possible. Over the past few years, we have actively reached out to partners (healthcare providers, other service organizations, and funders) to build a new service paradigm. We are partnering with Kaiser Permanente on a Care Plus pilot to determine if adding in-home supports has a measurable positive impact on health outcomes for participants, while also reducing hospital readmissions and emergency room visits.

Our evolution as an organization—from focusing on service delivery to recognizing the importance of addressing "upstream" health issues and providing post-acute transitional care—requires shifts in thinking and infrastructure. Although the way in which MOWSOS delivers services may remain the same, the positioning and structural changes are monumental, especially as the organization had no history of billing healthcare partners for services such as home-delivered meals, fall prevention services, or care management.

Building Strong Partnerships

Partnerships with healthcare organizations are the key to a managed care service model. To build strong partnerships, organizations first need to understand their strengths and weaknesses, and find partners who support their mission. Healthcare partners want a single point of entry (also known as "no wrong door").

→ABSTRACT Meals on Wheels and Senior Outreach Services is re-envisioning its service and revenue models to meet the demands of serving older adults under a managed care service model. The agency is partnering with Kaiser Permanente on a pilot to determine if adding in-home supports has a measurable positive impact on health outcomes for participants. This article provides advice on developing partnerships and infrastructure to implement a managed care service model. Key areas addressed include: strategic planning; IT tools and HIPAA; service tracking, evaluation, and billing; and board and staff involvement. **| key words**: *Meals on Wheels, Kaiser Permanente, value proposition, managed care*

Organizations will need to anticipate what a healthcare partner may need—case management, medication review, falls prevention intervention, home-delivered meals, etc. No single community-based organization (CBO) can offer every service, and may not cover the entire community. CBOs should know their limitations and find appropriate partners.

'The most critical IT decision an organization will make is to choose the case management software.'

Organizational leadership should identify which healthcare organizations would make great partners and begin to develop relationships with these healthcare organizations. Meet with people within these organizations. Look online for articles about their focus areas. Is the healthcare entity known for innovation? Is there already a relationship on which to build? Is the organization willing to share outcomes data? Can you find a champion within the organization to tell your story? Organizations can refer clients even before a healthcare entity requests the added services.

By assessing how the partnership can benefit the client, and parsing the possible issues around information-sharing and internal cultural differences, organizations can resolve any issues prior to analyzing and ultimately accepting a paying contract. The time to create formal partnerships with other CBOs is prior to contract negotiations with healthcare partners. All partnerships should be recorded in writing.

Understanding the Value Proposition

The Kaiser Family Foundation issue brief, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity* (Heinman and Artiga, 2015), summarizes research into the multiple and varied factors affecting health, with researchers estimating that 60 percent to 70 percent of health outcomes are due to social determinants, i.e., individual behavior, and social and environmental factors.

Healthcare partners need CBOs to intervene in the home and where patients socialize. By providing a nutritious meal, reducing fall risk, ensuring the patient has transportation to medical appointments, and has social supports to reduce isolation and depression, CBOs reduce healthcare readmissions and costs. CBOs are an integral part of the healthcare continuum, and all parties need to recognize this: healthcare partners, staff, volunteers, the board of directors, elected officials, and the community at large.

Focus Areas for the Managed Care Transition

There are six key focus areas organizations must consider as they move to a managed care service model.

Strategic planning

Organizations must review the ramifications of the decision to move from a traditional "output-focused" organization to one that can hold itself accountable to evidence-based outcomes. For many CBOs, this is a foreign concept, especially to legacy organizations or those where leadership at all levels has been in place for many years. Some questions to ask of management and staff might be:

- How will leaders introduce the change and develop consensus among staff and the board of directors?
- What impact will this have on how the organization defines success?
- How will the organization market the change to funders and community partners?
- Do personnel practices and job descriptions match the strategic plan?
- How must the new customer-focused approach be integrated into the way incoming calls are handled?
- Do current contracts preclude the organization from using certain personnel or assets for reimbursable services?

In our organization, this focused planning took place over a two-year period (and continues today). We established a new client intake process, and revised employee evaluations and job descriptions to place greater emphasis on client outcomes. We brought in a consultant for two workshops on collaborative communication and problem-solving, and held individual meetings with top leadership to discuss ways to improve the client experience.

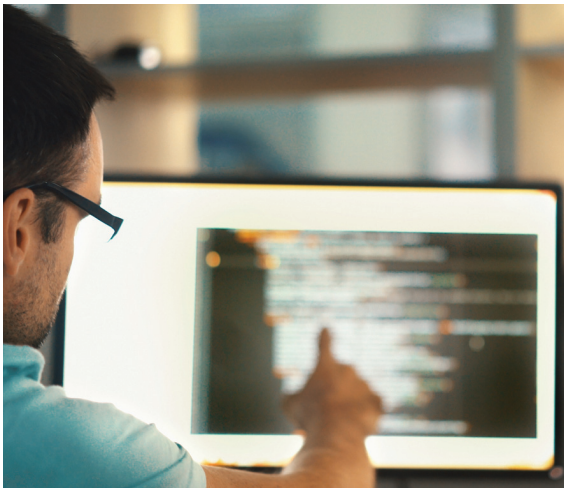
Information technology tools and HIPAA

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). Two key HIPAA provisions mandate industry-wide standards for healthcare information on electronic billing and other processes, and require the protection and confidential handling of confidential health information. When social service organizations begin to share clients or patients and referrals with healthcare entities, it is critical that HIPAA privacy protections be maintained and followed, and that the entire organization meets HIPAA privacy compliance requirements, as follows:

'The time to create formal partnerships is prior to contract negotiations with healthcare partners.'

Information Technology: All of the organization's Information Technology (IT) systems, including contact management software, phone equipment, mobile devices, fax machines, and case management software, must be reviewed to ensure compliance with HIPAA privacy regulations.

Case Management Software: When evaluating case management software, organizations should consider which systems case managers at local healthcare organizations use. At some point, organizations may share data through portals. The most critical IT decision an organization will make is to choose the case management software. The chosen software should be set up early to accommodate health-



care partners' systems. The system will be customized and must accommodate multiple users at various levels of access, and include service tracking for billing and customized reporting. This type of robust database will require an onsite IT support person, perhaps a new staff position; general administrative staff cannot absorb this position.

Fax Function: Due to HIPAA regulations, many healthcare organizations cannot e-mail client records and data outside of their organizations. Therefore, organizations will need to install a fax machine (in a secure location) to transmit patient information.

Phone System: The phone system needs to have direct-dial capability for each employee, as well as "hunt groups," which enable incoming calls to be sent to all lines until a free line is found and the caller is connected. This helps to ensure that a caller will reach a live person, rather than a recording. As many smaller organizations have antiquated phone systems that don't allow direct dialing, an upgraded phone system might be needed.

Mobile Devices: Providing mobile devices (smart phones, tablets) to all field workers enables staff to directly input data from remote locations, including from the client's home; this can improve accuracy, save time, and ensure that HIPAA safeguards are followed. In contrast, staff taking notes on paper and then transferring data later is a waste of time and can result in missed information. Just as moving from paper records to electronic records was difficult for some physicians, the same may be true for case workers, so organizations should anticipate push-back and train staff accordingly.

In short, conforming to HIPAA requirements is more complex than merely filling out a form. Practices to ensure client privacy must be in place. Regular employee training should occur. HIPAA consent forms signed by clients, which allow the sharing of data with healthcare partners, need to be secured. Check with healthcare partners to ensure they have these signed HIPAA documents in order to share healthcare data with the organization.

Service tracking, evaluation, and billing

To ascertain an organization's actual costs associated with each service, it is important to build multiple cost-capturing data and tracking fields into the case management software. Data to be captured typically include the following: time spent for each client interaction; products (assign a hard cost to each); and travel distances. It also is critical that the software allows tracking of multiple funding sources, and allows funding sources to be tracked to each client and service.

We recommend that organizations spend time up front anticipating how the information might be used. They will need to work with the case management software company to create fields as well as reports at the outset. There should be one person in the organization assigned to manage the database and reporting functions. Organizations should not assume this process will be simple and easily absorbed into the organization, unless there is an IT department.

Board and staff involvement

Boards of directors are composed of individuals who bring their collective knowledge and expec-

tations of the organization's purpose to the board member role. Is it "feeding people" or is it "keeping people healthy and independent for as long as possible?" To effectively involve the board, staff leadership will need to know board members' positions, create an ongoing board education plan that focuses on community needs and the organization's strategy for meeting immediate and future needs, and a sustainability plan. It will take numerous conversations with the board to ensure they understand the short-term and long-term impacts of transforming the organization.

'Board involvement is critical during times of organizational change.'

Board involvement is critical during times of organizational change. This is especially important when strategic changes result in downstream, unintended consequences, such as staff changes or increased employee compensation. For example, within MOWSOS, nearly half of the staff resigned or were asked to leave, as they were unwilling to adapt to the changes. Another short-term consequence was the need to increase compensation packages to attract and keep higher-level employees. An uninvolved board might have serious concerns about top leadership if so many changes are occurring.

Jim Collins' book (2011), *From Good to Great: Why Some Companies Make the Leap and Others Don't*, talks about having the right people in the right seats on the bus. In the new managed care dynamic, the seats have changed. The board needs to understand that turnover and compensation will change and not get overly worried about either. The board also might experience turnover. Setting the expectation that the board, as a whole, is a partner in these changes, and therefore is required to understand community needs and advocate publicly for the work being done, might be a significant and unacceptable change for some board members.

Although organizational leaders might think every staff member knows the new organizational strategy and focus, don't assume because the efforts have been discussed in leadership or staff meetings that the message has been engrained and incorporated into daily activities. Culture shifts take time, often years. Understanding the ramifications of being outcome-driven versus output-driven changes the focus of every position: staff, board, and volunteer.

What we have learned throughout the process of introducing change into our organization is that constant, focused messaging by every team member, at every level and at every opportunity is required to consistently deliver the same message. We no longer "feed people." Today, we "keep people healthy and independent for as long as possible."

While our managed care service pilot with Kaiser Permanente is still underway and it is too early to report final results, preliminary results confirm that providing in-home social supports for older adults in declining health is promising. Patients who make use of in-home supports are showing stabilized health outcomes.

Elaine Clark is chief executive officer of Meals on Wheels and Senior Outreach Services in Walnut Creek, California.

