Intersection of RW Services & ACA: Changes and Challenges

Kathye Gorosh, MBA

SVP Strategy & Business Development

AIDS Foundation of Chicago

Disclosures

Presenter, Kathye Gorosh, has no financial interest to disclose.

This continuing education activity is managed and accredited by Professional Education Services Group in cooperation with HSRA and LRG. PESG, HSRA, LRG and all accrediting organization do not support or endorse any product or service mentioned in this activity.

PESG, HRSA, and LRG staff has no financial interest to disclose.

Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Demonstrate the benefits and challenges to developing new models of HIV service delivery.
2. Describe lessons learned about CommunityLinks.
3. Identify concepts and action steps to inform organizations regarding service and financing transformation.

Obtaining CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

http://ryanwhite.cds.pesgce.com

IGNITE ACTION.

FUEL CHANGE.

No More “business as usual”

General Challenges: RW/ACA

1. RW Reauthorization and **Longevity** uncertain
2. **Proving** that coordinated CM works – what is our value-add?
3. **Model adaptability** to new health care landscape
4. How best to **measure** impact?
5. Addressing **payer of last resort**
6. Helping clients to **navigate** and improving health plan literacy

POLL #1: What types of Grantees are here today?

1. HIV Medical Clinic – Free standing
2. HIV Medical Clinic – Hospital-based
3. HIV Medical Clinic - FQHC
4. CBO – Non-clinical services
5. Health Department

POLL #2: For your clients with health insurance – what type?

1. Medicaid - FFS
2. Medicaid/Expansion State – Managed Care
3. Marketplace
4. No coverage
5. Medicare or Dual eligible

The Environment

AIDS FOUNDATION OF CHICAGO 30 YEARS OF ACTION

- Transformation
- Sea change
- Collaborative
- Sustainable

ACA
Managed Care

Sustainability/Growth & Innovation

I. Why did AFC respond/see this as a need?

II. How do we demonstrate “value-add”?

III. What was our approach?

IV. Where are we at today?

V. Action Steps

I. Why did AFC go this route?

1. Continuity: to serve some/many (?) of the clients we have been serving

2. Expand: To apply our experience and expertise to be able to serve thousands more

3. Diversify: funding sources

4. Adaptability & Sustainability

HIV is going from long history of Grants To FFS ➔➔ to ➔➔➔ Capitation

TODAY (YESTERDAY)	FUTURE (NOW)
1. Volume over Value	1. Value over Volume
2. Focus on Quality Can Hurt Bottom Line	2. Focus on Quality Rewarded
3. Payment & Accountability Fragmented	3. Payment & Accountability Aligned
4. Care Coordination often NOT reimbursed	4. Cost-effective Care Mgmt seen as an investment

FUNDAMENTAL FUNDING SHIFT: ENTIRE HEALTH/MEDICAL SYSTEM

TRANSFORMATION = Delivery & Payment Reform

Service Delivery - Integration, ACO, Care Coordination, Screening Tools

Finances - Health Insurance Marketplace/Exchange, Third Party Billing, Medicaid

Infrastructure - Workforce; Performance Outcomes; Business Capabilities; Data /IT

Rules/Regulations - HIT/EHR, Compliance, Contracts, MOUs/BAA, Confidentiality

AFC Service Model

Systems Integration

Link Health and Human Services Sectors
Training and continuing education
Contract and grants management

Partnerships

Convening diverse partners for collaborative efforts
Building multi-agency systems and partnerships

Quality and Data Management

Program evaluation
Training and certification
Data and performance management for funded services

AFC Care Coordination: Case Management

HIV/AIDS Case Management Network

Founded in 1988, AFC operates the nation's first and only coordinated case management system for people living with HIV/AIDS.

Braids public and private funds to create seamless case management system.

Trains all case managers to provide consistent, high quality services.

Adhere to quality standards and compliance with federal regulations.

Provides centralized data base to ensure conformity in care and achievement of standardized health outcomes.

Person-centered care -- evidence-based interventions

AFC's Coordination Role

- Contract Management
- Technical Assistance
- Data Collection
- Training
- Quality Improvement/Quality Management: Site Visits, monthly review of data, viral load
- Consumers'/Sub-contractors' Input: Client satisfaction survey, case management satisfaction survey
- Insurance Enrollment
- Process/Track Grievances

II. WHAT IS OUR VALUE ?

What does this mean to you?

What does Value Proposition really mean?

