



Summer 2015

WNY
INTEGRATED
CARE
COLLABORATIVE

COMMUNITY-BASED INTEGRATED CARE NETWORKS

Phase 2 Final Report

Key Findings | Recommendations

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Executive Summary

There has been a paradigm shift in the way policy makers think about healthcare and long term services and supports. This shift is changing expectations of what care looks like and how providers are paid. New thinking brings new opportunities for the aging network, but to capitalize on them Area Agencies on Aging and community-based organizations must embrace a new way of thinking as well.

To prepare for new partnership opportunities, the Administration for Community Living is encouraging Area Agencies on Aging to explore *community-based integrated care networks*. Similar to physicians' Independent Practice Associations, these networks allow participating organizations to remain independent while serving as a contracting vehicle for a group of partners. Integrated care networks can only be useful locally, however, if they make sense in the New York State regulatory environment, and if the provider community is ready to embrace one.

Do integrated care networks make sense in New York State? The experience of others across the country suggests that those who pay for healthcare and supportive services want to be able to contract with a single organization that has significant geographic reach, which can provide access to a variety of traditional and new services. Moreover, their experience suggests that these buyers increasingly want to be able to partner with organizations that can work within value-based, rather than volume-based, payment models where pay is dependent upon patient outcomes. The same holds true in New York.

Geographic reach is increasingly relevant as emerging opportunities are more often regional, rather than county or neighborhood-based. This applies to working with long-standing buyers, such as Medicare Advantage plans, and new buyers in New York, such as Performing Provider Systems. At the same time, managed care entities continue to have network adequacy standards that must be met. Given this, regional reach is increasingly essential for service providers, while local service delivery capacity continues to be a core need of managed care entities.

Like others across the country, payment systems in New York are also changing as efforts to control rising health care costs continue. This is incentivizing cost containment and investment in relatively low-cost preventive services that can decrease utilization of high-cost care. It is also shifting payment from volume-based to value-based. Those who partner with managed care entities must be able to deliver client outcomes and work within the constraints of new payment models.

Is the provider community ready to embrace an integrated care network? Aging network providers believe they have a valuable role to play in turning the curve on healthcare and long term care spending, but face considerable obstacles to participating in the marketplace. An integrated care network would be beneficial for overcoming a significant weakness—limited geographic reach—which is increasingly an elimination factor for those who wish to pursue new opportunities.

An integrated care network can also provide an organizational framework for providers to work together to develop and implement programs to meet new service needs, including health promotion, care transitions, and affordable long term services and supports (LTSS). Individually, providers lack the capacity to scale up, and to deliver consistent programming throughout a multi-county region. They also lack the capacity to communicate collective impact around client outcomes, which is increasingly needed to get the attention of managed care entities that are facing capitated rates and value-based payments. Local providers understand the potential of a regional integrated care network to overcome limitations that are hurting the competitiveness of stand-alone organizations.

How do we proceed? A long term incremental approach that creates a legal vehicle to meet immediate needs, while providing a way to evolve along with community readiness, is the best way to proceed. An integrated care network must immediately provide a vehicle for applying for regional grants, seeking accreditation for programs, and joining Medicare Advantage plan provider networks. In the short term, it should be able to offer a range of services to members that help demonstrate their value and give them an opportunity to do business with a range of new partners. In the long term, it must make doing business with the aging network attractive to buyers working under value-based payment systems.

A low-cost, quick set up solution that can grow with us. Successful efforts by others in the community, such as SNAPCAP, have employed an incremental strategy to network development, evolving from informal collaborations to 501(c)(3) over the course of several years. To give an integrated care network a legal form immediately, we recommend establishing a taxable not-for-profit corporation. This can be established as quickly as an LLC, while providing many of the benefits of the 501(c)(3). Moreover, it is able to be converted into a 501(c)(3) at a later date when the network is ready to evolve. This option provides a legal vehicle for implementing an integrated care network quickly, while giving us the ability to modify the structure as we grow.

Introduction

Health care reform is changing the way providers care for older adults and the disabled. The wall of separation between those practicing “medical model” patient care and those providing “social model” supportive services is growing thin as both work to meet new expectations for providing person-centered integrated care. To capitalize on new opportunities and financial incentives set down by principals at the national and state level, both medical and supportive services providers alike are moving to change the way they do business.

The aging network that was established with the passage of the Older Americans Act in 1965 has not been exempted from the movement toward integration. The gentle invitations to explore the frontier are beginning to give way to firmer insistence. Incentives are being replaced by mandates, and opportunities are increasingly limited to those who can navigate the new terrain.

Across the country, aging network providers are working to meet the demands of the new healthcare marketplace. As with all change, there are a handful of innovators who are providing best practice examples of what change can look like, and there are those who have decided to “wait and see” if change is here to stay. Most aging network providers are somewhere in the middle, responding to change where they can see how to do it effectively.

Several aging network providers in Erie and Niagara counties have been working together to define their role in the new systems being created and build new ways to deliver the home and community based services that are essential to achieving integrated care. This report describes the efforts of what has come to be called the *Western New York Integrated Care Collaborative* and the work it has done to explore new ways of organizing the aging network to meet changing service delivery expectations. It includes history, lessons learned, and recommendations for future network development.

Background

The Patient Protection and Affordable Care Act, passed in 2010, set the foundation for a flurry of health care reforms that are being implemented in a variety of ways in states throughout the country. It encourages enhanced integration between hospitals, health care providers and the community-based organizations that

provide day-to-day support to older adults and the disabled. As a result, many in the health care community are giving more thought to supportive services as evidence mounts that they reduce both hospital readmissions and the likelihood of nursing home placement. Similarly, the focus on better population health is resulting in a call for greater availability of evidence-based interventions, such as Stanford-model disease management programs, and new mechanisms being put in place to compensate providers for delivering these programs.

While opportunities are increasing for aging network service providers, the work that must be done to capitalize on opportunities is different from the work many providers are accustomed to doing. Grant-based reimbursement that pays for staff expenses regardless of program volume, and fee for service compensation independent of outcomes, is increasingly being replaced by performance-based payment models that emphasize shared risk. To make the most of new opportunities and not get lost in the changing marketplace, providers must develop the infrastructure and business processes to support contracting with health plans and other types of managed care organizations that are central to new opportunities that are emerging in the wake of health care reform.