References

Collins, J. 2011. *From Good to Great: Why Some Companies Make the Leap and Others Don't*. New York: HarperBusiness.

Heinman, H. J., and Artiga, S. 2015. *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity.* The Kaiser Family Foundation. kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/. Retrieved October 3, 2016.

Developing the Contract, Contingency Plan, and Relationship Management Plan

By Jamie Almanza

The community-based organization's survival guide for moving into a managed care world.

How does a community-based organization (CBO) go about developing contracts and contingency plans, and managing relationships to succeed in the new managed care world? Let's use Bay Area Community Services (BACS) as an example. A nonprofit community-based services agency that for sixty years provided older adults and adults with disabling conditions necessary services so they could thrive, BACS has spent the past five years transforming its traditional service delivery system, overhauling and investing in its infrastructure, and re-engineering its business development strategy so that it complements and leverages opportunities from the Affordable Care Act (ACA), such as value-based care, care coordination, and care transitions.

BACS is now a $22-million-dollar organization with a clear path to strategic growth and a new partnership with the healthcare sector.

It all started in 2012, when The SCAN Foundation advertised a Request for Proposals for the Linkage Lab, a program for CBOs aimed at preparing them to partner with the healthcare sector by building business acumen. BACS was one of six California agencies selected to participate in the Linkage Lab Academy—a two-year process that I dubbed a "mini-MBA program" for the senior leadership team. The program used curricula from UCLA's Anderson School of Business, as well as world-renowned consultants who work in negotiation, pricing, marketing, quality improvement, and more.

Fast-forward to 2016, and BACS has transformed itself from an $8 million organization with very little diversified revenue, to a $22 million organization with a clear path to strategic growth and a new partnership with the healthcare sector. How we got here was not easy, however. It required some major introspection;

→ABSTRACT This article uses Bay Area Community Services (BACS), a community-based, nonprofit organization, as an example of how to succeed in the new managed care world. BACS has spent the past five years transforming its traditional service delivery system, overhauling and investing in its infrastructure, and re-engineering its business development strategy to complement and leverage opportunities from the Affordable Care Act, such as value-based care, care coordination, and care transitions. **| key words**: *Bay Area Community Services, community-based organizations, managed care, Affordable Care Act*

letting go of significant programs that were part of our mission since the agency's inception; and transforming our workforce and infrastructure to respond to the innovation and accountability required for managed care contracts. The best news—it is not only possible, but is also a reinvigorating process for an agency, its staff, and its customers and funders.

Implementation Steps

There are three major steps an organization needs to consider when transforming itself to work within the managed care environment.

Leadership and vision toward investment in the future

I have worked and consulted in many organizations; the majority were nonprofits, all of which were well-meaning, with admirable missions tailored to community health and wellness. BACS was and is one of those organizations. The difference today is that BACS and its leadership have a methodology for business development, targeted strategy, and infrastructural investment to support contracting with managed care organizations and the healthcare sector. BACS had a strategic plan on paper, it applied for and was awarded many grants, and it recruited and hired individuals that were qualified and dedicated to the social services it provided.

However, BACS was not future-oriented. It had a business model and such a lean infrastructure that it excelled at crisis management, but never could get around to planning and innovation. The result? Contracts and services that repeated the same successes (and challenges) year after year, with the same scarcity mentality embedded in its service delivery system.

Each year, BACS faced these same questions: How many people did you serve? How big is the deficit in that program? How can we serve more people with fewer funds? The major cultural change BACS needed to make was to reverse its thinking, its goal-making, and even how and who it hired. The first item on the to-do list during our Linkage Lab experience: was to decide with our board to sunset our largest and longest-standing social service program—our home and congregate meal delivery program.

This program, one that we provided to the community for more than thirty years, received about 50 cents on the dollar of government reimbursement for the true cost of the program. Yet each year, it was chipping away further and further at our infrastructure and our reserve. It took the Linkage Lab Initiative, an external organizational development process, to help us understand our true costs and conceptualize that just because we are a nonprofit didn't mean that we could not make a profit for our community. Perhaps most importantly, we finally saw that if we did not adapt, we would die. This was a vision that required risk-taking, as we did not yet have another program or contract to replace the congregate meal program.

It also took seeing that the organization's leadership team itself was risk-averse. Through a strategic envisioning process, we changed our leadership team to support our new strategic plan. Once BACS took this leap, it created a vision and investment plan for the future.

Infrastructure toward accountability and growth

BACS started in 1953 and its major growth as an agency ended in the late 1970s. Its infrastructure was antiquated—it did not have sophisticated technological solutions or capacity to collect and analyze data on outcomes and impact of services provided. This was a

major gap in the organization's ability to market services and value in the new managed care world. Over the past three years, BACS overhauled nearly its entire infrastructure, including its data collection and healthcare records system, so that it could contract for services and report outcomes in a manner that met new funders' needs.

BACS overhauled its infrastructure so it could contract for services and report outcomes in a manner that met new funders' needs.

During this time, BACS also realized that agency-wide National Accreditation was integral to its success and prepared for and received a National Accreditation for its core services. Also BACS selected a framework for progressive service delivery and performance management and integrated it into its service delivery system. This change did not come without some expense, which was the unintended consequence of staff turnover.

Marketing and partnership development

After BACS created a vision to diversify its programs and revenue sources, made room for its new strategy to contract with the healthcare sector and develop new business relationships, and successfully invested and upgraded its business infrastructure, the agency was poised to begin the work of marketing its services to healthcare partners like hospitals and health plans. Included in this approach was overhauling our brand, pricing services and packages, and making negotiation a core competency of the organization. This was quite possibly the most difficult part of the transformation.

The biggest lesson as an agency was altering our organizational ego. We thought our services were unique and relevant, and underestimated exactly what type of service a managed care entity or healthcare organization might be interested in purchasing. After approximately ten separate efforts with ten different entities, a realization occurred: it is not what we have to offer, but what our customer needs! This lesson is what enabled BACS to secure a contract with a large hospital system to provide a niche service that drastically reduces unpaid inpatient acute bed days. Our recuperative care program is a short-term, post-acute-stay residential program for individuals who need a safe place to recuperate, but do not require an inpatient hospital bed.

Today, BACS, a 63-year-young organization delivering a system of behavioral health, homeless services, and housing, as well as other social-impact services to older adults and other groups, is thriving. Today we do not say yes to any and every funding opportunity and spend resources cobbling together funds to support a program, but instead we are selective, intentional, and entrepreneurial in our business-development practices. We have gone from an organization that chases the dollar to one that is invited to open new and innovative programs in different communities.

And most importantly, we have met our goal of diversifying our revenue and partnering with the healthcare sector to deliver holistic services that determine the health of a person, a community, and a system of care for our elders and their loved ones. Our new program has achieved more than a 90 percent successful outcome for ensuring individuals are not readmitted to the hospital within thirty days of an acute episode of care.

Jamie Almanza is the executive director of Bay Area Community Services (BACS). See bayareacs.org *for more information.*

A Helping Hand: CBOs Receive Philanthropic Support on Their Path to Managed Care

By Nora OBrien-Suric

Many philanthropic organizations are funding diverse efforts to teach CBOs how to succeed in partnering with healthcare entities.

As community-based organizations (CBO), Area Agencies on Aging, and healthcare organizations begin to grasp the need to work together to achieve much better health results and lower healthcare costs for older adults and persons with a disability, all will need to evolve so they may effectively interact with each other. Right now, the healthcare sector is not connected to social services and thus has little knowledge of the value of available programs and services. The social services sector must learn to proactively quantify and promote the health benefits and cost-savings it brings to care for older adults.

'The healthcare sector needs community-based partners that bring integrated, turnkey operations to broad geographic service areas.'

The healthcare sector needs community-based partners that deliver integrated, turnkey operations across broad geographic service areas. Right now, social service agencies offer supports based on specific eligibility requirements and silos funded in a local community. Successful partnerships with the healthcare sector require agencies to break down their silos and their requirements of individual services in a way that meets the needs of their new partner. In some cases, this calls for expanding the organization's geographic scope through building partnerships with other service providers in community. This transformation needs leadership and infrastructure support. While change is difficult, the payoff is worth it for the agencies and the people they serve.

→ABSTRACT As community-based organizations, Area Agencies on Aging, and healthcare organizations grasp the need to work together to achieve better health results and lower healthcare costs for older adults and persons with a disability, all will need to evolve so they may effectively interact. Numerous foundations that focus on aging, disability, and-or health issues are supporting this work, often called "developing business acumen," managed care models, "building capacity in community-based organizations," and integrated care. This article describes several initiatives supported by various foundations. **| key words**: *National Aging & Disability Business Institute, managed care, integrated care, building business acumen, community-based organizations, foundations*

Healthcare organizations also want their partners to have sophisticated information technology (IT) systems, financial reserves, and other business infrastructure features—resources not typical for social service agencies. Social services can help the healthcare entities meet the goal of improved health, while also lowering costs through avoiding inappropriate use of nursing homes and emergency rooms, as well as reducing hospital stays—but only by creating new agency structures for efficiently contracting with healthcare organizations to coordinate care and services.

Success in meeting the above challenges will be contingent upon social service agencies' ability to adapt their service and business systems to meet the requirements of the healthcare sector.

ACL Forges a Base of Support for Social Service Agencies

Social service agencies currently derive the bulk of their income from government contracts and fundraising efforts. Changes in healthcare financing provide opportunities for more consistent and expanded reach to those in need and new operational income sources from healthcare savings through agency interventions. But social service agencies need financial support and technical assistance to make the changes needed, to be ready to partner with healthcare entities, and to be sustainable until new revenue streams pay off.

The **Administration for Community Living** (ACL) is an operating division within the U.S. Department of Health and Human Services, and is the federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the life span. Its mission is to maximize the independence, well-being, and health of older adults and people with disabilities, and their families and caregivers.

Over the past several years, ACL has provided national leadership to help state- and community-based organizations (CBO) forge networks and respond to current delivery systems reform. This includes technical assistance not just for deploying evidence-based programs, but also for building states' and CBOs' business capacity to promote successful partnerships and contract with integrated care entities, and shape pathways to sustainability for aging and disability organizations. Since 2013, ACL has been funding the National Association of Area Agencies on Aging (n4a) and consultants who provide technical assistance to selected networks of agencies to help them develop new funding streams by partnering with the health sector. In 2015, ACL also approved a five-year strategic plan to continue to provide technical assistance to Area Agencies on Aging (AAA) and CBOs to gain the knowledge, experience, and tools needed to partner effectively with the health sector. From 2012 to 2020, ACL has committed more than $6 million to bolster the business capacity of aging and disability organizations through various grants and contracts.