VALUE PROPOSITION

CHAT TIME

STRATEGY AND MARKETING:
WHAT IS OUR VALUE-PROPOSITION?

- Why a customer should buy a product or use a service from *YOU*. Specifically targeted towards potential customers such as third party payers.

- Designed to convince customers that one particular product/service will add more value or better solve a problem than others in its competitive set. Remedy an unmet need.
- Needs to be **clear, concise and compelling**.

- **Why should XXX (insert: MCO, other health plans) purchase services from AFC vs other agencies" – Or, what do we bring to the table that others do not?**

The Value Proposition

- A concise statement which articulates why the target beneficiary will “choose to buy” or “consume” your product/service offering over other alternatives in the market.

- The Value Proposition is the distilled essence of the organization’ mission/strategy

YOUR TURN

POP QUIZ

Examples of Value Propositions

Examples of value proposition

Company (Product)	Target Customers	Benefits	Price	Value Proposition
Perdue (chicken)	Quality conscious consumer of chicken	tenderness	10 percent premium	More tender, flavorful, golden chicken at a moderate price premium
Volvo (car)	Safety conscious "upscale" families	Durability and safety	20 percent premium	The safest, most durable wagon your family can ride in at a significant price premium
Domino's (pizza)	Convenience minded pizza lovers	Delivery speed and good quality	15 percent premium	A good pizza, delivered hot to your door within 30 minutes of ordering at a moderate price premium

Poll #4: The Triple Aim – What are the components ?

1. Having a three point agency plan
2. It's a tradeoff: you either work on quality or you work on cost reduction.
3. Assume quality costs more so it's not included
4. Improve population health; individual health; at the lowest cost

UNIQUE SELLING PROPOSITION

- Consequences of Non-adherence to ART
- Barriers to Adherence
- “The Cascade”
- Case Management impact on VL Suppression

Consequences Non-Adherence

- **Although adherence is important in all chronic-disease management, it is crucial in HIV treatment because:**
  - Non-adherent patients are more likely to experience virologic failure and resistance[1,2]
  - Failure and resistance are often associated with disease progression, complications, and the need for alternate therapies[3]
  - Adherence may result in decreased health care utilization and associated costs[2,4]

- **References: 1.** Gardner EM, et al. *AIDS*. 2008;22(1):75-82. **2.** Paterson DL, et al. *Ann Intern Med*. 2000;133(1):21-30. **3.** Panel on Antiretroviral Guidelines for Adults and Adolescents. *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*. U.S. Department of Health and Human Services; March 27, 2012:1-239. **4.** Gardner EM, et al. *Appl Health Econ Health Policy*. 2008;6(2-3):145-155.

Barriers to Adherence

- Concomitant substance use/abuse
- Low level of health literacy
- Age-related challenges (i.e, polypharmacy, vision loss)
- Psychosocial issues (i.e, depression, homelessness)
- Stigma
- Regimens too complicated
- Difficulty taking medication (i.e. trouble swallowing, scheduling issues)
- Cognitive issues
- Side effects
- Not keeping clinical appointments
- Cost and insurance issues
- Treatment fatigue