In late 2012, the Health Foundation of Western and Central New York launched an initiative called *Ready or Not*, with the intent of helping local organizations build capacity to meet changing demands and expectations in the evolving healthcare marketplace. Several aging network providers in Erie and Niagara counties responded to the request for proposals, and were ultimately invited to participate in the initiative, including the Erie County Department of Senior Services, The Health Association of Niagara County, Inc. (HANCI), Amherst Department of Senior Services, and Catholic Charities of Buffalo. Within the first four months of *Ready or Not*, another capacity-building opportunity emerged—a Request for Applications to participate in a national Business Acumen Learning Collaborative issued by the U.S. Administration for Community Living (ACL). This opportunity produced a partnership between the Erie County Department of Senior Services, the Niagara County Office for the Aging, and several local community-based organizations (CBO), including several *Ready or Not* grantees. There was a natural synergy between the two projects, and they ultimately became intertwined for many of the organizations involved in both initiatives.

ACL's National Learning Collaborative

The WNY Integrated Care Collaborative was one of nine national partnerships to receive targeted technical assistance from the ACL. Designed to help Area Agencies on Aging (AAA) and their local non-profit partners build capacity to deliver high quality integrated care to older adults, the technical assistance included consultant services, on-site and webinar based training, and participation in a national learning community comprised of peer agencies from across the country.

The Western New York project group included a number of community based organizations that have been a part of the Erie Niagara aging network for several decades, including:

- ▶ Catholic Charities of Buffalo
- ▶ Community Concern of WNY
- ▶ The Dale Association, Inc.
- ▶ DeGraff Adult Day Care
- ▶ HANCI
- ▶ Hearts and Hands Faith in Action
- ▶ Meals on Wheels of WNY
- ▶ Schiller Park
- ▶ Schofield Residence Adult Day Health Care Program
- ▶ Town of Amherst Department of Senior Services
- ▶ Town of Hamburg Adult Day
- ▶ United Way of Buffalo and Erie County

At the time the project was launched, partners discussed what success would look like for the new learning collaborative. Consensus formed around 4 broad goals:

1. Increased awareness of our value among formal health care entities.
2. Increased understanding of our organizational roles in the new system.
3. Development of integrated service packages to meet emerging needs in the system.
4. More partnerships and stronger collaborations.

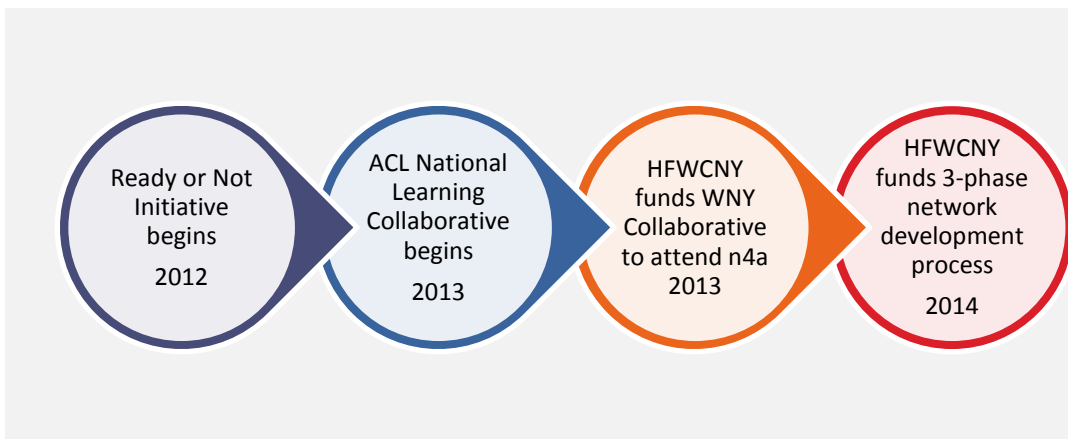
In addition, a common 'pain point' was identified by Mr. Tim McNeill, consultant to the ACL, for the national learning collaborative as a whole—developing multi-agency networks that can contract as a single entity with a variety of buyer types including managed long term care plans (MLTC), insurers, and Accountable Care Organizations (ACO). To address this need, the ACL encouraged learning collaborative participants to explore *community-based integrated care networks*

(ICN). Similar to physicians' Independent Practice Associations (IPAs), participating organizations remain independent while the ICN serves as a contracting vehicle, allowing partners to expand their geographic reach as well as the types of services offered, and providing economies of scale when it comes to core business functions.

An Integrated Care Network for WNY?

With assistance from the Health Foundation for Western and Central New York, a three phase process was established to guide the work of Erie and Niagara counties as they explored integrated care network models and their potential to help community based organizations build the capacity they need to take advantage of emerging business opportunities. Phase 1, the planning phase, resulted in the formation of a Steering Committee and produced the groundwork for deep exploration of network models during Phase 2. Steps to be conducted during Phase 2 included analysis of the regulatory environment; review of existing network models; determining if there is a will in the provider community to develop an integrated care network in Western New York; and if such a will exists, identifying the type and scope (geographic, service offerings), of the network to be implemented during a potential Phase 3.

Table 1: Timeline—WNY Integrated Care Collaborative & the HFWCNY



Fact Finding: Opportunities and Constraints for Integrated Care Networks in New York

Phase 2 commenced in the summer of 2014, with a mission to address four key questions that emerged from participation in the national Business Acumen Learning collaborative:

1. What are the regulatory and payment-system demands that buyers must meet at the state and federal level?
2. What network structure can best meet those demands and the needs of buyers, service providers and consumers of health and long term supportive services (LTSS) in our region?
3. Is such a network feasible in our current healthcare and LTSS marketplace?
4. What additional resources, including new partners, will be required for implementation?

Regulatory and Payment-System Demands in New York State

The national dialogue around integrated care networks is grounded in the experiences of aging network providers from across the country. A handful of states have been particularly influential in shaping this dialogue, especially California, Massachusetts, Michigan and Ohio. Their experiences point to the desire on the part of insurers, managed long term care plans, and other types of buyers, to be able to contract with a single organization with significant geographic reach, that can provide access to a wide variety of services. Moreover, their experience suggests that buyers want to be able to partner with organizations that can take on the financial risk associated with value-based, rather than volume-based, payment models where pay is dependent upon patient outcomes.

