Integrated Care Models: Landing the Contract and Beyond

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Wanting Something More

- Texas AAAs heavily dependent on Title III revenues
- Minimal state general revenue
- No history of involvement in Medicaid services
- Desire to reach broader population with proven programs

Starting the Journey

- Formed loose association of like-minded AAAs and Local Authorities, supported by SUA, for purpose of building capacity to contract
- Started out with dream, clunky name, and PowerPoint
- Got technical assistance from ACL/n4a/other AAAs that had blazed trails

Laying the Groundwork

- Researched Medicaid contracts to determine points of pain
- Met with state director of Medicaid managed care and asked for introduction to plans
- Met with Medicaid managed care organizations (MCOs) as group and individually to raise awareness of network services and determine plans' needs
- Developed proposals

Landing the First Contract

- Cigna HealthSpring for provision of Care Transitions/HomeMeds services to Medicaid only members

Looking Ahead to the Next Contracts

- Fall prevention
- Benefits retention (assistance with completing Medicaid applications)
- Case management
- Chronic disease self-management
- Caregiver support
- Nursing home relocation

Considering a Range of Payers

- Plans under contract for Medicaid waiver services
- Medicare Advantage Plans/plans under contract for Duals Demonstration
- Accountable Care Organizations
- Medicare: Diabetes Self-Management Education, Medical Nutrition Therapy, Diabetes Prevention Program

Creating Administrative Supports (1 of 2)

- Formed state association
  - Benefit AAAs by realizing economies of effort with marketing, developing proposals, and negotiating contracts
  - Benefit prospective payers by streamlining contracting process

Creating Administrative Supports (2 of 2)

- Secured Administrative Services Organization (ASO) to assist with:
  - Developing proposals
  - Obtaining Medicaid provider number
  - Building out network
  - Creating call center
  - Submitting claims
  - Receiving and distributing payments
  - Reporting and quality assurance

Lessons Learned: Pre-Contract (1 of 3)

- Ensure agency leaders on board
- Know prospective payers' needs, performance metrics, market share, quality history
- Be able to articulate value of services and demonstrate return on investment (RoI)
- Mitigate risk by focusing on existing, less expensive services

Lessons Learned: Pre-Contract (2 of 3)

- Focus on services that are broadly available
  - Survey members to determine service array/program reach/interest
  - Consider pilot if not available throughout entirety of plans' service areas
- Be ready to explain why plans should pay for "free" services
  - Serve members under age 60
  - Bypass screening criteria

Lessons Learned: Pre-Contract

- Plans like performance data that are specific to their members; consider amending intake to capture insurer

Lessons Learned: Post- Contract (1 of 2)

- Common challenges:
  - Managing volumes that are lower than anticipated
    - Cross-purpose staff
    - Don’t rely on plans alone to make referrals
    - Engage in conversations with plans about amending inclusionary/exclusionary criteria

Lessons Learned: Post Contract (2 of 2)

- Moving from cost reimbursement to capitation
  - Make sure you understand your true cost
  - Negotiate rates that are sufficient to cover costs
    - Title III can't be used to subsidize shortfalls with Medicare/Medicaid
  - Realize efficiencies where possible
- Responding timely to referrals
- Realizing it's okay to build the plane while you fly it

Questions?

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