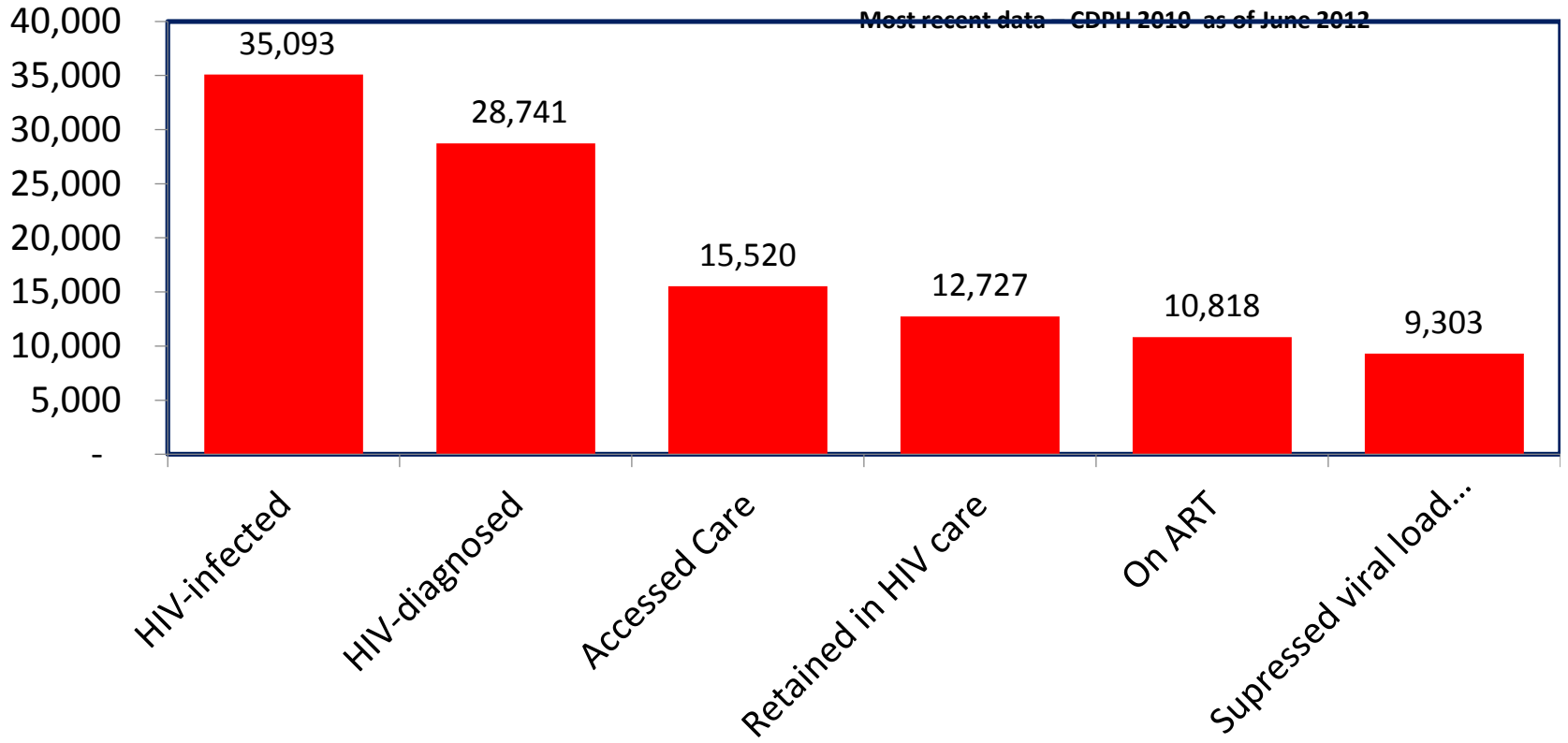
VL SUPPRESSION

AFC Case management viral load data

80% Ryan White Part B – Cook and Collar counties

74% Ryan White Part A – Cook and Collar counties

Current HIV Continuum of Care Chicago Metro Area



VERY FIRST STEP

MUST BUILD INTERNAL

CAPACITY

MUST BE READY !!

WHAT DOES THIS REALLY MEAN ?
HOW WILL WE/YOU BE IMPACTED ?

1. Staffing Capacity: Prevention, Care, Housing
2. Data: Collection, Analyze, Transmit
3. IT: hardware, software for data; fiscal; MCO reports
4. Finance/Billing/Contracts: Unit costs? How track? Who will do?
5. Evaluation: Outcomes; ROI
6. Communications: Website - different “visitors”
7. Funding: $ for Business Development; Legal
8. Operations
9. Policy

AIDS FOUNDATION OF CHICAGO

- **Link & Retain members in Care**
- **Systems Integration**
- **Engage the Hard to Reach & Complex to Manage**
- **Extensive Provider Network**

AIDS FOUNDATION OF CHICAGO

POLL # 5:

Working w/ Managed Care Health Plans: How's it going?

1. Haven't done too much
2. Thinking about what to do
3. Have met with a few health plans but nothing has happened
4. Actively meeting with health plans and negotiating contracts
5. I like things just as they are now - no changes needed