A key question for the Steering Committee to address was whether the assertions of this national dialogue are consistent with reality in New York State. Did buyers in New York want the same things as their colleagues across the country? More importantly, are those things possible to have given the policy and regulatory constraints in the New York State health and long term care system? In order to answer these questions and gain a better understanding of the changing regulatory

and payment-systems in New York, the Steering Committee secured the services of Freed Maxick Healthcare. The work done by Freed Maxick along with our own understanding of the evolving healthcare system suggests that in many ways, buyers in New York State do want the same sorts of things as their colleagues across the country.

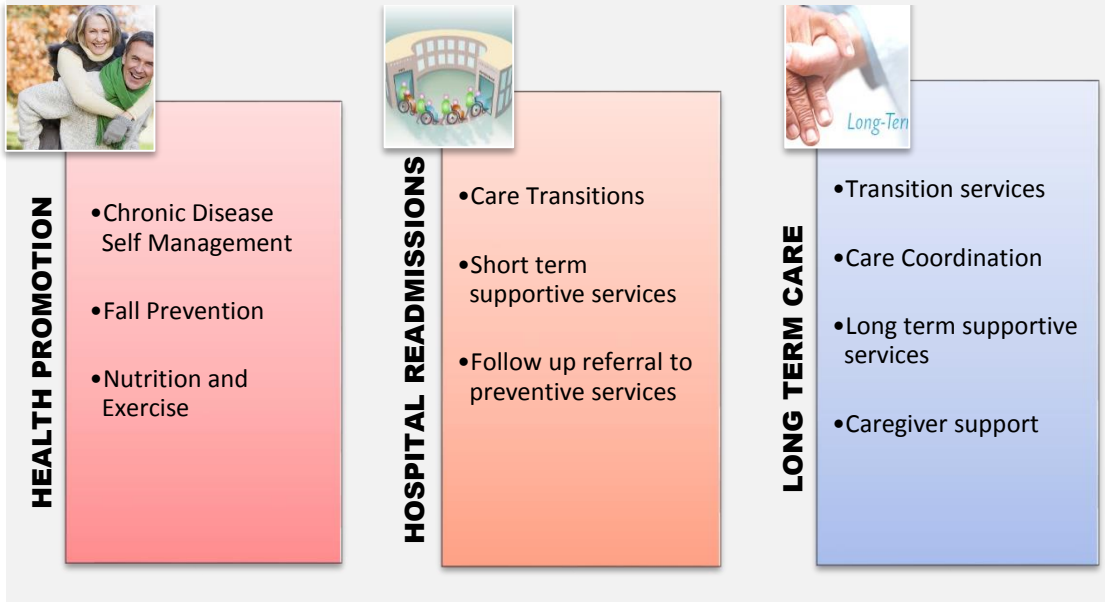
Geographic reach is increasingly relevant as emerging opportunities are more often regional in scope, rather than county or neighborhood-based. This applies to working with long-standing buyers, such as Medicare Advantage plans, which are organized regionally, and new buyers in New York, such as the Performing Provider Systems (PPS) created by New York's Delivery System Reform Incentive Payment (DSRIP) program. To appeal to these buyers, aging network providers must be able to offer programs and services that are available throughout their coverage area. **Regional reach is essential.**

However, in some policy areas buyers are still constrained by county-level regulatory requirements. The most important example of this pertains to mandatory managed long term care (MLTC) for individuals receiving Medicaid-funded long term services and supports. Here, MLTC plans must apply with the New York State Department of Health to serve individual counties within the state. To be successful, plans must demonstrate they have a sufficient provider network within the county of application to meet all the needs of future plan participants. The determination of adequate network capacity is predicated on the number of individual contracts the plan has with providers within the county of application. Other types of managed care entities face similar network adequacy standards. Given this, **managed care entities in New York State must be able to demonstrate that they have local capacity.**

In addition to issues related to geography, new regulatory and payment system demands are impacting the types of services managed care entities want to offer patients and members. For instance, DSRIP has focused attention on care transition programs and what they need to look like to minimize the likelihood of hospital readmissions. Similarly, the transition of nursing home populations to Medicaid managed care plans will incentivize paying for transition services for low acuity residents who can safely live in the community but need a range of services to support the return. The increased focus on population health under the Affordable Care Act also incentivizes health promotion programs and services including structured wellness programs and evidence-based interventions for disease

management and fall prevention. In short, **managed care entities need access to a wide range of new services.**

Table 2: Services Needed by Managed Care Entities



Those who want to deliver services for managed care entities must understand and be responsive to their financial constraints. Like others across the country, payment systems in New York State are changing as efforts to control rising health care costs continue. This is incentivizing cost containment and investment in relatively low-cost preventive services that can decrease utilization of high-cost acute and sub-acute care. Buyers receiving capitated, per member-per month, payments to provide comprehensive care to those members, must be mindful of how they invest care dollars. Similarly, those who deliver care, such as hospitals and safety net providers, are facing tremendous change in the way they will be paid, with significant emphasis being placed on providing higher margins to those producing client outcomes that ultimately reduce utilization.¹ Those who are receiving value-based payments as opposed to volume-based payments face substantial financial

¹ See “Value Based Payment Reform in New York State: A Proposal to align Medicare and NYS Medicaid Reforms”, draft published on 8/3/2015 Version 5.

risk. **They need partners that can deliver client outcomes and work within the constraints of new payment models.**

Finally, the Patient Protection and Affordable Care Act and resulting changes to CMS regulations, are encouraging managed care organizations to spend their money on those things that can improve population health and patient care. An important change made by the Affordable Care Act (ACA) was creating national limits on how much insurers and health plans can spend on administrative costs and profits, rather than clinical care and quality improvement efforts, as measured by their Medical Loss Ratio (MLR).² The ACA establishes standard MLR targets of 85% or higher for large group plans and Medicare Advantage plans, and 80% or higher for small group and individual medical care. Although many states, including New York, already imposed minimum MLR requirements on insurance companies, the national standard created considerable dialogue over what constituted “quality improvement activities,” and **incentivized investment in specific areas**, including:³

- Activities that **improve health outcomes** including case management, care coordination, and chronic disease management.
- Activities to **reduce hospital readmissions** including patient-centered education and counseling, comprehensive discharge planning and post discharge counseling.
- **Health promotion and wellness activities** including assessment, coaching, education and incentive programs.
- Efforts to enhance the use of **information technology for quality initiatives** that improve quality, transparency and outcomes.