Numerous foundations that focus on aging, disability, and-or health issues also are supporting this work that often is called "developing business acumen," managed care models,

"building capacity in community-based organizations," and integrated care. What follows are short descriptions of initiatives supported by various foundations.

Foundations Help Social Services Agencies to Be Financially Sustainable

One of the first foundations to understand the need for CBOs to develop business acumen was The SCAN Foundation.

The SCAN Foundation (TSF) considers the integration of care and financing for those with both Medicare and Medicaid (dual eligibles) an important opportunity to demonstrate at scale that better care can be delivered at lower costs. Over the past five years, TSF has invested close to $2 million to develop programs, resources, and tools to support CBOs in increasing their business acumen.

TSF created the Linkage Lab Academy, which is an organizational development program for leadership and management teams from selected California CBOs. Its goal is to prepare those CBOs seeking to deliver care coordination services for effective partnership with healthcare entities (e.g., health plans, hospitals), via structured management education and on-site technical assistance. Through the Linkage Lab Academy, twelve CBOs have completed training and received technical assistance with the goal of diversifying their revenue streams through securing new payer contracts with the healthcare sector to provide home- and community-based services. Most recently, TSF, in partnership with The John A. Hartford Foundation, the Gary and Mary West Foundation, the Marin Community Foundation, and the Colorado Health Foundation has supported the development of the National Aging & Disability Business Institute (aginganddisabilitybusinessinstitute.org).

The John A. Hartford Foundation (JAHF) in 2013 began funding a new initiative in collaboration with ACL. The initiative funded prototype regional consortiums in Southern California and Massachusetts to organize social service agencies and AAAs to win regional healthcare contracts and operate more efficiently with shared business services. The funding supported expert consultation on developing business systems, and ultimately enabled the creation of strong network infrastructures to support contracts providing integrated social services for older adults via capitated payment arrangements. JAHF, in partnership with ACL and a consortium of funders, also is providing funding to the n4a, the American Society on Aging (ASA), and Independent Living Research Utilization to develop a national Aging & Disability Business Institute that provides the tools and knowledge to help social services agencies collaborate with healthcare entities, including this special managed care supplement to *Generations* journal. Each foundation also is supporting ancillary initiatives within their geographic region. To date, JAHF has committed $6 million to this initiative.

The SCAN Foundation has invested about $2 million to support CBOs in building their business acumen.

The **Gary and Mary West Foundation** provides outcomes-based funding to support successful aging initiatives primarily in San Diego, California, and Omaha, Nebraska, with collaborators that include leading academic institutions and nonprofits focused on older adults. Aligned with the Foundation's mission, grants are awarded to organizations that enable older adults to successfully age in place, with access to high-quality, affordable healthcare and support services that preserve and protect their dignity, quality of life, and independence. The Foundation is co-funding a $45,000 grant to ASA for three years to support broad dissemination of resources and educational materials to improve the business acumen of nonprofit organizations that serve older adults.

The **Marin Community Foundation** (MCF) is funding the Accelerating Business Capacity of Aging Service Providers initiative. Its goal is to build the business capacity of key providers of home- and community-based services that serve older adults. Through this multi-year initiative, MCF is supporting the efforts of a small cohort of CBOs to develop the business capacities necessary to establish, deepen, or expand healthcare partnerships. These capacities include (but are not limited to) leadership skills to navigate the process; the ability to articulate a compelling value proposition; developing processes to price and sell services; and creating effective business development strategies. These arrangements can foster better care integration, reduce healthcare costs, improve patient experience, and improve health outcomes for older adults. To date, MCF has committed $800,000 to this initiative.

The Colorado Health Foundation in 2013 launched a three-year Long-term Services and Supports (LTSS) initiative to support Colorado in creating a high-quality, cost-effective, and person-centered LTSS system. Part of this initiative replicates the Linkage Lab Academy model. The Colorado Linkage Lab's goal is to promote integration between the healthcare sector (hospitals, insurers, healthcare providers) and LTSS CBOs that provide day-to-day support to older people and people with disabilities who reside in Colorado. The LTSS CBOs will likely be empowered to enter into contractual partnerships with the healthcare sector to improve the health outcomes for Colorado's aging and disability communities. Moreover, these contractual partnerships create important new revenue sources for the organizations, supporting their long-term sustainability at a time when current revenue streams are decreasing or ending. The Colorado Health Foundation has committed approximately $1.6 million to this initiative.

Prototyping region-specific models

Two foundations collaborated with The John A. Hartford Foundation in supporting two regions to prototype network models: the Tufts Health Plan Foundation in Massachusetts and Archstone Foundation in Southern California.

The **Tufts Health Plan Foundation** seeks to achieve lasting impact in communities in Massachusetts. Their funding focuses on collaborative approaches to build systems and scale best practices, as is demonstrated through the support of the Healthy Living Center of Excellence (HLCE). HLCE is a partnership between a CBO, Elder Services of the Merrimack Valley, and a medical provider, Hebrew Senior Life. A recognized local and national leader in delivering evidence-based programs, HLCE has developed a strong value proposition to win contracts with healthcare providers and payers to secure reimbursement for patients who participate in a wide range of evidence-based programs. In 2013, Tufts awarded a three-year grant for $725,000, and, in June 2016, a two-year grant for $349,870, for a total funding of $1,074,870.

Archstone Foundation is a private grant-making organization whose mission is to contribute toward preparing society to meet the needs of an aging population. Archstone Foundation has funded the Partners in Care Foundation in Southern California to develop an integrated network for medical and social services programs that would work in tandem to support

older adults who receive care through managed care structures. The Foundation also has supported the creation and expansion of the Evidence-Based Leadership Council to enhance the efficiency and dispersal of evidence-based programs. To date, Archstone has committed $736,889 to this initiative.

Another entity that provides statewide funding is the Health Foundation of South Florida.

The Robert Wood Johnson Foundation focuses on health and vulnerable populations, and is concentrating on what makes healthcare and CBO partnerships successful.

The **Health Foundation of South Florida** (HFSF) has a mission to be a catalyst for change, working with community partners to make the health system more effective and Floridians' health more vibrant. In 2008, HFSF invested in a seven-year Healthy Aging initiative. The initiative funded eighteen agencies on an annual basis to build their capacity to deliver evidence-based health and prevention programs. HFSF created a regional learning collaborative and supported a core staff to build a technical assistance center for these agencies, with regional licenses for programs, coordinated training, quality improvement, and data management. The Foundation also created and funded Florida Health Networks (FHN), LLC, for the purpose of supporting Aging and Disability Resource Centers in Florida to deliver evidence-based programs in the community and contract with health plans. To date, the initiative has served more than 40,000 individuals with at least one evidence-based program. The total amount of grant funding committed to the combined Healthy Aging Initiative and Bridge to Sustainability (FHN) has been $8.5 million. In addition, FHN was given an interest-free loan of $400,000 to assist with cash flow.

The goal of the **Maine Health Access Foundation** (MeHAF) is to create a sustainable infrastructure to support older people thriving in their homes and communities. Recognizing that limited new resources would be available to care for the aging population in Maine, a state with the oldest median age nationwide, a cadre of foundations aligned their efforts to focus on creating better awareness and services and supports coordination at the community level. Seven foundations across Maine, New Hampshire, and Vermont co-funded a TriState Learning Collaborative on Aging, which hosts monthly peer-community learning webinars and other trainings. In 2013, MeHAF also launched its Thriving in Place initiative, eventually supporting ten communities with four-year $340,000 planning and implementation grants to assess needs and opportunities, and coordinate multisector services to support older people staying in their communities. For example, health systems began contracting with local AAAs to provide Meals on Wheels for two-week durations for patients being discharged from the hospital and their caregivers.

There also are smaller foundations with a hyper local focus that provide targeted support. Two such foundations are the Health Foundation for Western and Central New York and the Altman Foundation.

The **Health Foundation for Western and Central New York** provides funding in sixteen counties in New York State. Through programs like GetSET (goo.gl/HV57I7), its precursor, Ready or Not (goo.gl/hveEt8), educational workshops, and online learning opportunities, the Health Foundation gives organizations the resources and expertise they need to respond strategically to a shifting fiscal and regulatory environment, as well as the breathing space to shore up their infrastructure for long-term success and sustainability. To date, the Foundation has committed $1.6 million to the initiatives. By providing financial and expert assistance, the Foundation enhances the capacity of healthcare and social service pro-

viders to improve health outcomes for older adults and young children living in poverty in western and central New York.

The **Altman Foundation** is a local foundation focused on education, health, arts, and strengthening communities in New York City. The Foundation supports CBOs in boosting capacity to meet healthcare needs, and in efforts to construct partnerships with health providers to address social determinants of health. Many community organizations confront similar challenges—deficits in infrastructure needed for billing and program tracking and reporting; inexperience managing and delivering evidence-based models; little marketing, negotiating, or contracting savvy; insufficient financial analytics from which to derive the fully loaded cost of delivering services; and insufficient scale (client numbers, geographic spread) to craft effective partnerships. The Foundation supports the following: training and technical assistance; capacity-building; planning and pilot projects; and policy and applied research. This support is aimed at assisting community organizations that seek to maximize opportunities, minimize challenges, or simply make informed decisions about choosing the right path to help transform the healthcare landscape. Between 2015 and 2016, the Foundation has invested $3.3 million in this initiative.

The above foundations have a focus on aging and health. The Robert Wood Johnson Foundation has a broad focus on health and vulnerable populations, and has begun a parallel effort to the initiatives described above.

The **Robert Wood Johnson Foundation** (RWJF), in partnership with the Center for Health Care Strategies and the Alliance for Strong Families and Communities, is funding the Nonprofit Finance Fund to develop examples and lessons about what is working well in connecting healthcare and social services and what could be the base for longer term, successful partnerships between CBOs and healthcare entities. Deliverables will include a request for information to bring to light relevant examples of existing or emerging partnerships; case studies that represent a diversity of services, target populations, community contexts, financial arrangements, and organizational sizes and geographies; and resources and tools to share lessons learned. To date, RWJF has committed $520,000 to this initiative.

