Webinar:
Building Pathways to Sustainability – Resources from the Aging and Disability Business Institute

January 23, 2019
Website: archrespite.org
Presenter

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Aging and Disability Business Institute
National Association of Area Agencies on Aging (n4a)
Connecting with Health Care Providers: Opportunities and Challenges

ARCH webinar
January 23, 2019

Marisa Scala-Foley
Director, Aging and Disability Business Institute
n4a
The Business Institute

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.
Our work

- Build a national resource center
- Develop an assessment tool to determine the capacity of CBOs
- Provide training and technical assistance
- Conduct an outreach and educational campaign targeting the health care sector
- Systems Change Through Stakeholder Engagement
Aging and Disability Business Institute

Connecting Communities and Health Care

When community-based organizations (CBOs) and the health care system work together, older adults and people with disabilities get the coordinated care that lets them live with dignity and independence in their homes and communities as long as possible.
Where community-based organizations add value

Managing chronic conditions

- Chronic disease self-management programs (CDSMP) & other health programs
- Diabetes self-management
- Nutrition programs (counseling, education & meal provision)
- Education about Medicare preventive benefits
- Peer supports
- Telehealth/telemedicine

Preventing hospital (re)admissions

- Evidence-based care transitions
- Care coordination
- Information, referral & assistance/system navigation
- Medical transportation
- Evidence-based medication reconciliation programs
- Evidence-based fall prevention programs/home risk assessments
- Nutrition programs (counseling & meal provision)
- Caregiver support
- Environmental modifications
- Housing assistance
- Personal assistance

Community-based aging & disability organizations

- Person-centered planning
- Peer supports
- Self-direction/self-advocacy tools and resources
- Chronic disease self-management
- Adult day health
- Evidence-based care transitions
- Information, referral & assistance/system navigation
- Benefits outreach and enrollment
- Employment related supports
- Community/beneficiary/caregiver engagement
- Community training
- Supported decision-making
- Assistive technology
- Financial management services
- Independent living skills
- Behavioral health services
- Nutrition education

Activating beneficiaries

- Transitions from nursing facility to home/community
- Person-centered planning
- Care coordination
- Self-direction/self-advocacy
- Assessment/pre-admission review
- Information, referral & assistance/system navigation
- Environmental modifications
- Caregiver support
- Adult day health
- LTSS innovations
- Transportation
- Housing assistance
- Personal assistance

Diversion/Avoiding long-term residential stays

Older adults & their families

Health care providers & payers

Aging and Disability Business Institute
RFI Survey

To Take the Pulse of CBO-Health Care Partnerships

RFI T1: 2017
RFI T2: 2018
Survey Methods

-Partnered with Scripps Gerontology Center at Miami University
-Disseminated via email directly to 617 AAAs and 623 CILs
-Key national agencies shared the survey with other CBOs
-Survey was in the field for 9 weeks between May and July of 2018 with a total of 726 respondents

### Response Rates

<table>
<thead>
<tr>
<th></th>
<th>RFI 1 2017</th>
<th></th>
<th>RFI 2 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>Area Agency on Aging (AAA)</td>
<td>351/623</td>
<td>56.3</td>
<td>409/617</td>
<td>66.3</td>
</tr>
<tr>
<td>Center for Independent Living (CIL)</td>
<td>119/313</td>
<td>38.0</td>
<td>174/623</td>
<td>27.9</td>
</tr>
<tr>
<td>Other CBO</td>
<td>106</td>
<td></td>
<td>143</td>
<td></td>
</tr>
</tbody>
</table>
Overall Contracting Status, by Year

<table>
<thead>
<tr>
<th>Category</th>
<th>RFI 1-2017</th>
<th>RFI 2-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, currently have one or more contracts</td>
<td>38.1%</td>
<td>41.3%</td>
</tr>
<tr>
<td>No contracts, but pursuing</td>
<td>16.5%</td>
<td>16.8%</td>
</tr>
<tr>
<td>No contracts, and not pursuing</td>
<td>45.4%</td>
<td>41.9%</td>
</tr>
</tbody>
</table>

Sample sizes:
- Yes, currently have one or more contracts: n=226, n=300
- No contracts, but pursuing: n=98, n=122
- No contracts, and not pursuing: n=269, n=304
Most Common Health Care Partners for CBOs Contracting with Health Care Entities T2 and T1

- Medicaid Managed Care Organization: 35.00% (T1), 41.60% (T2)
- State Medicaid that is not pass through via a MCO: 12.60% (T1), 28.50% (T2)
- Hospital or hospital system: 27.80% (T1), 26.50% (T2)
- Veterans Administration Medical Center: 19.30% (T1), 21.30% (T2)
- Commercial health insurance plan: 13.90% (T1), 17.90% (T2)
- Medicare/Medicaid Duals Plan: 16.10% (T1), 17.50% (T2)
- Accountable Care Organization (ACO) (including Coordinated Care...): 6.30% (T1), 12.70% (T2)
- Medicare Fee for Service (e.g., we are a certified provider for DSME, Medical...): 4.00% (T1), 8.90% (T2)
- Medicare Advantage Plan (including Special Needs Plan (SNP)): 5.40% (T1), 8.90% (T2)
### Most Common Services Provided through Contracts by CBOs Contracting with Health Care Entities T2 and T1