Working with Carol Cassell from Freed Maxick, the Steering Committee also convened community stakeholders to glean insight into their perceptions of

² The percentage of total collected premiums spent on medical care, including quality improvement programs. [TOTAL HEALTH CARE CLAIMS AND QI COSTS/TOTAL PREMIUM INCOME]

³ See —“Developing an Integrated Care Network—Summary of Recommendations to Support Engagement of Community Stakeholders,” issued to the WNY Integrated Care Collaborative by Freed Maxick. A very good discussion can also be found in “Issue Brief: Minimum Medical Loss Ratio Requirements” published by the American Health Care Association, which can be found at http://www.ahcancal.org/advocacy/issue_briefs/Issue%20Briefs/MLR_IB_final.pdf

healthcare reform efforts in New York; learn how aging network providers feel they can contribute to the Triple Aim to achieve better health, better care, and lower costs; and to gather information to support recommendations regarding the benefit of ICNs based upon stakeholder input. The outcomes of this effort can be found in the full report provided by Freed Maxick—“Developing an Integrated Care Network—Summary of Recommendations to Support Engagement of Community Stakeholders,” which was submitted to the Steering Committee on January 28, 2015.⁴

A key finding of this cumulative work is that aging network providers believe they have a valuable role to play in turning the curve on healthcare and long term care spending, but face considerable obstacles to participating in the new marketplace. An ICN would be beneficial for overcoming a significant weakness of many community-based organizations and Area Agencies on Aging in New York State—limited geographic reach—which is increasingly becoming an elimination factor for those who wish to pursue new opportunities in the healthcare and LTSS marketplace.⁵ At the same time, an ICN would allow CBOs and AAAs to bring their traditional strength to that marketplace—local capacity to deliver services. A well-designed ICN can also help in several other areas that are increasingly important. Critical considerations for an emerging ICN include:

- 1) Capacity to work with value-based payments
- 2) Ability for common data collection and data sharing
- 3) Ability to demonstrate client impact
- 4) Contract negotiations and relationship management
- 5) Potential cost savings and efficiencies

Network Features to Meet Demands

A second question to be addressed by the Steering Committee was what form an ICN ought to take to best meet both marketplace demands and community readiness. Given the increased need for enhanced geographic reach, it is clear that a multi-county ICN would be beneficial to those that typically provide service in only

⁴ A copy of the report was submitted to the Health Foundation of Western and Central NY in February 2015.

⁵ Further details provided under the section on Strategic Benefits of ICNs.

one or two counties. What that network ought to look like is a more complex question. To address the changing health care environment, an ICN should be able to do several things:

- 1) Get partners to the table with potential buyers as quickly as possible.
- 2) Serve as a vehicle for collective action on a regional level, including pursuing accreditation for common programs and applying for grants as a single entity.
- 3) Help build and manage relationships with funders and buyers of services.
- 4) Facilitate needed business functions including common data collection, data-sharing, contract negotiation and payment, marketing, service monitoring, quality improvement and regulatory compliance.
- 5) Insulate the collaboration from political dynamics and over-reliance on personal relationships.

Network Models

Fortunately, many of the needed network features can be found in varying degrees under several different network arrangements, from relatively informal collaborations to independently incorporated service organizations working on behalf of members. When choosing an appropriate network structure therefore, several factors should be taken into consideration, including the desired level of organizational integration, especially around pricing and shared financial risk.

Table 3 presents a side by side comparison of five network models that can be used to define the scope of an ICN. These include coalitions or collaboratives that are formalized through Memorandum of Understandings with partner agencies; the “Super Messenger” model where a network administrator serves a limited role including convening and communicating to buyers on behalf of members; clinical and financial integration models, where a network administrator performs a variety of administrative functions on behalf of members in addition to convening and negotiating with buyers; and the “Primary Provider” model, with a lead agency sub-contracting to other providers in the community.

Of the models, the most limited is the MOU-based coalition or collaborative. It can be used as a vehicle for collective action and in the short term allows partners to act on opportunities they otherwise may be unable to pursue. It lacks a dedicated network administrator and coalition leadership tends to be less formal. Traditionally, such coalitions have proven useful for facilitating common work to raise awareness and improve quality of services, and to pursue grant opportunities.

In the long term however, an ICN will need a more formalized structure if partners want to collectively take advantage of new payment models, including bundled payments, capitated rates, and payments based on patient outcomes.

Table 3: Network Models—Functions and Availability

	← Less Integrated More Integrated →				
	MOU Based Coalition	Super Messenger Model	Clinical Integration Model	Financial Integration Model	Primary Provider Model
Get Partners to Table Quickly	X	x			X
Regional Reach	X	x	x	x	x
Relationship Management		x	x	x	x
IT Infrastructure			x	x	X
Quality Improvement	x	x	x	x	x
Marketing	x	x	x	x	x
Billing (Medicaid/Medicare)			x	x	x
Contract Negotiation		x	x	x	x
Contract Monitoring					X
Credentialing ⁶			x	x	X
Utilization Review			x	x	X
Shared Financial Risk				x	
Common Pricing				x	

X = Local examples currently performing function x = possible network model feature

A network of providers that want to negotiate contracts together must be careful to avoid violating anti-trust law. Each of the remaining network models has developed in response to this need, along with partner preferences on level of network integration.

The Super Messenger model emerged when it was determined that independent provider associations could not negotiate with buyers without leaving themselves vulnerable to allegations of price-fixing and other violations of anti-trust law. Under this model, the network acts solely as a “messenger” or communication agent, and performs certain functions to facilitate contracting with buyers. To make it more

⁶ Credentialing would include selective member recruitment under the clinical and financial integration models, and criteria-based contracting under the Primary Provider model.

than a mere “middle man,” the Super Messenger model also includes an ongoing role in quality improvement efforts, measuring return on investment, and articulating value on behalf of members. However, unlike more integrated models, the negotiation cannot extend to pricing or division of markets, and the provider network does not assume any shared financial risk. Under this decentralized model, it is also typical for buyers to pay providers directly.⁷ As with MOU-based coalitions, this network model can help overcome certain impediments to working with managed care entities, but will be limited in its ability to “sell” the network as a unitary community partner.