III. OUR APPROACH

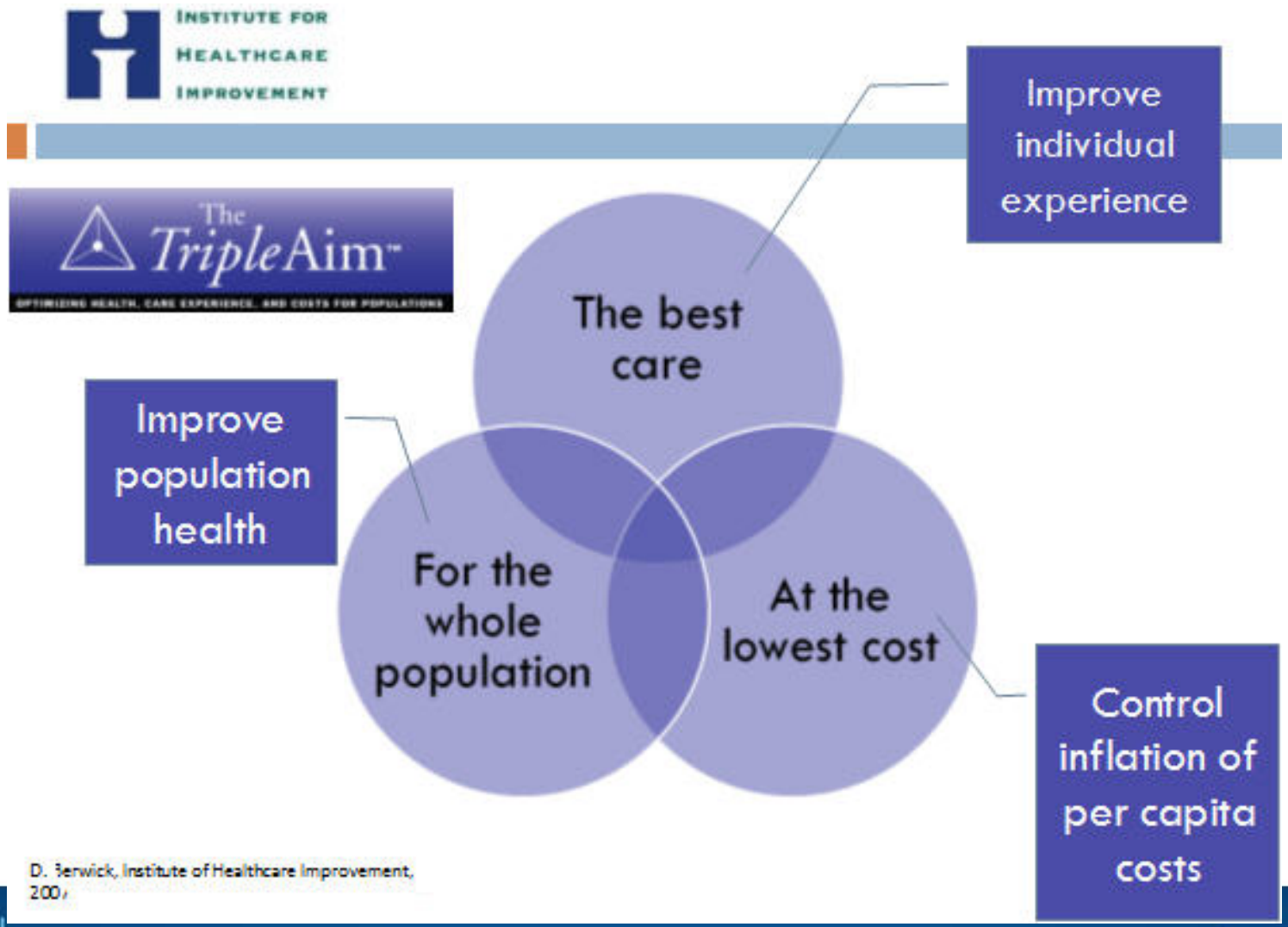
DOING BUSINESS WITH US

COMMUNITY LINKS
AIDS FOUNDATION OF CHICAGO

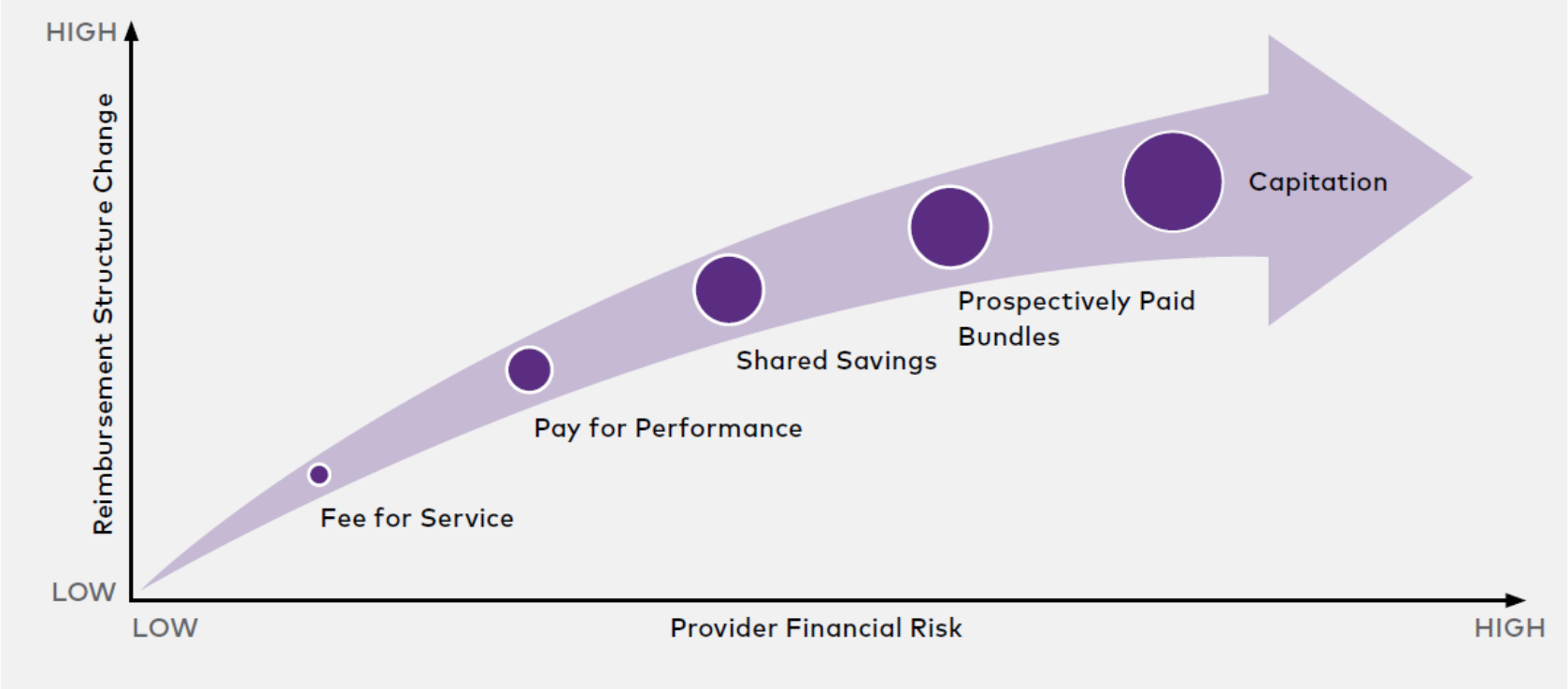
Lines of Business

CHAT TIME

THE TRIPLE AIM



Prepare for increased amounts of financial risk



STRATEGIC READINESS

Checklist for Managed Care/Health Plan Contracts

- Know your **costs**
- Know your **capacity**
- Define your **competitive advantages**
- Know your **market & define** for each MCE
- Understand the **requirements & standards** of each MCE

POLL #6: Have you calculated unit costs for each service you could potentially market to health plans?

1. No, don't see the need to do that
2. No, not sure where/how to start
3. Seeking technical/capacity-building assistance
4. Yes, working on it
5. Yes - DONE!

And…..STRATEGIC PROCESS

Prior to approaching Health Plans:

- Assessment of Managed Care landscape
- Reviewed IL HIV specific claims data
- Provided Series of workshops for network partners – Managing Change; SSP; Securing New Business
- Developed Lines of Business
- Prepared material for Managed Care proposals

Meetings w/ MCEs – Be Prepared

- Prepared a priority list
- Asked for meetings w/ Exec & Program staff to introduce ourselves
- Presented “Who We Are & What We Do”
- Made the “ask” (w/ HIV metrics)
- Identified next steps
- Follow up; Follow up; Follow up and MORE

CONTRACT REVIEW – Be Thorough!

