How To Move From Idea To Action: A Guide To Building Successful Partnerships With Managed Care Organizations

The 2016 OPEN MINDS Strategy & Innovation Institute
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Agenda

I. Why Marketing To Managed Care Matters

II. Trends In Health Plan Contracting

III. Marketing To Medicaid & Commercial Health Plans

IV. The BioCare Recovery Case Study: Andrew F. Vitullo, Executive Director, BioCare Recovery

V. Questions & Discussion
Why Marketing To Managed Care Matters
Managed Care Is Expanding – More Enrollment & New Populations

Increasing use of managed care financing and service delivery models

- Commercial
- Medicaid
- Medicare
- Dual eligible

New populations

- Complex disabilities
- Long-term care
### More Managed Care For All Populations

<table>
<thead>
<tr>
<th>Insurance Category</th>
<th>Total Enrollment (Millions)¹</th>
<th>% Of Population</th>
<th>In Managed Care (Millions)¹</th>
<th>% Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>53.8</td>
<td>16.8%</td>
<td>15.6</td>
<td>29.0%</td>
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<tr>
<td>Medicaid*</td>
<td>54.0</td>
<td>16.9%</td>
<td>36.2</td>
<td>67.0%</td>
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<td>Commercial Insurance</td>
<td>165.2</td>
<td>51.6%</td>
<td>164.4</td>
<td>99.5%</td>
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<tr>
<td>Military Insurance</td>
<td>4.9</td>
<td>1.5%</td>
<td>4.9</td>
<td>100%</td>
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<tr>
<td>Uninsured</td>
<td>42.0</td>
<td>13.1%</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td><strong>Total U.S. Population²</strong>: 320,769,714</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹Medicaid enrollment is net of Medicare/Medicaid dual eligibles

²Total U.S. Population is based on 2013 estimates from the Census Bureau.
Health Plan Roles Are Shifting

- Population health management
- Medical necessity and clinical appropriateness criteria with preferred treatment protocols
- Decision on specific service provider and professionals in system
- Professional and provider organization performance standards
- Payment models and rates for services, drugs, and devices

- Shift from carve-out by specialty to carve-out by consumer type – the vertical HMO
- Moving care coordination and population management role to provider organizations – often with ‘gain sharing’ relationship that shifts many traditional system roles
- Acquiring care delivery capacity
Strategic Implications For Health Plans

- Margin squeeze due to medical loss ratio requirements
- Increased integration
- Repositioning as marketing, technology, and analytics organizations
- Search for value
- Shift from “providers as vendors” to “providers as partners”
  - The “narrow network” phenomenon
Provider Roles Are Shifting

- Assuming care coordination and population management role – often with ‘gain sharing’ relationship
- Addition of many population management functions traditionally provided by health plans
- Acquisition by health plans

Traditional System Roles

Delivery of consumer treatment

Expanding System Roles
Strategic Implications For Service Provider Organizations

- Preference for risk-based contracts with provider organizations creating ‘narrow networks’
- Technology requirements (of P4P, of compliance, of consumer preference) increases need for economies of scale for investment
- Role of marketing increasing
Key Concerns Of Provider Organization Executive Teams About Managed Care

- Rates
- Administrative requirements – authorization, documentation, billing
- Reporting requirements
- “Narrow” networks
- Gain sharing models
- Performance-based contracting
Payers Focused On “Superutilizer” Care Coordination For Individuals With Complex & Comorbid Conditions

- 5% of U.S. population account for half (49%) of health care spending
  - $43,212 average expenditure per person per year

- 50% of U.S. population account for only 3% of health care spending
  - $253 average expenditure per person per year

“Superutilizers”
Shorthand term for people with complex physical health, behavioral health, and social issues who have high rates of utilization of emergency room and hospital services

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1 Source: [1]
2 Source: [2]
The Effect Of Mental Illness On Health Care Spending¹

<table>
<thead>
<tr>
<th>Condition</th>
<th>No Behavioral Health Disorder</th>
<th>With Mental Illness</th>
<th>With Mental Illness &amp; Addiction</th>
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</thead>
<tbody>
<tr>
<td>Asthma/COPD</td>
<td>$8,000</td>
<td>$14,081</td>
<td>$24,598</td>
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<tr>
<td>Congestive Heart Failure</td>
<td>$9,488</td>
<td>$15,257</td>
<td>$24,927</td>
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<tr>
<td>Coronary Heart Disease</td>
<td>$8,788</td>
<td>$15,430</td>
<td>$24,443</td>
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<tr>
<td>Diabetes</td>
<td>$9,498</td>
<td>$16,267</td>
<td>$36,730</td>
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<tr>
<td>Hypertension</td>
<td>$15,691</td>
<td>$24,693</td>
<td>$35,840</td>
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</table>

For Consumers with Co-Occurring Mental Illness & Chronic Health Conditions, Annual Medicaid Costs Increase By 200%+

¹Source: [Open Minds](http://www.openminds.com)
Trends In Health Plan Contracting
Trend 1: More Transparency In Fees

- The internet has created more venues for fee transparency
- Health plans facilitating consumer choice – essential with higher consumer financial contributions
Members can compare clinicians by cost (actual out-of-pocket expenses) as well as clinical performance ratings on quality and efficiency.