<table>
<thead>
<tr>
<th>Service</th>
<th>RFI T1-2017 (n=223)</th>
<th>RFI T2-2018 (n=287)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case management/care coordination/service coordination</td>
<td>49.30%</td>
<td>50.20%</td>
</tr>
<tr>
<td>Care transitions/discharge planning</td>
<td>29.10%</td>
<td>38.30%</td>
</tr>
<tr>
<td>Assessment for long-term services and supports (LTSS) eligibility</td>
<td>10.30%</td>
<td>30.30%</td>
</tr>
<tr>
<td>Nutrition program (e.g., counseling, meal provision)</td>
<td>19.70%</td>
<td>27.90%</td>
</tr>
<tr>
<td>Evidence-based programs (e.g., fall prevention programs, Chronic Disease)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person-centered planning</td>
<td>22.00%</td>
<td>27.20%</td>
</tr>
<tr>
<td>Home care (e.g., homemaker, personal assistance, personal care)</td>
<td>26.50%</td>
<td>25.80%</td>
</tr>
<tr>
<td>Options/Choice counseling</td>
<td>14.30%</td>
<td>24.70%</td>
</tr>
<tr>
<td>Transportation (medical or non-medical)</td>
<td>20.60%</td>
<td>22.30%</td>
</tr>
<tr>
<td>Participant-directed care</td>
<td>20.60%</td>
<td>20.90%</td>
</tr>
<tr>
<td>Caregiver support/training/engagement</td>
<td>17.90%</td>
<td>20.20%</td>
</tr>
</tbody>
</table>
Most Common Changes Experienced by Contracting CBOs

- Obtained funding from new sources: 55.6%
- Positioned the agency as a valuable health care partner: 47.0%
- Expanded or enhanced the types of services offered: 34.8%
- Expanded visibility of our organization in the community: 33.3%
- Increased number of people served: 29.6%
- Expanded the type of populations served: 26.7%
- Enhanced our organization’s sustainability: 25.6%
- Increased agency net revenue: 24.8%
## Top 5 Challenges in Contracting by Contracting Status

<table>
<thead>
<tr>
<th>#</th>
<th>Organizations with one or more contracts (n=274)</th>
<th>Organizations with no Contracts but pursuing (n=122)</th>
<th>Organizations with no contracts and not pursuing (but tried and were unsuccessful) (n=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Time it takes to establish a contract</td>
<td>Common understanding of proposed programs/services</td>
<td>Attitudes of health care professionals toward your organization</td>
</tr>
<tr>
<td>2</td>
<td>Common understanding of proposed programs/services</td>
<td>Integration of your organization’s services into health care system workflow</td>
<td>Competing priorities within the health care community</td>
</tr>
<tr>
<td>3</td>
<td>Referrals and volume</td>
<td>Attitudes of health care professionals toward your organization</td>
<td>Leadership changes within health care entities</td>
</tr>
<tr>
<td>4</td>
<td>Attitudes of health care professionals toward your organization</td>
<td>Willingness of your organization to take financial risk</td>
<td>Integration of your organization’s services into health care system workflow</td>
</tr>
<tr>
<td>5</td>
<td>Integration of your organization’s services into health care system workflow</td>
<td>Time it takes to establish a contract</td>
<td>Common understanding of proposed programs/services</td>
</tr>
</tbody>
</table>
Why partner with health care providers and payers?

• Margin
  • Opportunity to generate more sustainable revenue sources

• (But More Importantly) Mission
  • Opportunity to build a more seamless, responsive, person-centered system that can better serve older adults and their families
CBO-Health Care Partnerships: What Works and Why?

- Finding and nurturing champions
- Shared vision and mission
- Common understanding that CBO services are NOT free
- Flexibility
- Laser focus on your partner’s pain points
- Clearly defined and open data-sharing protocols
Key needs and issues going forward

• Understanding the decision to build vs. buy
• Responding to new payment models and opportunities
  • Medicare Advantage supplemental benefits
  • Value-based payment models
• Preparing organizations to accept risk
• Referrals and volume
Where to begin?
Building blocks: Organizational culture

• One of our most important lessons from our work related to building business capacity...

Culture matters
In a lot of ways, this shift can feel like...

"What I'd like for you to do is change everything about yourself and get back to me."
This involves commitment at all levels... Staff, Managerial, Executive, Board
What kind of culture are we talking about?