- 3 basic steps – topline view:
  - Preparation process – do your homework
  - Contract analysis + what you want to add
  - Negotiation with MCO

- Domains: business, operational, clinical, and legal perspectives (risk; HIPAA, BAA,)

Contract Analysis & Service Delivery

- I. Contract
  - Scope of services
  - Covered services
  - Referrals/Prior Authorization
  - Payment Terms (invoice vs claims)

- II. Services
  - Transfer of member from MCO to you
  - Method of Information Exchange
  - Metrics/Data Analytics
  - Reporting

CHALLENGES:

- Different Language
- Need to meet MCOs where THEY are at
- Making “braided services” REALLY work (RW services; ADAP, Housing; Testing; L2C)
- Compatible database systems; exchange data
- Staffing Capacity
- Risk Management

HURRY UP and WAIT

- Many Health Plans new to IL and/or pop'n
- Revolving Door of Executive MCE staff
- Contracts with the "community" – new concept; round peg/square hole
- Contract/procurement staff not always aligned with their clinical/program staff
- Delegation vs "co-manage"
- Many Contract negotiation "hoops"

AND…..Our Partners?

Readiness is Challenging:

1. Secured Data Transfer
2. New Contracts/BAA
3. Payment structure: units of service vs grants
4. Staffing Capacity
5. Increased Accountability – documentation; reports; tracking
6. Willingness to join AFC on this journey??

IV. CommunityLinks Today?

- Renewed Contract for HIV-Connect w/ some initial "Locate/Reach" service: Year 2 - expansion
- Renewed Contract: Reach/HRQ/Testing and Linkage to Care; not HIV Specific; Year 2 - expansion
- 2 to 3 others "in the works"
- Forms, Flows, & Fields
- Sub-contracting partners: contracts; SOW; training; data

MILESTONE Summary
So Far….Work in progress

1. Developed our program model: lines of business/service lines
2. Developed pricing structures – based on unit costs of service; focused on encounters
3. Branded our model as CommunityLinks – logo; website; marketing materials
4. Held MANY meetings with the Managed Care Entities – MCEs, partners, SPC
5. Hired a Director for CommunityLinks

What's Next for AFC ?

- Continue to implement and expand CommunityLinks
- Overall data analysis – outcomes, ROI
- Address State Policy changes as needed

  (i.e. HFS/Medicaid; AIDS Waiver; Testing)
- Develop other markets

V. ACTION - What Can You Do NOW ??

1. Understand your State Medicaid plan – where/how does Managed Care fit?
2. Assess Needs, Identify appropriate partners
3. Educate/engage Medicaid leadership, MCOs, new partners
4. Determine level of risk you can take
5. Determine your level of readiness
   a) How do your services fill an unmet MCE need?
   b) Can Value-add be demonstrated?
   c) Infrastructure to support new service delivery & payment models?
6. Identify $ or personnel for TA/Coaching
7. Collaborative Options for “Network Formation”:
   a) Management Services Organization (MSO)/Provider Services Organization (PSO)
   b) Independent Practice Association (IPA)
   c) Mergers/Strategic Alliances
   d) Service Integration with other complementary providers
   e) Data Exchange Coordination

OPPORTUNITIES

- ➔ Population Management
- ➔ Disease Management
- ➔ Care Management
- ➔ Treating Multiple Chronic Conditions
- ➔ Treating other Chronic Conditions
- ➔ Bi-Directional Co-Located Services
- ➔ Tele-Medicine
- ➔ MAT
- ➔ Veterans

Promoting Networking, Coordination, Cooperative Agreements and Collaborative Arrangements Among Organizations

COMMUNITY TOOL BOX

ctb.ku.edu communityhealth.ku.edu

How to build organizational relationships

- Involve stakeholders.
- Establish one-to-one relationships and build trust.
- Clarify goals.
- Decide on a relationship that makes sense.
- Establish ground rules.
- Learn how to listen.
- Build on points of agreement.
- Learn about each other's cultural group.
- Don't require organizations to give up their identities.
- Expect problems and disagreements.
- Celebrate success.

RESOURCES

2 General Types

1. Reports

   a. Enhancing sustainability of RW-funded ASOs

   and CBO's – National Center for Innovation in HIV Care

   https://www.careacttarget.org/sites/default/files/file-upload/resources/NCIHC%20ASO%20Sustainability%20Brief.pdf

   b. Compilation:

   LINK TO COMPILATION

   c. Financing HIV Prevention: LINK TO FINANCING HIV PREVENTION

2. Tools:

   a. Organizational Self-Assessment Tool:

   LINK TO ORGANIZATIONAL SELF ASSESSMENT TOOL

   b. Collection of topics: LINK TO COLLECTION OF TOPICS

Shifting Gears

BE PART OF THE SOLUTION.

MAKE AN IMPACT.

SO….TOGETHER……

In the end….

It's about change and….

moving forward w/ a broad vision of "health”

Thank You!