All of the foundations mentioned in this article and the ACL are members of the Funders Learning Circle, hosted by Grantmakers in Aging, and which includes the Maine Community Foundation, Cambia Health Foundation, The Retirement Research Foundation, The Henry and Marilyn Taub Foundation, and the John Muir Health Foundation. Every other month, these foundations and others convene a conference call to discuss updates on initiatives and next steps and potential for new initiatives and funding.

Together, these foundations and government agencies are supporting the creation of new partnerships between the healthcare and social services sectors to address social determinants of health and to provide the evidence-based care and quality of life our vulnerable citizens need and deserve.

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Preparing Aging and Disability Organizations for Delivery System Reform

By Marisa Scala-Foley

The role of the Administration for Community Living in CBOs transitioning to integrated care.

The rapid movement during the past several years toward managed long-term services and supports (MLTSS), systems that integrate healthcare, long-term services and supports (LTSS), and other social services has had profound implications for older adults and people with disabilities, and the state and community-based organizations (CBO) that serve them. The goals under these integrated systems are to ensure that consumers and their families are aware of their service options, have access to needed services under a person-centered and self-directed plan, and use their resources wisely—areas in which many aging and disability organizations have long been engaged.

The ACL has worked with states and CBOs to help them build business capacity.

As these reforms unfold, there has been an increasing focus on how social determinants of health affect individuals' overall health outcomes, and on the value of community living to not only potentially reduce costs, but also positively affect a person's quality of life. As such, healthcare providers and payers are looking to collaborate with community-based social services providers, especially to support older adults and people with disabilities. This creates an opportunity for CBOs to contract with health systems to provide services that can address social and functional needs, and help improve members' health and quality of life. But because CBOs have been largely grant-funded, many lack the business expertise needed to contract with health plans, Accountable Care Organizations, health systems, hospitals, and other integrated or risk-bearing entities.

How ACL Is Helping

The Administration for Community Living (ACL), an agency within the U.S. Department of Health and Human Services (HHS), is responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities. Our mission is to maximize the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers. We work closely with na-

→**ABSTRACT** How can state and community-based aging and disability organizations play a role and add value to nationwide delivery systems reforms? And how can they increase their business capacity to contract with healthcare providers and payers and generate more sustainable revenue streams? The Administration for Community Living's work with national, state, and local partners is helping to meet that challenge. **| key words**: *business acumen, business capacity, community-based organizations, delivery system reform, Administration for Community Living*

tional, state, and community-based aging and disability organizations to achieve that mission.

Over the past several years, ACL has provided national leadership to bridge the gap between healthcare and community-based LTSS by preparing state and community-based organizations to demonstrate their value, and to ultimately partner with healthcare entities. The ACL has provided technical assistance to help the aging and disabilities networks become eligible for a wider range of funding by shifting toward evidence-based programming with demonstrable outcomes. The agency also has worked with states and CBOs to help them build business capacity to promote successful partnerships, contracts with integrated care entities, and pathways to sustainability for the organizations and their programs.

ACL efforts in building business capacity include the following:

- **Business Acumen Learning Collaboratives**

  Between 2013 and 2016, using a unique public–private partnership with The John A. Hartford Foundation, The SCAN Foundation, other private philanthropies, and national and community-based organizations, ACL convened two Business Acumen Learning Collaboratives focused on building the business capacity of networks of CBOs. Funding from the foundations supported in-person meetings. Networks in the collaborative shared the goal of entering into at least one contract with healthcare providers and payers during the course of the collaborative. They received technical assistance from ACL and its contractors and grantees in organizational culture change, market analysis, developing service packages, pricing services, negotiating contracts, and more to help them achieve this goal.

  As of September 2016, the twenty learning collaborative networks had twenty-eight signed contracts with integrated care entities such as health plans and systems, Accountable Care Organizations, physician practices, and hospitals, with many more under negotiation. The networks also worked to create structures to support their business operations (infrastructure, billing, finance, technology, and more), whether it was a management services organization, a limited liability corporation, a brokerage model, or another type of arrangement.

- **Building Business Capacity for Managed Long-Term Services and Supports**

  From 2012 to 2016, ACL funded cooperative agreements with the National Association of Area Agencies on Aging (n4a) and the

National Association of States United for Aging and Disability (NASUAD) to increase the capacity of state- and community-based aging and disability organizations to play leading roles in MLTSS design and delivery in their states. Through these cooperative agreements, the organizations provided a variety of forms of technical assistance—resource materials (e.g., webinars, readiness tools), directories of business acumen consultants, and one-on-one consultations—to build the business acumen of aging and disability networks. The n4a targeted community-based aging and disability organizations in its work, while NASUAD focused on state aging and disability agencies.

One focus of the Resource Center is to help organizations sustain their work outside of federal funding.

- **Diabetes Self-Management Training Medicare Reimbursement Project**

  The ACL has provided technical assistance (in-person, via phone, and e-mail, as well as Web materials and webinars) to numerous sites on various topics related to phases of the Diabetes Self-Management Training (DSMT) accreditation and reimbursement process. This assistance included writing business plans, estimating market share, applying for a Medicare provider number, scouting for and successfully negotiating with Medicare partners, pricing services, negotiating fair and profitable distributions of the reimbursements, marketing services, and staffing.

  The ACL-funded Chronic Disease Self-Management Education Resource Center (see following paragraph) also launched a DSMT learning collaborative in January 2016 to provide targeted support to grantees and other organizations interested in this funding stream. To date, sixteen sites have achieved accreditation; about half of them have their own Medicare provider number, and the balance have Medicare provider partners, with others expected to follow.

- **National Chronic Disease Self-Management Education Resource Center**

  Since 2012, ACL has provided funding to support a National Chronic Disease Self-Management Education (CDSME) Resource Center, housed at the National Council on Aging's Center for Healthy Aging. The National CDSME Resource Center offers resources to networks and organizations implementing evidence-based programs that help older adults and people with disabilities manage chronic conditions and improve health outcomes and quality of life.

  A key focus of the Resource Center is to develop a capacity among all organizations implementing CDSME programs to sustain their work outside of federal funding and to integrate their work within healthcare settings. The Resource Center works closely with ACL-funded organizations (including state agencies) to help build business plans, develop a reimbursement infrastructure, and work toward contracting with healthcare providers and-or payers. The Resource Center also provides expertise on the ongoing changes to Medicare and Medicaid, including ways to support CDSME programs.

- **National Resource Center on Nutrition and Aging**

  Since October 2011, ACL has provided funding to support a National Resource Center on Nutrition and Aging (NRCNA; housed at Meals on Wheels America), which focuses on enhancing the skills, knowledge, business acumen, and sustainability of the nutrition and aging network. The NRCNA also has developed nutrition program action learning collaboratives (patterned after ACL's Business Acumen Learning Collaboratives). NRCNA's collaboratives provide limited funding and technical assistance to awardees to support the integration of their nutrition programs and services into the

healthcare system. Findings and promising practices are disseminated throughout the network via webinars, pre-conference intensives, briefs, coursework, and the like. In addition, NRCNA uses information gathered from ACL's learning collaboratives with recipients of its mini-grants, allowing the technical assistance to be disseminated through the nutrition programs' broader audience.

- **No Wrong Door/Aging and Disability Resource Center Systems**

  The ACL, the Veterans Health Administration (VHA), and the Centers for Medicare & Medicaid Services (CMS) have partnered for a number of years to support state efforts to develop consumer-driven statewide systems of access that make it easy for older adults, people with disabilities, and family caregivers to learn about and access LTSS. In 2010, the ACA provided $10 million in funding to strengthen the Aging and Disability Resource Center (ADRC) program and also created the Medicaid Balancing Incentive Program, which provided an enhanced federal match to states that committed to increasing their support for home- and community-based services, while developing statewide No Wrong Door Systems (NWD).

  In 2012, building on the experience of states across the nation, the three federal agencies launched a three-year project to partner with eight states to develop a uniform set of guidelines all states could use as a model, a national training program for NWD/ADRC Person-Centered Counselors, and a sustainable long-term funding strategy.

  In late 2015 and early 2016, the federal partners rolled out two main pillars of the long-term funding strategy: CMS Medicaid Claiming Guidance and VHA Billing Guidance, both of which are designed to help states tap these permanent funding sources to help pay for their NWD/ADRC systems. If every state took advantage of these two funding streams, it is estimated it would generate more than $100 million annually in additional revenue for NWD/ADRC systems. The three federal partners work together to provide technical assistance to help states leverage these two sustainable funding streams to build out their NWD/ADRC systems.

Moving Forward

As this work moves into its next phase, it is critical to capture and disseminate the lessons learned from our initiatives and those of our partners to the larger aging and disability networks. To that end, ACL has funded two new cooperative agreements.

Through the Business Acumen for Disability Organizations grant, NASUAD and its partners seek to help disability networks to be active stakeholders in developing and implementing integrated systems in their states. The program will include education, training, technical assistance, state-based learning collaboratives, and the distribution of promising practices and resources.

Similarly, through the Learning Collaboratives for Advanced Business Acumen Skills grant, the n4a and its partners will conduct a series of learning collaboratives to explore "next generation" issues such as continuous quality improvement, infrastructure, and technology, generating and maintaining volume, and other topics that emerged during ACL's early business capacity-building work. Continuous learning and partnership-building will be key parts of ACL's role in preparing state and community-based aging and disability organizations for the vital roles that they can play in delivery system reform around the country.

Marisa Scala-Foley is director, Office of Integrated Care Innovations, at the Administration for Community Living in Washington, D.C.

Case Study: San Diego County's Cal MediConnect Pilot

By Kristen D. Smith

A promising care coordination pilot project yields mixed results, with lessons learned.

In 1999, the County of San Diego, in partnership with numerous community stakeholders, launched the Long-Term Care Integration Project (LTCIP) with the goal of creating a system of care that would better coordinate medical and social services. The Long-Term Care Integration Project is led by Aging & Independence Services (AIS), a division of the County of San Diego Health and Human Services Agency. AIS also serves as the region's Area Agency on Aging, offering Older Americans Act services and other state and Medicaid-funded programs, including long-term case management through the Multipurpose Senior Services Program (MSSP) and personal care assistance through the In-Home Supportive Services (IHSS) program.