There are two alternative models available for networks that want to be able to collectively negotiate with buyers—the clinical integration model and the financial integration model. The clinical integration model emerged as an option for organizing a network for those who want to respond to the call for integrated healthcare, while foregoing shared financial risk. Without shared financial risk, networks must be able to demonstrate that individual organizations or practices are integrated in other meaningful ways including significant capital investments in shared information systems, an investment in quality assurance and utilization management, development and implementation of cost and quality benchmarks, member accountability for meeting benchmarks, and selectivity in network membership.⁸

The signature characteristic of the financial integration model, on the other hand, is shared financial risk. This includes sharing income and expenses,⁹ providing services at a capitated rate, or creating financial incentives for network members to achieve cost containment goals.¹⁰ Financially integrated ICNs are joint ventures that allow members more flexibility with common pricing, value-based compensation, and revenue sharing. Like the Super Messenger model, both of

⁷ See *The Messenger Model Handbook* published by the American Bar Association 2008

⁸ See Gary J. McRay (2008) “Clinical Integration as an Alternative to the Messenger Model,” in the *Foster Swift Health Care Law Report*. See specifically his review of Policy Statement 9 of the 1996 revision of the Statements of Antitrust Enforcement Policy in Health Care, issued by the Department of Justice and the Federal Trade Commission.

⁹ See “The Value of Provider Integration,” in *Trendwatch* (March 2014) published by American Hospital Association.

¹⁰ See Gary J. McRay, “Clinical Integration as an Alternative to the Messenger Model,” in the *Foster Swift Health Care Law Report* (June 2008).

these network types negotiate contracts on behalf of members, and organize quality improvement efforts. However, under integration models, the network also receives payment and compensates members. Each has significant legal issues that must be addressed in implementation to avoid legal concerns with pricing and competition.

The final model, the Primary Provider Model, is the most integrated of the examples with one lead agency that sub-contracts to other organizations in the community. It negotiates with potential buyers on behalf of itself, and then pushes work down to its network of contracted providers in the community. Under this model, the lead agency can take on substantial financial risk if it chooses to, but that risk is not shared directly with partners. The lead agency can then structure its sub-contracts to either pass risk on to willing partners or not. This model is closest to the traditional contract based networks that currently make up what is known today as “the aging network.” However, it is not a model for a multi-agency network with shared governance, and therefore not considered a true integrated care network model. Leadership is vertical with the lead agency as principal and sub-contractors as agents.¹¹

Consideration of network models should also include consideration of who would qualify as an appropriate network partner. ICNs can encourage both horizontal and vertical integration. Horizontal integration occurs when two or more like providers, such as two hospitals, join forces. Vertical integration, on the other hand, brings together providers at different points along the continuum of care, such as hospitals and physicians.

Assessment—Integrated Care Network Achievability

The Steering Committee used a two-prong test to determine if bringing aging network providers together to form an ICN is achievable in Western New York. First, an ICN would have to make sense given the incentives and constraints present in the New York State policy and regulatory system. Second, a network model that matches community need and readiness would need to be identified and relatively easy to establish.

¹¹ For more information on these network models, see Appendix A.

Policy Alignment: Counties continue to be a relevant geographic unit for service delivery-systems, especially in the LTSS marketplace. As previously indicated, MLTC plans must submit county-level plans demonstrating adequate network capacity in order to gain access to the LTSS marketplace. Additionally, county-level Community Alternative Systems Agencies (CASA) continue to play a role in assisting individuals with Medicaid-funded LTSS. Delivery systems for non-Medicaid funded LTSS available through the Expanded In-home Services for the Elderly Program (EISEP) also continue to be county-based, as are the Aging and Disability Resource Centers (ADRC) that are responsible for helping individuals navigate those systems. However, there has been a noticeable shift in New York State toward the use of regional service delivery systems.

Although county-level infrastructure continues to be essential to the delivery of LTSS, New York State has chosen to give several new initiatives a regional, if not state-wide, locus of organization. A notable example of this is the choice to have one state-wide entity responsible for the “conflict-free” assessment process for MLTC plan eligibility, rather than relying on traditional mechanisms available through local Departments of Social Services. Healthcare reforms are also resulting in significant new regional infrastructure. The most notable are Performing Provider Systems that are at the heart of the DSRIP Program.

Given the policy shift around organizational focus in New York State, the Steering Committee believes **a regional ICN is in alignment with the emerging policy preferences within New York State.**

Strategic Benefit: Organizations that lack regional reach are effectively barred from pursuing many of the new opportunities that are emerging in New York State. Again looking at the example of eligibility assessment for MLTC plan coverage, several government and non-profit agencies with long-standing involvement and experience doing eligibility assessment could not take advantage of their expertise, simply because the state-issued Request for Proposals (RFP) required the applying organization to have geographic reach beyond the county level. This has held true for other state-issued RFPs as well, which seek traditional services for new initiatives. Two prime examples are the “Consumer Assistance for the Aged, Blind, and Disabled” (2014) RFP to provide facilitated enrollment in government-sponsored health insurance programs, and the recent “Alzheimer’s Disease Caregiver Support Initiative” to provide a range of home and community based services similar to those traditionally provided by AAAs through the National Family Caregiver Support Program.

In addition to being barred from pursuing new opportunities, those without geographic reach beyond the county level are beginning to lose the ability to continue work they have traditionally done. Increasingly, New York State is opting to reorganize existing efforts, transitioning from traditional county-wide programs to ones with a regional administrator. For example, several organizations including AAAs and non-profit CBOS lost their ability to continue to provide long term care ombudsman services because they lacked the ability to deliver services to multiple contiguous counties. The Steering Committee believes a regional ICN can offer strategic benefits to AAAs and CBOs by providing **a vehicle to pursue opportunities that require a broader geographic reach** than they currently have.

