Welcome to TIM Talks: Business Acumen

"Engaging Managed Care Organizations"

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Engaging Managed Care Organizations

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1. Understanding the MCO Landscape
2. Steps to Contracting with MCOs
3. Summary of the Process
4. Q & A

Managed Care and the Community Based Organization (CBO)

- Is it possible for CBOs to contract with Managed Care Organizations?
  - YES
- Can CBOs provide value to MCOs?
  - YES
- Have any CBOs been successful in contracting with MCOs
  - YES

What is an MCO?

- The acronym MCO stands for Managed Care Organization
- The term MCO is used collectively to describe a company that will implement a series of managed care techniques to provide cost containment and improved health outcomes for a designated population
- The MCO is paid on a per member per month (PMPM) basis
  - All of the healthcare expenses for the population have to be covered by the PMPM payments
  - Cannot deny services if deemed Medically Necessary
  - The MCO takes financial risk for the population

Types of MCOs

- Medicare Advantage Plans
- Medicare Special Needs Plans (SNPs)
  - D-SNP
  - C-SNP
  - I-SNP
- Duals Demonstration MCOs
- Medicaid Managed Care
- Managed Long-Term Services and Supports

Risks DRIVE the MCO

- It is CRITICAL that you determine the risks to the MCO
- Risks will drive the decision making for the MCO
  - What are their risks?
  - What population presents the most risk?
  - Their ability to manage these risks
  - Your access to the population that presents the most risk
  - Your ability to mitigate risks for the MCO

MCO Attempts to Shift Risks

- Value-Based Payment Models are designed to shift the risk to the provider
- When a provider shares in the risk, they are financially motivated to improve outcomes and reduce costs
- Many large Payers are embracing VBP contract models and there will be growth in this area
- Recent mandates from CMS require alignment of payment incentives between Medicare and Medicaid programs

Example of Understanding Risk

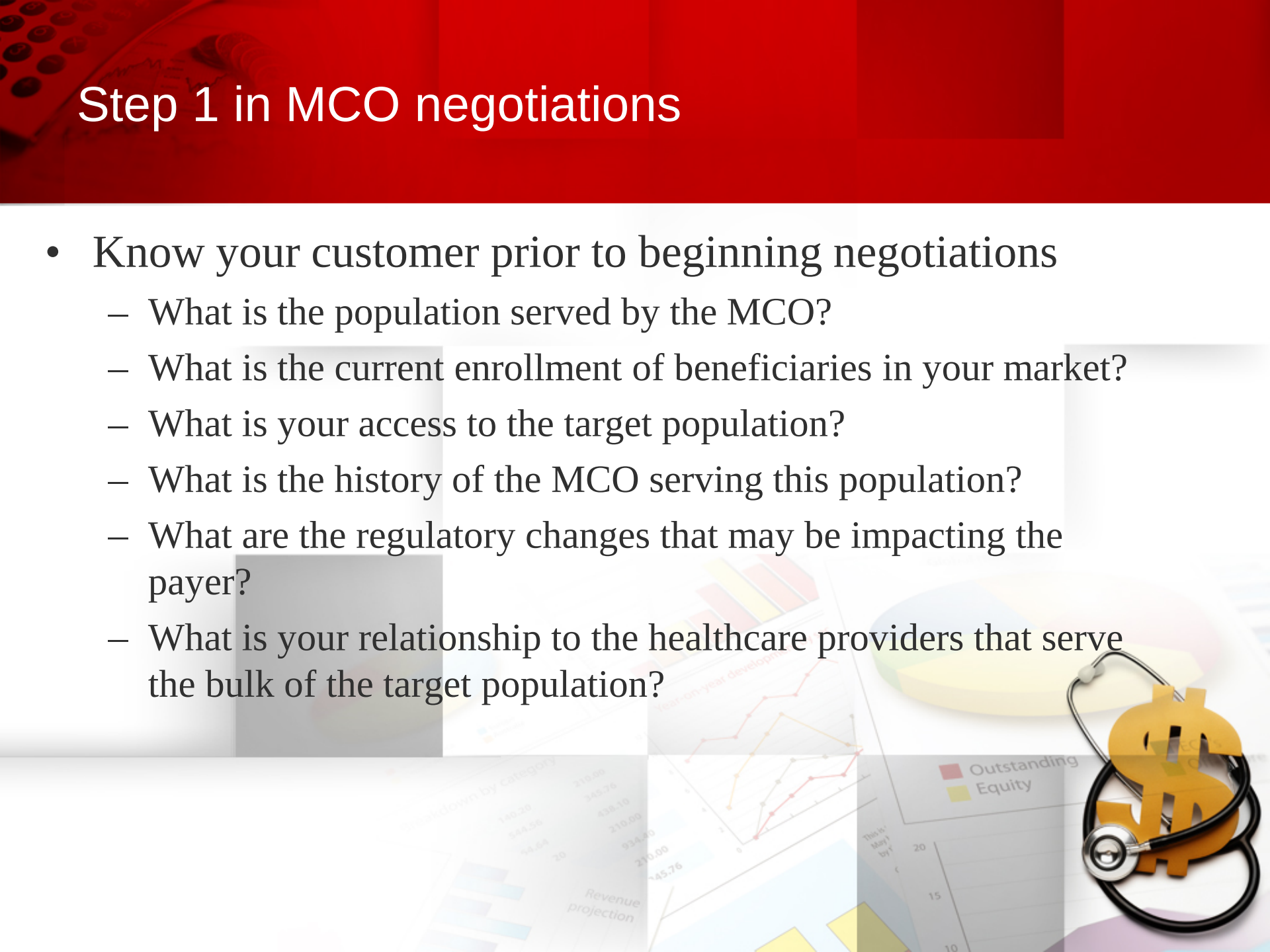
- Managed Long-Term Services and Support Plan serving a dual that still has their Medicare benefits in place
- Will a care transition intervention address the point of pain of the MLTSS MCO
  - Common Third Party (CTP) focused on reducing 30-day readmissions
  - CTP focused on limiting a Skilled Nursing Facility (SNF) placement and transitioning a beneficiary to the community as soon as possible (preferably before day 20)
    - Goal: Avoid or limit a Long Term Care (LTC) facility placement
    - Aligned with Medicare VBP incentives

