MLTSS Opportunities – *Building New Service Lines*

When considering, building, and prioritizing new business lines, a number of issues and questions should impact what programs an agency ultimately decides to offer.

Each program should be marketable, metric and data driven, and capable of delivering health improvements or cost savings results for the payor and a ROI for your CBO.

The following questions are designed to help focus your CBO on important considerations necessary to successfully offer social services as business service offerings in the payor setting.

When considering whether to offer a new service line that your agency has historically offered in a social service setting, the following questions and considerations should be addressed.

- Do current service providers meet the thresholds established by MCOs, hospitals, and other payors?
- Does the CBO and its service providers carry adequate insurance coverage?
- Are employee staffing and training levels appropriate and verified?
- Do service providers have high quality, standardized training and retraining programs with documented processes and procedures?
- Do service provider's IT systems and documentation processes and protocols follow acceptable standards and provide for ease of integration with your agency and potential payor systems?
- Are service providers experienced and capable of meeting response time and customer service level expectations and are they willing to be held to performance standards?
- Do they have the capacity to deliver data, reports, and documentation in a manner and quality that will meet the needs of a payor?
- Are service providers able to accommodate a quicker response time in serving a new client or urgent need, including emergency calls?
- Do service providers have experience managing no-wait-list capacity requirements?
- Does your CBO have backup plans and alternate service providers as part of your sub-contractor network?
- Do you have the organizational expertise and capacity to staff and support these new programs without compromising or conflicting with your grant and government funding sources?
- What resources does your agency need to develop the new service line? (Human resources, capital, legal support, systems support, marketing, etc.)
- What specific payors are you targeting for the program and why?

- Determine data available related to the programs and services you wish to offer; do you have data or other tools to show results – health improvement, behavior change, and financial return.
- Who are your competitors? What are their (and your) strengths and vulnerabilities?
- Is your program or service unique, rather than something that is widely available?
- Does the program require capital to expand to a payor business line? If so, do you have existing capital (or capital source) to start the program?
- Can you articulate the cost effectiveness of a potential program?
- Has another AAA had success launching this or a similar program as a new line of business?
- Are you able to launch a pilot to test the new business line with a payor?
- What is the cost of the program? (hard costs, staff costs, overhead)
- What is your proposed profit margin? (What return do you need on the proposed program or service for this to be a positive venture for your agency?)
- What is the return on investment for the payor? (What is the basis for the ROI calculation?)
- What data or other evidence demonstrates health care cost savings?
- What is your current sub-contractor's capacity to serve large numbers of new clients? Have you confirmed this with them?
- Do your sub-contractor agreements allow you to bind them to service agreements with new payors?
- Have you identified back up providers to secure your ability to build and prove your network to a payor?
- Do you have systems in place that can ramp up quickly and accommodate a significant number of people in a short period of time?
- Does your CBO's IT systems have the capacity to manage and provide status updates on care plan activities to meet the payor's requirements?
- Can your systems manage and report data to support your billings?

If you are considering a new program or service, what do you know about the program?

- Identify value – why would a payor want the program or service?
- What specific payors are you targeting for the program or service, and why?
- Determine data available related to the program and outcomes.
- Identify health outcomes and other benefits of the program from the payor's perspective.
- Is this program or service something about which the agency has a unique ability, perspective, or a competitive advantage or is it widely available or easily replicated?
- Does the program require capital? If so, do you have the capital to start, the program?
- Is the potential program or service cost effectiveness for the payor and can you prove that?
- Has another AAA (or other CBO) had success with this or a similar program or service?
- Are you able to launch a pilot to test the program or service?
- What is the cost of the program? (hard costs, staff costs, overhead)
- What is your proposed profit margin? (What return do you need on the proposed program or service for this to be a positive venture for your agency?)
- What is the return on investment for the payor? (What is the basis for the ROI calculation?)
- What data or other evidence demonstrates health care cost savings?

For all programs in consideration:

- What are the payor's needs and does your program or service meet those needs?
- Can the program be priced to be viable for the agency while being competitive in the marketplace?

Please be mindful of Anti-trust rules! Do not engage in discussions about markets, actual costs of or price points of any services across competitors (and recognize that in some instances, you may compete with other CBOs).

Get Strategic with Your Service Offerings

Performance Measures: When preparing for discussions with potential contracting partners, it is important to show the potential partner that your offerings can help those organizations meet their federal, state, or employer-driven requirements. For example, MCOs increasingly face quality-based performance metrics. These metrics include measurements that CBOs can impact.

Hitting those goals is paramount for the MCO's success in maintaining their contract and receiving financial incentives under their MCO's Medicare or Medicaid contract. As a result, it is imperative that you understand the program's goals, incentives, and other contracting requirements in order to frame your proposal as solutions for the MCO.

Because every state and federal program carries different requirements, it is not possible to provide a comprehensive list. To find those specifics, consult the RFP, or ask your state, or your local MCOs, for information on the particular program you are considering. One of the most often used set of measures is the Healthcare Effectiveness Data and Information Set (HEDIS). According to NCQA, this tool is "used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 81 measures across 5 domains of care."[i]

So, how can you help local MCOs achieve success under HEDIS? Laser in on specific measures that align with your organization's strengths. For example, the Medicare portion of HEDIS includes a beneficiary survey component known as the Health Outcomes Survey (aka "HOS")[ii]. HOS contains questions about whether or not the beneficiaries has been asked about things like: physical activity, continence, and falls risk. Many CBOs have programs and services that address these areas, so that's a great place to start!

Pricing and Billing Codes: Aligning your services with CPT codes is essential in many instances. MCOs' systems are typically set up to manage billings based on this standard set of codes. Familiarize yourself with the CPT codes, how your products and services align with the codes, and develop your CBO's pricing to match. Examples include:

- Some state Medicaid waiver programs provide coverage for non-traditional HCBS services. Familiarize yourself with your state's structure and organize your product offerings to fit the state's Medicaid waiver fee schedule and aligned with these codes.
- For those CBOs with an assigned provider number, some medical services may also be billable. In other cases, your organization may be in a position to help the MCO identify and secure appointments for their members with specific health needs.
- Other services will fall into a more general, administrative support category. These will be harder to put into a code (EX: network development and enrollment assistance) and will rely on negotiation with the plan. For example, with network development – for a new plan coming into a market or bidding on a new MLTSS contract with a state – they will have to do significant network development. If a CBO can offer a service area or statewide network of service providers, many plans will value that type of service. Regarding service areas, remember that your traditional geographic area may not align perfectly with the MCO's need. For success, ensure that you can directly – or through contractual relationships – deliver a network that covers the entire area. That way, you become a one-stop-shop for the MCO and that is what they're looking for in most cases.

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[i] http://www.ncqa.org/HEDISQualityMeasurement.aspx
[ii] http://hosonline.org/surveys/hos/download/HOS_2014_Survey.pdf