In 2010, our long trek to integrated care was advanced by the Affordable Care Act (ACA), which created the opportunity for states to test new systems that integrated care for people receiving both Medicare and Medicaid (Medi-Cal in California), or "dual eligible" beneficiaries. State legislation led to the Coordinated Care Initiative (CCI), with the aim to create a sustainable, person-centered system of care by shifting services out of institutional settings and into community settings of a beneficiary's choosing. Healthy San Diego, a partnership of the County Heath and Human Services Agency, five Medi-Cal health plans, beneficiaries, and providers, successfully applied to include San Diego among the seven counties participating in the CCI. San Diego County is unique in California, with five managed care organizations serving the Medi-Cal population, while other CCI counties have either a county-operated health system or just one or two health plans.

'Thirty-three percent of eligible individuals enrolled at the program's peak.'

The Coordinated Care Initiative

Begun in 2014, CCI consists of two components: mandatory enrollment of dual eligible beneficiaries into managed care for all of their Medi-Cal benefits, including long-term services and supports (LTSS); and the dual demonstration project, Cal MediConnect (CMC), which pro-

→ABSTRACT San Diego County's Cal MediConnect is a model for integrating health and social services that has not yet fulfilled its promise. Only a third of eligible beneficiaries enrolled, and care coordination and discretionary LTSS use were limited. Communication with beneficiaries must better convey care coordination benefits, and the need for LTSS must be consistently assessed; California is creating a standardized Health Risk Assessment for determining LTSS needs. We recommend the tool, and the results from applying it, be shared with all participating LTSS providers. **| key words**: *San Diego County, Cal MediConnect, care coordination, social determinants of health*

vides dual eligible beneficiaries the option of selecting one managed care plan to administer Medicare (acute medical care and hospitalizations) and Medi-Cal benefits. Those duals who do not choose this option continue to receive fee-for-service Medicare. Health plans are required to offer four types of LTSS: MSSP, IHSS, adult day healthcare, and skilled nursing care. In San Diego County, health plans must partner with AIS for the administration of MSSP and IHSS. CMC health plans may offer other discretionary LTSS known as Care Plan Options (CPO), which include a wide array of à la carte services and support, and also offer transportation and vision benefits.

CMC's care coordination model calls for each beneficiary to be offered a care coordinator (health plan staff), who works with the beneficiary to create a care plan and assists with tasks such as convening interdisciplinary care teams and securing needed appointments or transportation. Through better care coordination, CMC is expected to reduce healthcare use and service duplication, while improving health outcomes and resulting in overall cost-savings.

The assumption was that the majority of San Diego County's more than 57,000 dual eligible beneficiaries would choose to participate in CMC and thus receive care coordination and discretionary LTSS services. During program roll-out, beneficiaries were sent multiple notices informing them of the opportunity to select a CMC plan or to opt out. Those who did not make a selection or opt out were passively enrolled into a CMC plan.

Shaping CCI for San Diego

AIS and the health plans met regularly to collaboratively tailor the MSSP contract and IHSS memorandum of agreement. AIS and its network of stakeholders worked with the health plans to create a CCI Advisory Committee to guide implementation and outreach, share best practices, and address and remedy challenges. AIS developed an internal "care coordination unit," staffed by trained social workers, to serve

as liaisons to the health plans to participate in interdisciplinary care teams and address other care plan needs.

MSSP is a complex case-management program that includes the purchase of comprehensive LTSS such as transportation and medical alert systems. As a Medicaid waiver, only 550 MSSP participant slots are available to San Diego County; any beneficiaries served over this limit would be part of the CPO investment by the plans. AIS created a look-alike program, MSSP-Like, to allow health plans to contract with AIS to provide case management as a CPO benefit.

Educational materials for both medical providers and beneficiaries seemingly failed to convey the benefits of participation.

Low enrollment. Few beneficiaries have opted into CMC thus far across the seven CCI counties. In San Diego County, 33 percent of eligible beneficiaries were enrolled at the program's peak, and currently 25 percent (approximately 14,000) of eligible beneficiaries are enrolled. Educational materials for both medical providers and beneficiaries seemingly failed to convey the benefits of participation, especially the value of care coordination. External evaluators found that physicians were reluctant to join managed care networks and often encouraged their patients to opt out and continue seeing them a on a fee-for-service basis. Even among those enrolled into CMC, only 20 percent to 30 percent have made use of the care coordination benefit, although those beneficiaries report being satisfied.

LTSS utilization. AIS was prepared for enrollment in IHSS to significantly increase as a result of CCI; however, while the program caseload has been growing, (between 2 percent to 5 percent per year), it does not appear that CCI has yet caused a significant increase. The IHSS program in San Diego presently serves approximately 27,000 recipients. Among the 550 MSSP program participants, only 47 (9 percent) are enrolled in CMC, which is markedly lower than the overall San Diego CMC participation of 25 percent. The reason for this striking difference is not known. As a group, they are very fragile (qualified for skilled nursing facilities), and they receive coordinated, intensive case-management services in their homes from AIS social workers and public health nurses. They may not have seen the added value of the care coordination benefit of CMC.

AIS originally saw CCI as an opportunity to contract with managed care plans to serve more clients with comprehensive case management through our MSSP-Like program. However, fewer than twenty beneficiaries were identified to receive MSSP-Like services as a health plan CPO.

Health plans are required to conduct a Health Risk Assessment to assess their members' need for LTSS. However, the assessment was not standardized across the plans, and we have not seen the proprietary tools that were used. Thus far, no quantitative data have been released from the state on the use of LTSS and CPO or on changes in beneficiary health as a whole resulting from CMC or CCI. Therefore, making a comparison between health plans and evaluating the impact of additional services on health outcomes and cost is not possible. California is working on creating a standardized Health Risk Assessment tool that will be used by all health plans beginning in 2017.

Comparison

Although outcome data are not available for CCI, a similar LTSS program provided by AIS for older veterans at high risk of nursing home placement has shown great promise. In the San Diego Veterans Independence at Any Age program, veterans referred by the Veterans Administration receive care coordination and LTSS similar to the benefits available in CCI (personal care, transportation, medical alerts, help with household chores, etc.). During the three years of program

operation, hospital admissions for those served have been reduced by 57 percent, saving the Veterans Administration $2.6 million.

Conclusion

Over almost three years of involvement in San Diego County's CCI pilot, we have learned important lessons about implementing a complex initiative that involves many eligible beneficiaries and multiple health plans. Communication with beneficiaries and their physicians must adequately convey the benefits of participation, if significant enrollment is to be achieved. Frequent communication between AIS and the health plans was crucial for implementing meaningful coordination at the AIS social worker and plan care coordinator level. The state is now creating a standardized Health Risk Assessment for determining specific LTSS needs and that will be used across all health plans. We recommend the tool be shared with all LTSS providers to provide a basis for better understanding the needs across the whole population. For future efforts, building in resources for quantitative evaluation of utilization and outcomes, and creating the mechanisms to share such data with all stakeholders, should increase the opportunity to achieve the objectives of the pilot.

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Case Study: One AAA's Journey Toward Managed Care

By Connie Benton Wolfe

Aging & In-Home Services of Northeast Indiana's long, winding road to success.

Every journey begins with a single step. In late 2010, Aging & In-Home Services of Northeast Indiana, Inc. (AIHS) took its first step into the integrated care arena. At that time, healthcare entities—providers and health plans—did not come looking to community-based organizations (CBO) for anything more than a referral option for a discharge planner. And, Area Agencies on Aging (AAA) such as AIHS did not necessarily see themselves as part of the healthcare delivery system.

As AIHS explored how the organization could best serve the frail, complex clients who made up the largest portion of its service group, it became clear that the path forward included developing a strategy to position the agency as a partner with the healthcare system.

AIHS's first step was to build a relationship with the largest healthcare system in Northeast Indiana. This process began with a meeting between the agency's CEO and the healthcare system's CEO to discuss a small pilot care transitions program. That initial pilot demonstrated successful outcomes and, five years later, this initial healthcare relationship has grown into a true partnership. Also, AIHS has leveraged this experience to expand into business agreements with nine additional hospitals, a managed care company, and a regional insurance company, with other contracts pending.

Healthcare entities are learning that success in reducing hospital readmissions often happens in the community and in the home.

Looking back, what becomes clear is that AIHS's strategic positioning decision (toward integrated care) aligned with the changes in healthcare reimbursement models (from volume to value), fostering success. The system transformation also aligned with the emerging CMS Triple Aim: to improve population health, improve the quality and experience of care, and reduce cost.

Concurrently, research emerged demonstrating that social determinants of health were major drivers of rising healthcare costs. There was heightened awareness that reducing hos-

→ABSTRACT One area of focus in moving to integrated care and value-based payments is care transitions that prevent and reduce hospital readmissions. Community-based organizations (CBO) that are early adopters of evidence-based strategies have changed their business models to partner with hospitals, physician groups, and health plans to implement interventions that reduce hospital readmissions and transform care. This article is a case study of Aging & In-Home Services of Northeast Indiana, Inc., and the path they took to value-based care contracts. **| key words**: *AAAs, CBOs, hospital readmissions, care transitions, integrated care, population health, Aging & In-Home Services of Northeast Indiana, Inc.*

pital admissions, readmissions, and emergency department use didn't necessarily happen within the four walls of a healthcare setting, but in the community and, more importantly, in the home.

AIHS and other AAAs are—and have been—"boots on the ground" for more than forty years. We have offered planning and delivery of long-term services and supports, such as Aging & Disability Resource Centers, congregate and home-delivered meals, transportation, family caregiver education and consultation, and other services. We are experts in addressing social determinants of health, which are beyond the scope of many healthcare providers, and we have a trained workforce ready to deploy to the homes of individuals who are at risk for needing expensive healthcare interventions.

Build the Relationship and Adapt to New Market Forces

The process of building a relationship with healthcare providers happened over time. Initially, discussions about a possible time-limited pilot program in care transitions led to a series of meetings between AIHS and the leadership of a local health system. A visionary healthcare CEO championed the cause of testing this new integrated care model. From there, AIHS had to prove it was committed to partnering and bringing value to the table.

Our organization needed to shift its culture to fit the needs of the healthcare community, moving from traditional work week hours, to being ready to respond to discharges no matter when they occurred. AIHS began adding clinical staff, such as nurses and registered dietitians, to create a multidisciplinary team. We sought out conferences and training in the healthcare arena to learn the vocabulary of our potential healthcare system partner, and to understand the challenges it faced. We created an LLC (Limited Liability Company), called Preferred Community Health Partners, and left many of the geographic boundaries that had restricted our operation behind to match the healthcare system's established market boundaries.