Dual Demonstration risk

- A Dual that has opted into a Dual Demonstration now has their Medicare and Medicaid services managed by an MCO
- A Dual that has opted out of a Dual Demonstration maintains their Original Medicare benefits but likely still has their Medicaid benefits covered by a MCO

Step 1 in MCO negotiations

- Know your customer prior to beginning negotiations
  - What is the population served by the MCO?
  - What is the current enrollment of beneficiaries in your market?
  - What is your access to the target population?
  - What is the history of the MCO serving this population?
  - What are the regulatory changes that may be impacting the payer?
  - What is your relationship to the healthcare providers that serve the bulk of the target population?



Medicare Advantage Risks

- Medicare Advantage Plans must cover all Medicare Part A and Part B services
- All MA plans must meet the 85% MLR requirement
- All MA plans must maintain a Star rating of 2 or higher or risk having their contract terminated
  - Part B mandated services
    - Diabetes Self Management Training (DSMT)
    - Health Behavior Assessment Intervention (HBAI)
    - Transitional Care Management (TCM)
    - Chronic Care Management (CCM)

Where to Find Data on the MCO

- Publicly traded MCOs are required by the Securities and Exchange Commission (SEC) to provide an annual Prospectus
  - Provides plans for growth
  - Details target markets/populations and reports the MCO's strategy for growth
- CMS / State Division of Medicaid
  - Enrollment data
  - STAR Ratings
  - Medical Loss Ratio reports
  - Contracts
- NCQA
  - HEDIS Measures

Step 2: Understand MCO Quality Ratings

- MCOs must adhere to defined quality metrics.
- Research how the MCO fared in their performance on defined quality metrics.
- Review how the MCO fared on quality metrics as compared to their competitors in the market

Step 3: Define Potential Points of Pain for the MCO

- You must understand the issues that are negatively impacting the MCO
  - Research the required quality metrics
  - How did the MCO fare in the most recent reporting of quality metrics?
  - Is the MCO required to adhere to the Medical Loss Ratio requirements?

Step 4: Understand the Role of the Medical Loss Ratio

- The Affordable Care Act mandates that commercial and Medicare Advantage plans adhere to Medical Loss Ratio requirements
  - Determine how the MCO faired on meeting the MLR requirement
  - Review past spending patterns of the MCO
  - Review past MLR spending history for MCO competitors

Step 5: Establish Your Value Proposition

- Your research of the potential point of pain for the MCO should help define your value proposition
  - VP should define how your service will help the MCO address their Point of Pain.
  - VP should be something that you have strength and capacity to perform for the target population.
  - You should be prepared to express how you will capture and report data for the item that brings value.

Step 6: Establish a set of Data Points and a Quality Improvement Plan

- Managed Care is heavily data dependent.
- You must be prepared to capture and report clinical and non-clinical outcomes
- Data management and reporting helps to solidify the ROI for your services
- Data reporting should conform to the needs of the customer

Step 7: Define Your Return on Investment

- Define the Return on Investment (ROI) for your services
  - ROI must provide value that is greater than the cost of the service
  - ROI is not only measured in terms of cost savings
  - A service that improves quality and outcomes can provide a “Return” to the MCO, even if it does not provide immediate cost savings

Step 8: Develop your Customer Engagement Strategy

- Now that you have thoroughly researched your potential customer, you have to be prepared to engage the customer:
  - Develop a 2 minute ”Elevator Speech”
  - Develop a longer presentation and PowerPoint defining your organization and planned services
  - Determine if you have any contacts or direct relationships with key stakeholders at the MCO
  - Discuss your interest in contracting with key stakeholders prior to making your approach

Key Point: Know Your Market

- Medicare Population
- Those at-risk for Institutional Care
- Target services to those impacted by change
- Define how your services will lead to cost reduction and improved health outcomes
- Drive value and continually document the ROI that you provide

Summary of Additional Things to Consider

- Volume vs Quality
  - Can I serve the target population as a single organization or will I be stronger as a network of CBOs
  - If we are presenting a network, can we assure consistency of services across the target area
- Meaningful Use and Data Reporting
  - Do I have IT systems that can interface with MCOs and providers
- Clinical and Financial metrics
  - How will I measure success
  - Do I have both clinical and non-clinical success measures

Summary of Additional Things to Consider (Cont.)

- Alignment of MLTSS and Medicare VBP models
  - Some States are now requiring MCOs to establish Medicaid and MLTSS Value-Based Payment models that align with Medicare VBP
  - This will require greater adoption of the following contract types:
    - Bundled Payment
    - ACOs
    - The possibility exists for LTSS ACO Networks that align with Medicare ACOs and Bundled Payment Programs

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