Moreover, a regional ICN can provide an organizational framework for aging network providers to work together to develop and implement programs to meet new service needs, including health promotion, care transitions, and affordable long term services and supports. Individually, providers lack the capacity to scale up, and to deliver consistent programming throughout a multi-county region. They also lack the capacity to communicate collective impact around client outcomes, which is increasingly needed to get the attention of managed care entities that are facing capitated rates and value-based payments from their payors. **A regional ICN can help overcome organizational limitations that are hurting competitiveness of stand-alone organizations in the evolving healthcare and LTSS marketplace.**

Community Readiness: The degree of community readiness to form a regional ICN is less clear than the policy and strategic incentives to do so. On the one hand, the Steering Committee found a great deal of good will and enthusiasm among stakeholders for working together collaboratively. The Steering Committee hosted two well-attended community forums to look at the evolving healthcare and LTSS systems and reached out in other ways to gain insight into stakeholder opinions. There is near universal recognition that systems are changing and providers need to change along with them. This is undoubtedly due to several high profile efforts, most notably the NY State DSRIP initiative. There also seems to be a real enthusiasm in the community to work collaboratively to pursue new opportunities. A heartening example of this would be a regional coalition of AAAs and CBOs that

came together as the WNY Alzheimer’s Care Collaborative to respond to the RFA for the Alzheimer’s Disease Caregiver Support Initiative.¹²

At the same time however, there are factors that will impede the development of an ICN. Some are based in predictable organizational dynamics that result from a system where organizations are competitors for resources in addition to being collaborators toward community outcomes. It is natural to wonder and worry about how one’s organization will fare in the marketplace, and if it would be better to “go it alone.” Other obstacles are rooted in a lack of familiarity and understanding of the evolving healthcare and LTSS systems and how an ICN might help. The ICN concept is foreign to most. This makes it difficult for agency leadership to fully understand the potential benefit of an ICN, and difficult to communicate that to governance bodies that must support and authorize organizational decisions. Without this, efforts to form an ICN will inevitably be stalled.

The Steering Committee believes that the level of **community readiness is sufficient to move forward with a regional ICN**, but the scope and structure of the network may need to be limited in the beginning.

Options for Organization¹³: The benefits of an ICN can be realized with relatively modest organizational commitments. Indeed, the quick formation of the WNY Alzheimer’s Care Collaborative is evidence that, at minimum, providers would be able to produce an MOU-based ICN, which can be used as a vehicle for collective action. A similar network effort is already underway between Erie and Niagara counties to secure AADE¹⁴ accreditation for its diabetes education program. As indicated in Table 3, these coalitions are currently helping partners get to the table to address opportunity, and providing regional reach. However, these efforts tend to be ad hoc and can drain resources away from the day to day operations of the organizations involved.

¹² This coalition included Catholic Charities, serving as lead agency, the Alzheimer’s Association of Western New York, and the Area Agencies on Aging for all the counties in the designated Western region, including Erie, Niagara, Chautauqua, Cattaraugus, Allegany, Genesee, and Wyoming.

¹³ There are several options for organization of an integrated care network. Those presented are a small sample of those that would allow partners to get to the table quickly—it is not an exhausted list.

¹⁴ American Association of Diabetes Educators

Beyond MOU-based efforts, another available option is to leverage existing AAA networks, which are essentially county-level Primary Provider Model ICNs. AAAs already perform several key network functions for buyers and sub-contractors including the provision of IT infrastructure, credentialing, contracting and contract monitoring, and utilization review. The limitation, of course, is that the geographical reach of AAAs is limited to the county-level. To harness the full potential of an AAA-centered ICN, a legal structure allowing the AAAs across Western New York to contract as a single entity would need to be put in place.

A final option that can help partners get to the table quickly is working through a Super Messenger Model ICN. This model requires little organizational commitment beyond membership dues.¹⁵ WNY does not currently have an organization performing all the functions associated with this model, but there are several local examples of organizations that are currently playing a convening role. Two such examples would be Catholic Charities of Buffalo, which has been working with social adult day care providers to prepare and respond to new MLTC partners, and the P2 Collaborative of WNY which has served as a convener for several population health initiatives, including their current role as administrator for the New York State Population Health Improvement Plan (PHIP). Neither of these organizations plays a “messenger” role per se, and it may be beyond their organizational mission to do so. Still, the relative success of these organizations in bringing organizations together to think about collective service delivery suggests there may be a willingness in WNY to join a membership-based network, with an accompanying Shared Services Organization (SSO) that is compensated for providing services such as contract negotiation, quality improvement, and relationship management. The weakness of this model is the inability to contract on behalf of member organizations, which will limit the types of opportunities the ICN can pursue.

Given the options that are readily available, the Steering Committee believes that **a network development strategy can be found to match community readiness.** However, to take full advantage of the opportunities emerging under healthcare reform, **community readiness is going to have to deepen.**

¹⁵ Membership dues may be cost-prohibitive if there is not an adequate number of members.

Recommendation

Given the increased emphasis on regional service delivery systems, an ICN that brings agencies together from across Western New York absolutely makes sense and can yield several benefits to traditional county-based AAAs and CBOs. The ICN would need to be organized in a way that helps individual providers work more effectively within new regulatory and policy constraints in New York State, while providing a vehicle for pursuing new opportunities. The effort to organize an ICN would also need to take community readiness into account. The Steering Committee recommends a long term incremental strategy that creates a legal vehicle for the ICN, which will meet immediate needs and be able to evolve along with community readiness.

Regional and Low Cost: The most pressing need that an ICN can help meet is geographic reach. To be effective, an ICN will need the immediate ability to act as a legal entity that can enter into contracts on behalf of member organizations, while leveraging existing resources that reside in individual member organizations for many of the needed administrative functions. In the beginning it will be essential for the ICN to be a low cost endeavor, so that partners can realize true gains from participation. The ICN must help generate revenue, and cannot consume more resources than it helps to draw in. A bare-bones ICN must immediately provide a vehicle for applying for regional grants, seeking accreditation for programs, and joining Medicare Advantage plan provider networks. It needs to be able to receive payment from buyers and make payments to partners.