Multi-Tiered Levels of Planning Pay Off

Planning for the first Care Transitions Pilot Project involved establishing a timeframe for the pilot and criteria for patient eligibility, as well as developing a referral process and setting standards for response time and coverage; identifying resources needed; training staff; providing orientation to hospital discharge planners; and embedding AIHS Care Transitions staff at the hospital. They met regularly with hospital staff and were entrusted with access to the hospital's electronic medical record, which proved key for referral volume.

The Care Transitions Pilot Project included a hybrid model of care transitions with components of the Care Transitions Intervention (CTI) (The Care Transitions Program, n.d.) developed by Dr. Eric Coleman, and components of the Bridge Model (The Bridge Model National Office, n.d.), developed by the Illinois Transitional Care Consortium.

The successful pilot and results of a multi-faceted root cause analysis (RCA), completed in February through March 2012, drove the decision to apply for Community-based Care Transitions Program (CCTP) funding from the Centers for Medicare & Medicaid Services (CMS). To make an informed decision to determine the target population and select the most effective intervention to reduce unnecessary hospital readmissions, AIHS completed a five-step RCA designed to determine key drivers for Medicare fee-for-service patient readmissions within thirty days post-discharge, specific to the proposed service area.

The RCA strategy used qualitative and quantitative data including hospital self-evaluation surveys; stakeholder surveys; targeted patient/caregiver surveys and interviews; focus group discussions; and demographic data and hospital performance/readmission trends analysis.

It can be a game-ender for security-sophisticated partners if there is no IT platform in place to collect and analyze data and outcomes.

Since March 2013, AIHS has participated in the CMS CTTP demonstration project, using CTI with Medicare fee-for-service patients in ten hospitals (eleven locations) in thirty-eight counties in eastern Indiana. The hospitals vary in size from small, rural, community-based hospitals to large urban facilities.

Trained CTI coaches are assigned to specific partner hospitals, and provide CTI to eligible patients as outlined in the CTI model (i.e., hospital visit prior to discharge, home visit within forty-eight hours of discharge, and three follow-up phone calls over a period of thirty-days, post discharge). All visits and calls review the four CTI pillars: Medication Self-Management; Personal Health Record; Primary Care Provider/Specialist appointment follow-up; and Red Flags review. To date, the program has served more than 13,000 patients and netted a 41 percent decrease in hospital readmissions, saving more than $5,000,000.

Experience + Data + Outcomes = New Business Lines and Revenue

Our experience with the Care Transitions Project was used in combination with results of another successful pilot conducted by the Indianapolis-based AAA with a managed care organization (MCO), resulting in the first statewide AAA managed care contract (for Medicaid Managed Care). Because of our experience bringing a care transitions program to scale, AIHS took the lead statewide in MCO contract implementation and management, setting quality standards and creating a statewide training program to ensure standardized interventions.

Also during this time, AIHS joined with other Indiana AAAs in the Administration on Community Living's (ACL) Business Acumen Collaborative, with a goal to strategically expand its business model to create new partnerships, increase revenue, and contribute to redefining the healthcare system to include CBOs.

In 2015, AIHS signed another care transitions contract, this time with a regional insurance company. Its protocol was similar to CMS CCTP with value-added services, including registered nurses and registered dietitians to create additional flexibility in the intervention and additional billings. The population served is younger, often with post-traumatic injuries, and often is employed.

A Sophisticated IT Platform Is Essential

Multiple contracts with corresponding unique interventions at varied price points drove AIHS's search for an information technology (IT) platform that could support its new business model. AIHS needed a solution to overcome technology limitations that were getting in the way of contracting opportunities within the

integrated care arena. AIHS's ability to collect data efficiently, manage client data across programs (not to mention multiple customized interventions), provide risk stratification and data analytics, and measure outcomes was a game-changer. It can be a game-ender to security-sophisticated partners if such a platform is not put in place. We lost out on one early contract at the final negotiation stage due to our lack of a sophisticated IT health platform—we won't make that mistake again.

In late 2015, AIHS joined forces with Preferred Population Health Management, based in Indianapolis, to develop Population Health Logistics (PHL) as the health IT platform developed specifically for AAAs and other CBOs. PHL is a secure cloud-based, HIPAA-compliant electronic data platform. It is adapted from its original version, which was developed and validated by researchers at the Indiana University Aging Brain Center and Indiana University Research and Technology Corporation under a CMS Innovation Center grant.

Their clinical team originally developed the technology to support an interdisciplinary team—a clinical- and community-based approach to managing the care of individuals diagnosed with dementia or depression. AIHS customized the platform to address social determinants of health in the community-based setting, and then introduced the platform to the national AAA network, the ACL, and the Office of the National Coordinator for Health Information Technology.

AIHS is now developing a Population Health Management menu of products that includes various care transition interventions, a bundled payment intervention with a ninety-day span, and an ongoing population health management program for dementia and depression patients.

Transformation for Success

Each step on this journey of transformation—to strategically expand our business model to create new partnerships; to gain trust and respect from healthcare and managed care entities; to increase revenue; to benefit our clients; and to contribute

to redefining the healthcare system to include CBOs—has been an adventure. Some steps were deliberate, others were tentative and often fortuitous. But each step provided important lessons and foundational growth for our organization.

What follows are some of our most important "takeaways" to date:

- This is not a journey for the faint of heart. Board leadership and executive staff must have a deep commitment to changing the way business is done. The organization must be ready and willing to invest resources in new business lines. There must be readiness to change significantly and rapidly to be a part of integrated care.

Each step on this journey of change has been an adventure.

- Most likely, AAAs and CBOs will have to be the initiators. Healthcare systems generally do not reach out to "buy" what they need; rather they tend to build and manage what they need. They will have to be convinced that the AAA or CBO can provide the required services more effectively and more efficiently then they can on their own. Construct a value proposition, present it with confidence, and emphasize the return on investment they will see if they engage in a contract with you.
- Work to understand the new business partner and adapt to their needs. Reputation in the community will not be enough for them to want to include you in their service offering. Instead, bring them the solution to a problem they are trying to address—reducing hospital readmissions, driving down emergency room use, enhancing quality scores, etc.
- Managed care and other contracting groups are looking for scale, so plan to "go big or go home." Expanding the operation or banding together with other community providers to give them a centralized point for contracts and quality control both are good options.
- IT is critical. Data management and exchange are essential. AAAs or CBOs cannot be part of this work if their IT systems cannot communicate with health IT, cannot stratify risk, manage referrals, and provide outcomes data.

Perhaps most importantly, we remind ourselves every day that this is a journey. It is a path we have chosen: we adjust it as we learn more, and we aren't afraid to change course as we gain new insights and information. Also, it is a journey that has revitalized our agency and elevated it within our community. We have recognized our contribution to the health and quality of life of our clients, and we see many growth opportunities that lie ahead.

Connie Benton Wolfe, M.A., is president and CEO of Aging & In-Home Services of Northeast Indiana, Inc., in Fort Wayne.

References

The Care Transitions Program. n.d. "The Care Transitions Intervention." caretransitions.org/about-the-care-transitions-intervention/. Retrieved October 6, 2016.

The Bridge Model National Office. n.d. "The Bridge Model." www.transitionalcare.org/the-bridge-model/. Retrieved October 6, 2016.

Case Study: The Indiana Association of Area Agencies on Aging

By Kristen LaEace

AAAs across the Hoosier state unite to capture an MCO contract.

We considered creating a subsidiary corporation to engage in statewide contracts with Indiana managed care organizations (MCO) for two years before we finally took action.

In June 2014, the board of the Indiana Association of Area Agencies on Aging (a statewide trade association representing Indiana's Area Agencies on Aging [AAA]) voted to incorporate the Indiana Aging Alliance statewide network with the intent of capturing business from Indiana Medicaid MCOs. We successfully negotiated one contract, and by September 30, 2016, we had received 1,800 referrals and billed more than $561,000.

But that's not the whole story. From the decision to incorporate a limited liability corporation (LLC), to capturing more than a half million dollars in business, we have been learning lessons that can help other community-based organizations (CBO).

The Indiana AAA Landscape

First, a bit about Indiana AAAs. There are sixteen AAAs, which serve separate regions that cover all of the state, ranging in size from two to nine counties. One AAA serves more than 20 percent of the state's population, and two serve less than 2 percent. Some are primarily urban-suburban, and others primarily rural. Fourteen are 501(c)(3) corporations and two are affiliated with universities. Five are combined Community Action Program Agencies and one is combined with an economic development district. Some are 211 providers (community-wide human services information and referral services), rural transit operators, housing developers, Indiana health insurance marketplace navigators, and Head Start and First Steps providers. Some operate specialized transit fleets for older adults and people with disabilities. Others operate

Across a two-year span, we had received 1,800 referrals and billed more than $561,000 on just one MCO contract.

→ABSTRACT The Indiana Association of Area Agencies on Aging (IAAAA), in June 2014, incorporated the Indiana Aging Alliance, LLC, statewide network. The intent was to capture business from Medicaid managed care organizations (MCO). By September 30, 2016, it had received 1,800 referrals and billed more than $561,000 on just one MCO contract. From the decision to incorporate, to capturing more than a half million dollars in business, IAAAA has learned lessons that can help other community-based organizations. **| key words**: *Indiana Association of Area Agencies on Aging, managed care, referrals, MCO contracts*

guardianship programs for vulnerable adults.

Despite the wild diversity found among AAAs, we are united in providing a continuum of care for older adults and people with physical disabilities, with an emphasis on empowering our clients to live and age safely and independently in their own homes and communities. We are all designated Aging and Disability Resource Centers (ADRC) that offer specialized information and referral services for older adults and people with disabilities, telephonic and in-home Options Counseling, short- and long-term case management services, and evidence-based healthy aging prevention programs. We all broker in-home services with local providers on behalf of our clients, and we all manage public and private subsidies.

Ultimately, it was this shared mission that united us around new opportunities for improving our clients' outcomes and agency sustainability. We face the same challenges as other CBOs: declining federal and state grant resources, limitations to Medicaid budgets, and the inevitability of Medicaid managed care and managed long-term services and supports. We also see doors opening in the healthcare system as it embraces the critical role social determinants of health play in improving consumer health outcomes, service quality, and cost management.

In this environment, we had the opportunity to build on a thirty-day care transitions intervention pilot project that one of our large AAAs had with an MCO. The MCO was interested in expanding the project statewide, and this was the impetus that moved us to incorporate the Indiana Aging Alliance, LLC, with all sixteen AAAs participating, as a subsidiary of the Indiana Association of Area Agencies on Aging (IAAAA).