Prefered clinicians “star-rated” for quality can earn a second star rating for meeting cost-efficiency standards.

“This looks a lot like picking a flight… it is already feeling familiar.”
“Ratings matter.”
— Consumer Testing Responses
Trend 2: More Transparency In Performance Measures

- Many initiatives to measure and report on “performance”
Trend 3: More Value-Based Purchasing

- Increased transparency of performance
  - Increase ‘pressure’ for improvement
  - Facilitate consumer-directed care
- Reimbursement linked to desired performance
  - Improved access to care
  - Increase care integration and coordination
  - Person-centered planning and recovery focus
- Focusing on controlling costs of care
  - Financial incentives to help consumers become and remain healthy for longer periods of time
  - Increase lower-cost interventions for ‘not yet seriously ill’ population
  - Reduce unnecessary use of high-cost services
All Payers For All Populations Moving Toward Pay-For-Value

Small % Of Financial Risk

- Fee-for-service
- Performance-based Contracting
- Bundled & Episodic Payments
- Shared Savings

No Financial Accountability
- Management Via 100% Case By Case External Review
- Passive Involvement

Moderate % Of Financial Risk

- Shared Risk

Moderate Financial Accountability
- Internal Ownership Of Performance Using Internal Data Management
- Provider Active In Management

Large % Of Financial Risk

- Capitation
- Capitation + Performance-based Contracting

Full Financial Accountability
- Provider Assumes Accountability
Marketing To Managed Care Plans
Building Successful Partnerships With Managed Care – Improving Your Positioning

- The fee-for-service payer network contract
- Being ‘preferred’ within a payer network
- Gaining ‘exclusivity’ within a payer system
The Fee-For-Service Payer Network Contract

Most fundamental of all business relationships for provider organizations in health and human services

Often need to begin with privileging professionals individually, rather than being privileged at the organization level

Difficult market position but often necessary

No assurance of volume and no likelihood of referrals

Often ‘commodity’ positioning
The Goal: Preferred & Exclusive

Being ‘Preferred’ Within A Payer Network

- Having preferential referrals due to some market differentiation
- Need a demonstrable value proposition – almost always involving P4P or value-based payment

Gaining ‘Exclusivity’ Within A Payer System

- Having a financial relationship (most often with significant financial risk) that gives you exclusivity by geography and/or consumer type
- Your organization is the ‘narrow network’
Steps To Building Successful Partnerships With Managed Care Organizations

1. Market mapping
2. Solution-focused sales and payer strategy development
3. Developing a service with the payer value proposition in mind
# 1. Payer Market Mapping – Payers, Consumers, Competitors

## XXXXXXXXXX Payer Market Map

### Payer Profiles

Last updated: April 1, 2013

<table>
<thead>
<tr>
<th>Government Insurers</th>
<th>Total Enrollment (CA)</th>
<th>Enrollment, San Diego</th>
<th>Enrollment, Imperial</th>
<th>Enrollment, Orange</th>
<th>Enrollment, San Bernardino</th>
<th>Enrollment, Riverside</th>
<th>Headquarters Street Address</th>
<th>City</th>
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</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>5,000,198</td>
<td>178,583</td>
<td>2,466</td>
<td>189,292</td>
<td>123,223</td>
<td>152,359</td>
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<tr>
<td>MediCal</td>
<td>7,339,884</td>
<td>453,494</td>
<td>55,519</td>
<td>469,970</td>
<td>484,988</td>
<td>410,932</td>
<td>1501 Capitol Ave., MS 4400</td>
<td>Sacramento</td>
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<tr>
<td>Tri-Care/Military</td>
<td>(UnitedHealthcare beginning April 1, 2013)</td>
<td>290,219</td>
<td>1,823</td>
<td>20,586</td>
<td>49,946</td>
<td>43,653 425 Market St., 27th Fl.</td>
<td>San Francisco</td>
<td></td>
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</tbody>
</table>

Blue Shading indicates plan with enrollment ≥ 1000 - threshold to complete demographic research for this plan.

Note: Medicare Advantage Enrollment data does not include numbers <10 in each county according to Health Plan.

Some Medicare Advantage plans are under same plan name/entity but have a different contract number with CMS, therefore under separate columns (Plan ID included in the last column).