Able to Grow: Beyond grant opportunities and drawing down standard reimbursement for services, providers will need new ways of doing business to compete effectively in the evolving healthcare and LTSS marketplace. In the short term, an ICN should be able to offer a range of services to members that help demonstrate their value and give them an opportunity to do business with a range of new partners. This will require a Shared Services Organization that can negotiate contracts on behalf of members, manage relationships, and drive quality improvement efforts. In the long term, an ICN must make doing business with the aging network attractive to buyers working under value-based payment systems. Ultimately, a successful ICN should be able to take on the financial risk associated with performance-based contracts.

Table 4: Incremental Network Needs



A low-cost, quick set up solution that can grow with us. Successful efforts by others in the community, such as SNAPCAP,¹⁶ have employed an incremental strategy to network development. Over the course of several years, the nucleus of that group evolved from what organizers would describe as a “coffee club” to a Limited Liability Corporation (LLC), before finally going on to become a 501(c)(3) that is now a central part of the Millennium PPS. The question for the Steering Committee was how to go about doing that. Would we need to establish a new organization? If so, did it need to be a 501(c)(3) to reach our immediate goals, which would be a time consuming undertaking, or could we set up a LLC, which can be done in as little as a couple of weeks? What were the responsibilities, obligations, and potential obstacles? And how would a proposed venture be met by the governance bodies of potential partners? It was clear that we wanted something expedient, and needed something that was relatively easy to understand for both public sector principals, and non-profit Board members.

To address these questions and concerns, members of the Steering Committee met with Mr. Mike De Freitas, an attorney that has assisted several other local collaborations to form network organizations including Evergreen, SNAPCAP, WNY Public Health Alliance, BECOME, and the Southern Tier Health Care System. Mr. De Freitas presented a number of options along with their advantages and disadvantages, and there was one alternative that clearly met our needs—forming a taxable not-for-profit corporation.

A taxable not-for-profit has several advantages over alternative arrangements. First, it passes the speed test. Taxable not-for-profits can be established as quickly as an LLC, while providing many of the benefits of the 501(c)(3). Moreover, the statutory law concerning these legal structures is well-defined, and can be used in lieu of organizational by-laws. This would allow the structure to be operational

¹⁶ Safety Net Association of Primary Care Affiliated Providers of WNY

while by-laws are being created—a plus as the ICN works through the questions that will surface as it evolves from a loose coalition to one that is more fully integrated. Although taxable not-for-profits have tax obligations, those can be expected to be minimal as long as incoming revenue is used to compensate member agencies for services performed, and fund balances are kept at a near break-even point.

While all these features made the taxable not-for-profit attractive to the Steering Committee, the deciding factor was its ability to be converted into a 501(c)(3) at a later date when needed. This option provides a legal vehicle for implementing an ICN quickly, while giving us the ability to modify the structure as we grow.

Phase 3—Next Steps

Phase 2 has produced a clear recommendation from the Steering Committee. It includes a legal structure for an entity that can connect providers across multiple counties to give them regional reach, and a vehicle for collective action including seeking accreditation for services, joining provider networks, and pursuing regional grant opportunities. Still, it is a minimal recommendation and a great deal of work has yet to be done if an ICN is going to be a reality for WNY's aging services providers. There are several unanswered questions that need to be addressed regarding the ICN itself including:

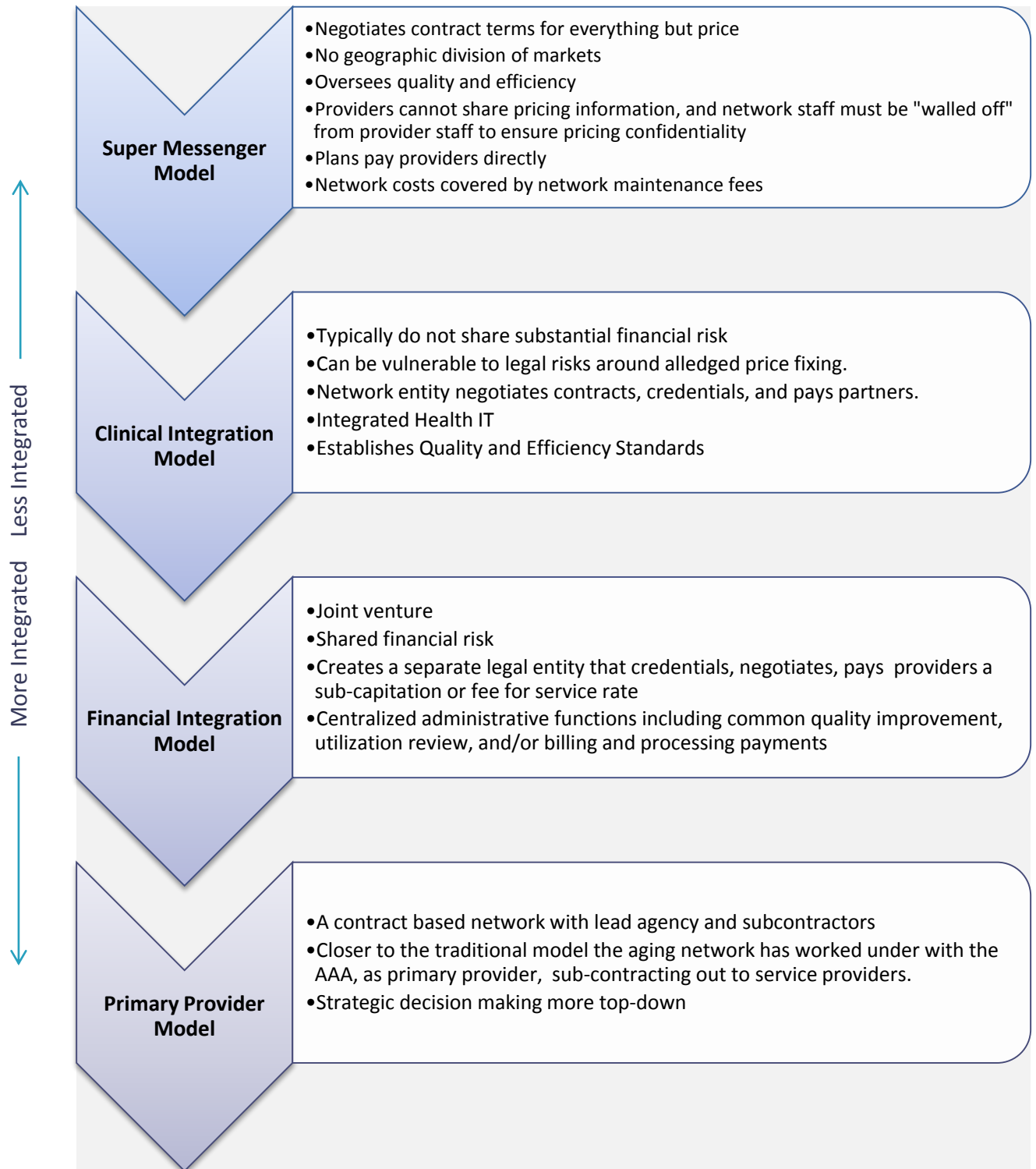
1. What is the ownership and governance structure?
2. How will the membership agreement be structured? How does an organization become a member? How and under what circumstances can a membership be revoked?
3. Will it be a horizontal network between like agencies, or a vertical network that brings together several provider types?
4. How will the ICN cover start-up and ongoing administrative costs?