A key takeaway is that these initiatives are a long time in coming.

We chose to incorporate as an LLC to insulate the AAAs and IAAAA from risks associated with the new line of business. An LLC is a flexible corporate structure that allowed us to design governance and operations to best meet the needs of the business and address priorities and concerns of the AAAs. Because we anticipated our two university affiliates would have difficulty navigating a new corporate ownership through their larger institutions, we decided to incorporate the Indiana Aging Alliance as a

subsidiary of IAAAA rather than a free-standing corporation owned by each of the sixteen AAAs.

We have three governing documents, including Articles of Incorporation, an Operating Agreement—which is akin to a set of traditional nonprofit bylaws—and a standard AAA Participation Agreement; these define the relationship, rights, and responsibilities of the Indiana Aging Alliance and each AAA. Because IAAAA is incorporated as a 501(c)(6) trade association, the Indiana Aging Alliance also has a 501(c)(6) tax status, and its financial statements are ultimately consolidated with IAAAA's.

The Four Phases of Development

Our development broke down into the following four phases:

Consensus-building and incorporation. While it only took about three months of work in 2014 with our attorney to make the governance decisions resulting in our LLC incorporation, the idea had been percolating since 2012. We had AAAs successfully take advantage of the Community-Based Care Transitions Program through the Affordable Care Act, and other prior care transitions initiatives in the state that whetted everyone's appetite and interest for collective, statewide impact.

Contract negotiation. Following incorporation, we spent six months in negotiation over the design and price of the service we would offer the MCO. We paid a Certified Public Accountant (CPA) to develop a statewide pricing model, and a team, including the CPA, worked through pricing issues to arrive at consensus pricing for negotiation purposes. During this time, we were also accepted into the second cohort of the Administration for Community Living's (ACL) Business Acumen Collaborative.

Contract implementation. It took about three months of joint planning with the MCO to move the service from concept to implementation, including in-person and Web-based training we offered for AAA staff who would be performing and managing the service.

Contract performance. Since the April 2015 project launch, we have continued to work hand-in-hand with the MCO to ensure consistent statewide performance and quality levels. We have been testing and learning from our management model for future contracts and growth.

Lessons Learned

The biggest takeaway from our experience and that of our Business Acumen Collaborative cohort is that these initiatives are a long time in coming. From building consensus among network partners, to developing new business, negotiating contracts, and implementing the program, the process does take longer than CBOs will ever anticipate.

Sometimes it will feel like taking two steps forward and one back as your staff and the MCO's staff turn over, as the state changes how it is manages Older Americans Act and Medicaid services, and as the Centers for Medicare & Medicaid Services (CMS), ACL, and the state unit on aging and disability promulgate new regulations. Be patient and realize it is a long haul.

The biggest challenge to face is culture change within the board, leadership, and staff. Engaging in these initiatives requires that all involved with the CBO think differently about their futures. This is a "change or die" time for CBOs. Leaving behind the old and embracing the new is scary and exciting, requiring the leadership's constant attention to bringing everyone along in the process.

'The biggest challenge to face is culture change within the board, leadership, and staff.'

Within a network, CBOs will need to overcome tensions with other CBOs as each agency balances what is in its best interests with the network's interests. Leaders also must build trust that will move a network from more conserva-

tive business decisions to ones involving greater risk.

The larger the number of organizations in a network, the more important it becomes to choose an experienced attorney who can facilitate decision making regarding network governance. This goes hand-in-hand with the need to be as statewide (or regional) as possible to ensure coverage of the entire service area of a contracting partner.

Creating as much flexibility as possible in the network is crucial from the start. To ensure all Indiana AAAs were comfortable with incorporating the Indiana Aging Alliance, we had to define a very narrow scope of work in the governance documents, which restricted the kinds of opportunities the Alliance could pursue, as well as its geographic reach. As a result, we missed out on some business opportunities that would have required more flexibility on our part. Working together over the past two and a half years has built a greater level of trust among our network partners, and we have been able to adopt a more flexible governance framework that supports future growth.

Technology for data management will be one of the largest financial investments a CBO makes. These initiatives require working with "meaningful-use" electronic health

record and health information exchange systems. Ownership and analysis of the data will be key to being able to contribute to population health management and create value for the contracting partner. Access to the data platform and information can be a source of revenue. We are moving along this road but are not there yet, statewide.

In fact, two of our larger AAAs stepped forward to provide capacity for the health information technology platform, contract implementation, ongoing contract management, and quality control. We started our first contract without a significant financial investment from our members, but this is not a sustainable model for growth. Standardization of the intervention and quality control are central to making a statewide contract work, so going forward, we will need to price contracts to cover those expenses.

While we believe having a single statewide AAA network contracted with an MCO is unique to Indiana, the movement for CBOs to capitalize upon opportunities in integrated care is not. It takes a collective willingness to envision and realize our new futures.

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The Common Denominator: A Secret Sauce for Success

By W. June Simmons and Sandy Atkins

A tried-and-true formula: what it really takes for CBOs to make a successful transition to managed care.

Sociologist Everett Rogers noted some time ago that real change takes about seventeen years. Evidence of this abounds in the field of aging services. Almost twenty years ago, Partners in Care Foundation was started with the modest tagline: "Changing the shape of healthcare." The vision was proactive and reactive—to bridge healthcare and social services and avoid the siloed, fragmented system facing older adults and people with chronic health conditions and disabilities.

The focus has always been on partnership and collaboration—the secret sauce for success. But due to the shift toward managed care and acceleration in the pace of change in the healthcare world, now is the time for home- and community-based services (HCBS) providers to finally become important partners for health.

The articles in this supplement to *Generations* confirm a strong common denominator—to change the shape of healthcare, community-based organizations (CBO) must form working partnerships with each other and with the healthcare sector. It will take this unity, plus great skill and determination, to evolve into a new health system that addresses the psychosocial, economic, and physical determinants of health. Joining together lends strength and boosts a unique value proposition—regional delivery systems that make it easier to access and deploy resources and services. The time for HCBS networks has come.

'The focus has always been on partnership and collaboration—the secret sauce for success.'

Because of the rapidly changing landscape in healthcare financing—as the nation moves toward value-based care—healthcare and social service agencies need flexible partnerships of mutual respect and shared financing. Such partnerships can affect person-centered regional

→ABSTRACT For sustainability, community-based organizations (CBO) must establish partnerships with healthcare payers and providers. Vanguard CBOs share high tolerance for risk, employ staff with cross-sector perspective, and recruit board members from healthcare. They immerse themselves in concerns of healthcare colleagues by participating in healthcare associations and educating themselves, attending webinars and conferences. Successful partnerships start at the top, but staff from both sides need to buy into the benefits enough to bear change and extra work. If CBOs are willing to meet healthcare more than halfway, they can achieve expanded impact. **| key words**: *CBOs, sustainability, partnerships with healthcare, board member participation*

systems of care that improve quality, consumer and provider experience, and reduce cost.

The depth and scale of change required are deep for both healthcare and HCBS communities. How do CBOs seize the opportunity for fundamental change? CBOs can help build systems of human services to more practically address the wide range of factors that lead to better health outcomes—self-management, coordination and access to essential resources, and responsive and integrated health and social services systems.

What is and will be needed to forge such partnerships with often behemoth and rapidly consolidating managed healthcare organizations? This article details principles gleaned from the Partners in Care experience, as our organization worked closely with the national learning communities supported and advanced by The John A. Hartford Foundation, Archstone Foundation, and The SCAN Foundation, with leadership from the Administration for Community Living and its allies, other key national leaders in the field, National Association of Area Agencies on Aging (n4a), Meals on Wheels America, and the American Society on Aging.

The work of transforming an organization to achieve "business acumen" has dramatically shifted the field of aging and disability services. Such endeavors are laying the groundwork for a new culture of care, and forging tools to undergird success as the field of aging services moves forward into the promising, but still rapidly evolving, future.

Opening the Door: Partnerships with Healthcare

Looking back at principles common to agencies that are enjoying early success, three lessons predominate:

- **Background and complementarity of staff.** The cultural shift within vanguard organizations is fostered by the experience of staff leadership. Leadership must include a combination of healthcare and social services expertise and relationships. It is crucial to establish a strong vision and deep commitment to fundamental change, moving from the past stability of grants and government contracts, to include the more enterprising and unpredictable world of contracts with health plans, physician groups, health systems, and others carrying risk for the costs and outcomes of healthcare.

Visionary and entrepreneurial leaders must be flanked by a management team with skills in planning, business development and contracting, team-building, research and evidence-based practice, new information technology (IT) and business systems, and results-oriented practice. In addition to governance and infrastructure changes, practice teams and their leaders must build easy and efficient relationships with resistant teams in other settings, and also bring high energy and speed, a focus on productivity, and the ability to thrive on continuous change. Also key are quality measurement, the IT systems to support it, and accreditation.

- **Board of directors.** Having a board with full commitment to the home- and community-based agency purpose, yet one that sees the future and the need to evolve, is essential to mastering the set of changes noted in the prior paragraph. Because it is expensive for a CBO to meet the infrastructure requirements of large, risk-averse healthcare payers, the board must support management in making investments in agency systems and staffing. The board's ability to tolerate the risks of major change and to work to build relationships with new health partners is vital. This can mean adding to the board, although many of the first agencies leading this transformation benefitted from already having this kind of governance strength early on.

  Board members from healthcare settings can play an important role to open doors, serve as champions, and work as ambassadors to advance healthcare partnerships. If they are strong in the healthcare arena, they know the landscape and can help educate agency leaders, guide them through key issues, identify allies, and voice the vision to potential healthcare-sector partners via presentations at association meetings and conferences.

- **Being there.** HCBS providers must establish a new brand. Half the battle of opening doors to potential partnerships is becoming known in the healthcare world. Writing key health players into grants for change, joining hospital and physician associations, attending state and national health plan associations' meetings, presenting at Medicaid directors associations—taking a place in these worlds helps to define HCBS leaders as peers.

  Building this credibility comes about partly by just showing up, even more by being featured in publications and presentations. This may seem out of reach, as many healthcare associations are expensive to join. Asking for a scholarship or a nonprofit or government discount can be successful, as can be requesting a spot on their conference program—especially with or through an association member.