• An expanded view of who your customers are: Clients & payers
  • Also, who your competitors and partners are
• Sales and customer service focus
• Data-informed decision making
• Flexibility
• Understanding your real costs
• Emphasis on speed and volume
• Focus on outcomes, quality, performance and results
• Having the systems in place to support the strategy
• Vision, innovation, and excitement
Building blocks: Market analysis

• Understanding your market (aka...do your homework)
  • Existing and changing
  • Who are your customers (payers AND clients)?
  • What do they want/need?
  • What are your network’s strengths (and weaknesses)?
  • Who are your competitors?
  • What regulatory and political factors might impact your ability to deliver services and attain contracts?
Building blocks: Service lines/packages

- Which service(s) does your organization or network have the capacity to deliver?
- What is your history of delivering those services?
  - What is your organizational stature in the market?
Building blocks: Developing your value proposition

• What is the business case for buying your services?
  • Communicating your services and value clearly and consistently
    • Stories and data
    • Return on Investment (ROI)
  • How do the services you can offer meet your customer’s needs or solve their problem(s)?
• How can your services help a payer meet the quality requirements to which they must adhere?
Building blocks: Relationships/champions

- Who is in your network? Who isn’t, but needs to be (based on customers’ needs)?
- Who are your champions -- especially those closely tied to your target customers?
  — (And who are potential saboteurs?)
Building blocks: Infrastructure

• What is your infrastructure for referrals, billing, and tracking outcomes?

• Health Information Technology
  • Which data elements do you need to collect?
  • How will you transfer information to other entities (payer, state health information exchange, partners, etc.)?

• How will you bill for services?
Building blocks: Pricing/cash flow

• What are your costs to deliver the service(s)? What can the market bear?
  • True cost to deliver the service (direct costs)
  • Indirect rate required to deliver said services
  • Market rate for the service
  • Value of the service to the payer
  • Market demand for said services
  • Access to proposed services in the market
Building blocks: Volume

• How will you generate and sustain client volume?
  — Contract language
  — Referral processes
  — Plan/provider staff level buy-in

• How will you meet potential demand? (Staffing, partnerships)
Building blocks: Quality

• How will you track quality of the services you provide?
  — Process and outcomes
• How will you use what you collect to manage performance?
• How will this factor into payer quality systems (i.e. star quality ratings, reporting systems, etc.)?
• How will you ensure the quality of services of network partners?
• Will you seek out accreditation?
What is the value CBOs bring?

- Return on Investment/ROI (Total Savings from Program – Total Cost of Program)/Total Cost of Program)
- HEDIS/Star Measures/Hospital Compare
- Cost savings to provider/payer
- Avoiding penalties
- Consumer/patient/family activation and satisfaction
Opportunities – Medicare Advantage (MA)

• Expansion of Medicare Advantage supplemental benefits
  • Includes flexibility to offer some types of long-term supports and services (LTSS)

• Changes in the following areas:
  • Uniformity requirements
  • Targeting of beneficiaries
  • Definition of “primarily health-related”
## Changes for 2019

<table>
<thead>
<tr>
<th>Benefit uniformity</th>
<th>Old Rules</th>
<th>New Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plans must offer the same benefits to all enrollees of the same plan</td>
<td>Now allowed to target benefits to groups of enrollees who share certain diagnoses</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supplemental benefits</th>
<th>Old Rules</th>
<th>New Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental must be “primarily health-related” which means, in part, not for the purpose of “daily maintenance”</td>
<td>Broader definition of the term “primarily health-related”</td>
<td></td>
</tr>
</tbody>
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*advocacy | action | answers on aging*

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Defining “primarily health-related”

• Benefits must:
  • Diagnose, prevent or treat an injury;
  • Compensate for physical impairments;
  • Act to ameliorate the functional/psychological impacts of injuries or health conditions; OR
  • Reduce avoidable emergency or health care utilization
  • **Cannot be** “solely or primarily used for cosmetic, comfort, general use, or social determinant” purposes

• Benefits must be recommended by a licensed professional as part of a care plan
Examples of allowable types of supplemental benefits

- Adult day care services
- Home-based palliative care
- In-home support services
- Respite care
- Transportation (to doctor’s visits)
- Home modification (e.g., safety devices and modifications like grab bars, shower stools, stair treads)
- Support for caregivers
- (Meals excluded for 2019)
What are we seeing in 2019?

Further changes in 2020

• Expands supplemental benefits to allow benefits that “with respect to a chronically ill enrollee, have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits.”

• The Secretary may waive uniformity requirement for supplemental benefits to chronically ill enrollees
Opportunities (and Advice) for Community-Based Organizations

• Define your value proposition in terms of how the services you offer address the plan’s pain points

• Results, results, results

• Think about approaching MA plans with your existing health care partners

• If you have contracts with Medicaid/duals plans, approach their MA plans

• Don’t underestimate the value of retention
Questions?

For more information:
www.aginganddisabilitybusinessinstitute.org

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Please take a moment to provide feedback here:

https://www.surveymonkey.com/r/DV7PLZQ

Thank you for joining the Webinar!

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Lifespan Respite
Technical Assistance Center

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