These are some of the initial questions that need to be answered so that a proposal can be drafted for presentation to the governing bodies of potential partners. Given the lack of familiarity with the ICN concept, an education campaign will also need to be developed so that the benefits of the proposed ICN are clearly understood by those who will take up the question on membership.

Success in Phase 3 will require further legal assistance, and possibly the services of a neutral facilitator if agreement on key issues is not easily reached. However, we are at a point where the most essential resource will be assistance with articulating the idea of an ICN to a broader audience, and making the case for participation.

As a final measure, the Steering Committee compiled a list of strategies, goals, and objectives to guide the work of the WNY Integrated Care Network through the end of 2016. This is included in this report as Appendix C. The work outlined in that document is ambitious, and additional hands will be needed to see it through. The time is now to seek renewed commitment from current partners and recruit others who will be essential to our work moving forward.

Appendix A Network Model Options¹⁷



¹⁷ From "The Future Is Now—Preparing for the New World of Medicaid Managed Care, Contracting with Private Health Plans and Development of Community Care Networks" Center for Disability and Aging Policy Administration for Community Living Webinar Series. March 11, 2014.

Appendix B: Vision, Mission, Values

Western New York Integrated Care Network

Exceeding expectations. Improving health. Improving lives.

Vision

The recognized leader of a network of services that empower older adults to remain independent in their communities. We provide a range of best practice home and community based services offering choices to older adults and their caregivers that support a high quality of life and low cost to government and health plans.

Mission Statement

We produce better health outcomes by working together to provide comprehensive, cost-effective, integrated care that promotes high quality of life for those we serve.

Core Values and Beliefs

Working together to provide more complete and responsive care to older adults to enhance support for families and caregivers.

Helping community based organizations and the public sector to be more effective partners to health care providers and insurers.

Assisting health care providers and insurers better serve their clients and patients by easing access to service experts in the community.

Valuing the individual entities of each organization and belief that partners are engaged in the work and committed to shared goals.

Appendix C: Strategies, Goals, Objectives

Goal: Home and community-based services are delivered in a high quality, coordinated and self-sustaining service system to promote better health and better care.

Strategy 1: Increase the availability, accessibility, and use of integrated service packages delivered through a community-based integrated care network.

Objective 1.1: By March 2016, the WNYICN will have a regional network infrastructure in place to deliver integrated community-based service packages to older adults in Erie and Niagara counties.

- Consult legal professional on previous approaches taken by county governments and community-based organizations to organize networks.
- Draft a proposal on potential options for organizing network action.
- Develop a relationship-building strategy for engagement with local and state health care leaders.
- Develop a plan to educate the providers on the new model and implement education strategies across the professional field.

Objective 1.2: By December 2016, the WNYICN will have a comprehensive continual quality improvement infrastructure in place to support network activity.

- Develop consistent definitions of service quality and identify performance measures and indicators (using RBA and HEDIS measures).
- Develop a process for on-going evaluation of the service need beginning with the priority service lines.
- Evaluate the network's ability to deliver high quality, reliable service packages in sufficient quantities to meet the need of Erie and Niagara county residents.
- Explore national best practices for CQI structures.

Objective 1.3: By December 2016, improve regional capacity to collect and analyze performance data.

- Explore existing platforms for data-sharing between health and human service systems to enhance the WNY RHIO (such as connecting HEALTHeLINK and PeerPlace)

- Gain agreement on an IT solution that facilitates an integrated clinical and community population health model.
- Secure funding to implement IT solution.

Strategy 2: Establish a funding platform to sustain a Community-based Integrated Care Network.

Objective 2.1: By March 2016, secure short-term funding to support start-up of community-based integrated care network.

- Estimate start-up costs
- Explore funding collaborative opportunities

Objective 2.2: By December 2016, develop a long-term funding plan to sustain community-based integrated care network.

- Develop cost models for service priorities (evidence-based health promotion/care transitions)
- Engage state leaders in discussions regarding the project, priorities and their roles in facilitating success.
- Engage local health care leaders in discussions regarding the project, priorities and gain their input and buy-in as partners.

Strategy 3: Increase the availability and accessibility of reimbursable Chronic Disease Self Management and Diabetes Self Management programs in Erie and Niagara counties.

Objective 3.1: By December 2015, the Evidence based Leadership Council will establish a coordinated system for regional CDSMP/DSMP program delivery.

Objective 3.2: By March 2016, the WNY Integrated Care Network will have an accredited DSME program in place.

Objective 3.3: By end of 2015, the Evidence based Leadership Council will double program capacity over 2014 baseline level.

- Develop a marketing strategy that maximizes the engagement and retention of the consumer market.

Objective 3.4: By March 2016, the Evidence-based Leadership Council will have completed an evaluation of health promotion efforts in Erie County.

Strategy 4: Increase the availability, accessibility, and use of Care Transitions.

Objective 4.1: By December 2015, the WNY Integrated Care Network will establish the current state of Care Transitions work in the region and develop a strategy for offering care transition packages through the network.

- convene stakeholders
- identify an organizational project lead

Objective 4.2: By December 2015, engage DSRIP stakeholders to determine their Care Transition needs and identify ways we can work together.

Objective 4.3: By December 2016, have infrastructure in place to deliver reimbursable Care Transition programs in place.

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