  Co-teaching in healthcare settings is critical to detail a vision and report successful results of new integrated models of care. This activity helps one to learn and advance in the changing environment and has been powerful in transforming the culture of the aging services sector. However, speaking publicly in a formal way to potential partner entities has a different effect, but also is key. Leaders who ventured out early onto these pathways have found allies who share concerns about gaps in healthcare that only HCBS can fill. New voices and new friends appear, reaching out together to help achieve needed changes. This is a key role for a CBO chief executive officer and a board ally. Only when the chief executive officer and board invest the time for such outside advance work can they accomplish some of the biggest changes required in the evolution toward integrated care.

The board's ability to tolerate the risks of change and to work on building relationships with new health partners is vital.

  Contracts come from relationships, which lead to credibility and, eventually, to engagement. This has been a much longer process across the country than most expected—winning a contract can take a year. And then the work to achieve behavior change within the new contract that would assure adequate referrals and success is another set of changes and skills CBOs need to strengthen and systematize the move toward broad success.

Learning to Listen

It helps immensely to go to healthcare organizations' meetings, serve on their internal committees, read their journals, and listen to podcasts, such as those from the Institute for Healthcare Improvement and *Health Affairs*. These activi-

ties not only familiarize CBO staff with the relevant vocabulary, but also reveal the concerns and challenges facing healthcare—it is vital to understand these challenges. Also, CBOs should note the areas in which healthcare entities are seeking new solutions, and identify these organizations' fears and concerns, which must be resolved to break through to true partnership.

This understanding is crucial if CBOs are to successfully present a clear and compelling value proposition to potential health partners. It is doubly important because of the fast pace of change—in one year, avoiding penalties by reducing readmissions topped the list; the next year, it was dealing with MACRA (Medicare Access and CHIP Reauthorization Act of 2015), MIPS (Merit-based Incentive Payment System), and APM (Alternative Payment Models).

It takes time and care to discover what CBOs are asking of hard-working front-line healthcare staff.

This accelerating pace of consolidation and reimbursement change in healthcare makes it doubly important to continually listen. The Centers for Medicare & Medicaid Services' (CMS) Community-based Care Transitions Program (CCTP) is an interesting case in point. At the beginning, CBOs were told that CCTP was aimed at testing the feasibility of a CBO care transitions Medicare benefit. At the same time, Medicare penalties for disproportionately high readmission rates were being phased in. CCTP had a fairly rough start because to be meaningful to CMS, interventions had to reach a high volume of patients. Many—even most—of the CCTP-selected CBOs had difficulty gaining partnership from the hospitals to achieve sufficient volume and were dropped in spite of excellent results in reducing readmissions among the people they were able to reach.

Forcing these contract cancellations for lack of volume reflects CMS's early misunderstanding of the depth of resistance to HCBS solutions in the medical community, especially on the front lines of patient care. Gaining cooperation to identify and connect with patients in need of these important new services is a profound challenge requiring new tools and skills. Given the CCTP program's failure to anticipate this problem, many sites were not able to achieve the needed volume required by CMS for success.

The CCTP story highlights a number of the following key lessons that CBOs must master to succeed in partnering with and being paid by healthcare entities:

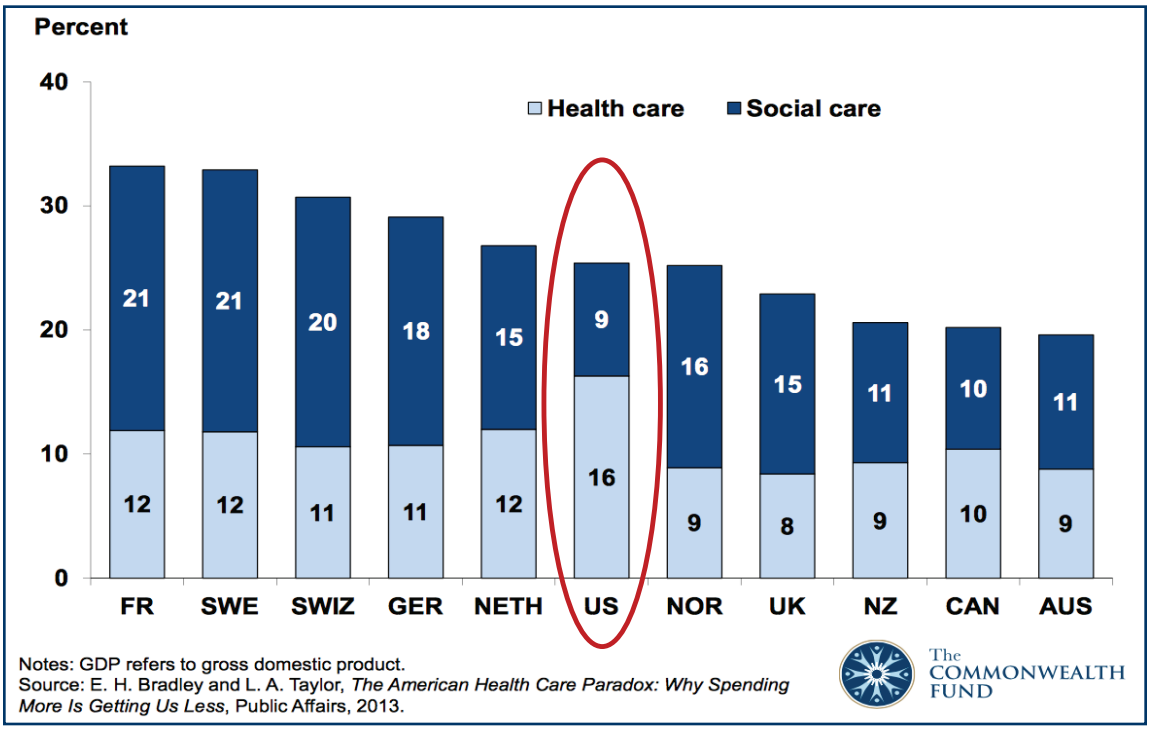
- CBOs must understand what the potential partner perceives as the elements of return, both tangible and intangible;
- CBOs must understand the full scope of investment, often more than the price of an intervention; and
- CBOs must realize that achieving volume is hard, especially because contract decisions often are made several levels above the people who will need to collaborate in order to achieve success.

What is return?

Integrated and managed care models typically shift the use of medical dollars over to HCBS. America lags behind the international community in this respect—our ratio of social to healthcare services is off balance and our results are worse than many other members of the Organisation for Economic Cooperation and Development, as shown in Figure 1 on page 69.

To move money now being spent on healthcare services over to community care, it is essential to demonstrate the value proposition—to show there are more savings from interventions than there are new costs. Each type of healthcare entity—hospitals, health plans, Accountable Care Organizations, physician groups—has a different economic model; plus, these models are evolving rapidly in tandem with healthcare reform and alternative payment models.

Figure 1.



Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

Just as each type of healthcare entity has its own calculus regarding the potential value proposition for HCBS, different staff positions in a healthcare organization perceive return differently. It's important to anticipate both objections and selling points germane to the major decision-makers: the CEO and chief financial officer; clinical heads of medical, nursing, quality, and case management; and legal and chief information officers.

After learning to listen to health plans, hospitals, and medical groups, at Partners in Care Foundation we began to take a step back and re-visualize our services, first breaking them down into smaller components—qualifying people, performing assessments, providing social care coordination, helping with advance directives discussions—and then reconfiguring them to match what we had heard.

The essence of our services offerings is the same, but as we listened to hospitals, for example, we heard that readmissions weren't their main issue—rather, they were challenged by inappropriately long, unpaid stays by people with mental health problems, or by sending people home from the emergency room with no in-home caregiver support. We knew we could help with these scenarios, but when we were selling readmission reduction, the hospitals weren't buying. It was therefore essential to frame our service outcomes as having positive impacts upon our new payer-partners' highest issue priorities.

What is investment?

Beyond the obvious cost for an intervention, there are many other costs that potential contracting partners may consider. One of the biggest is the political cost of one more change for a staff already awash in change. For every hour CBOs spend planning, communicating, and adjusting, there is at least one hour of the same on the healthcare organization's side of the equation. Weekly meetings, changing workflows,

awkward communication requirements due to IT departments' resistance to facilitate data exchange with a CBO—these are the usual hallmarks of learning to do business with someone new. There may also be perception of competition, and fear of job loss. When the front-line healthcare staff don't understand or experience the value of what CBOs bring to their patients and members, the perceived cost will outweigh the benefit.

Building volume

Healthcare organizations' staffs, who may feel that the cost of working with CBOs outweighs the benefit, need to be heard and responded to. Their concerns may or may not be legitimate, but, if left unaddressed, they may sink what could be a positive partnership that improves care and quality of life for their patients and members. This is where learning to listen operates at more of a micro level. Interventions can change the daily workflow for the staff with whom CBOs and other nonprofits directly interface—often nurse case managers or healthcare-based social workers. CBOs should realize it takes time and care to discover what they are asking of these hard-working people.

Success requires showing a willingness to go more than halfway, and to deploy multiple approaches, from catered training sessions that earn continuing education credits, to reminders, comparisons, and flowcharts. One area in which building volume has been easier is in contracting to provide evidence-based self-management programs to health plans. As part of their disease-management activities, healthcare providers have begun to provide CBO networks with tens of thousands of names from chronic disease registries, and are paying CBOs to enroll as many plan members as possible.

The Goal Is Achievable!

Integrating healthcare and social services around the needs, goals, and preferences of people with chronic conditions is closer to being achieved than ever before. As CBOs step boldly out of the comfort zone of government and grant funding into the new world of paid contracts and partnerships with healthcare, keeping that goal in mind can help CBOs maintain focus.

The process is expensive, it is difficult, and it takes time, but at the end of the road lies a sustainable future, an ability to reach substantially more people who need our services, and the promise of better health and quality of life for millions of people—at a much lower cost. Future generations need the system we're building—we just have to keep listening, learning, and moving forward.

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The SCAN Foundation, The John A. Hartford Foundation, the Administration for Community Living, the Gary and Mary West Foundation, the Marin Community Foundation, and the Colorado Health Foundation have united to fund a three-year grant to develop and establish the Aging and Disability Business Institute, housed within n4a. Under the grant, lead partners ASA and n4a (*aginganddisabilitybusinessinstitute.org*) are collaborating on a three-part series of yearly supplements to ASA's *Generations* journal that will help to prepare, educate, and support aging and disability community-based organizations and healthcare payers to provide quality care and services. This 2017 supplement is the first in that series.