## Sample Data

<table>
<thead>
<tr>
<th>Medicare Advantage</th>
<th>Total Enrollment (CA)</th>
<th>Enrollment, San Diego</th>
<th>Enrollment, Imperial</th>
<th>Enrollment, Orange</th>
<th>Enrollment, San Bernardino</th>
<th>Enrollment, Riverside</th>
<th>Headquarters Street Address</th>
<th>City</th>
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<td>Aetna Health Of California, Inc.</td>
<td>25,452</td>
<td>1,844</td>
<td>2,410</td>
<td>5,837</td>
<td>6,813 P.O. Box 10169</td>
<td>Van Nuys</td>
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<tr>
<td>Anthem Blue Cross Life And Health Ins Company</td>
<td>37,375</td>
<td>4,668</td>
<td>745</td>
<td>1,420</td>
<td>2,463 50 Beale Street</td>
<td>San Francisco</td>
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<tr>
<td>Blue Cross Of California</td>
<td>12,251</td>
<td>1,746</td>
<td>16</td>
<td>945</td>
<td>2,463 50 Beale Street</td>
<td>San Francisco</td>
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<tr>
<td>California Physicians’ Service</td>
<td>66,727</td>
<td>569</td>
<td>118</td>
<td>18,124</td>
<td>4,422</td>
<td>2,522 50 Beale Street</td>
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<td>Care360 Health Plan</td>
<td>30,369</td>
<td>7,288</td>
<td>1,075</td>
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<td>Caremore Health Plan</td>
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<td>Central Health Plan Of California, Inc.</td>
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<td>121</td>
<td>748</td>
<td>1,320</td>
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<td>Diamond Bar</td>
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<td>Citizens Choice Healthplan</td>
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<td>1,313</td>
<td>1,543</td>
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<td>3,220</td>
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<td>Community Health Group</td>
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<td>Easy Choice Health Pla Inc.</td>
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<td>Health Net Of California</td>
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<td>Humana Health Plan Of California, Inc.</td>
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<td>1,449</td>
<td>3,491 5421 Avienda Encinas, Suite N</td>
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<td>IEHP Health Access</td>
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<td>9,452</td>
<td>9,452</td>
<td>3,491 5421 Avienda Encinas, Suite N</td>
<td>Carlsbad</td>
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<tr>
<td>Inter Valley Health Plan, Inc.</td>
<td>20,101</td>
<td>102</td>
<td>17</td>
<td>6,859</td>
<td>8,230 100 South Park Avenue, Suite 300</td>
<td>Pomona</td>
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<tr>
<td>Kaiser Foundation HP, Inc.</td>
<td>881,902</td>
<td>70,539</td>
<td>102</td>
<td>47,975</td>
<td>47,975</td>
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<td>Molina Healthcare Of California</td>
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<td>1344</td>
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<td>1,357</td>
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<tr>
<td>Orange County Health Authority</td>
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<td>14,646</td>
<td>14,646</td>
<td>14,646</td>
<td>105 City Parkway West</td>
<td>Orange</td>
<td></td>
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</tr>
</tbody>
</table>
2. Solution-Focused Sales & Payer Strategy Development

- Solution-focused sales is focused on understanding the needs of the customer – and developing a solution (rather than ‘selling’ the services currently offered)
- Meeting with payers to identify problems and concerns
- Developing ‘services’ that address those payer problems
3. Developing A Service With The Payer Value Proposition In Mind

- Concept development
  - Service description
  - Cost/benefit or ROI analysis
- Proposal development
- Contracting
- Implementation
- Expansion

1. Concept
2. Build
3. Test
4. Feedback
5. Revisions

Concept Development Cycle
Partnering With MCOs: Get It Right

- Provider organizations must deliver:
  - Rapid Access
  - Demonstrate Outcomes
    - Clinical effectiveness
    - Process efficiency
    - Reduced inpatient utilization
    - HEDIS and other national measures
  - Follow through on contractual and clinical expectations
  - Demonstrate operational excellence via national accreditation, licensing and MCO site visits
Partnering With MCOs: Innovate

- Be creative - conduct pilots and share what you learn
- Integrate with medical and behavioral partners
- Evidence-based practices
- Peer and/or family support models
- Centers of excellence
- Telepsychiatry
- Web-based member engagement and social networking options
- EMR and data management
- Submit claims electronically and promptly
The Golden Rule Of Managed Care Contracting

Treat the MCO like a partner – not an adversary

- Communicate
- Develop relationships with clinical and network staff
- Participate in periodic meetings with MCO clinical staff
- Learn about their needs and plans, and how you can help them
- Keep them informed about you
- Track your outcomes, share your data, talk about your accomplishments
Use A Solution-Focused Payer Strategy

Focus on understanding the needs of the customer – and developing a solution (rather than ‘selling’ the services currently offered)

Meet with payers to identify problems and concerns

Develop ‘services’ that address those payer problems
Andrew F. Vitullo
Executive Director
BioCare Recovery
A Novel Approach To Treating Substance Use Disorders
Agenda

- Review of Traditional Treatment Models
- BioCare Recovery Treatment Model
- BioCare Recovery Contracting Model
- Aligning Goals, Outcomes and Compensation
- Lessons Learned
Traditional Treatment Model

- Inpatient/Residential
- “Florida Model”/Partial
- Outpatient
- Misaligned Incentives
- Communication Deficiencies
- Continuum of Care
Traditional Treatment Model

- Emergency Department: Highest Cost, May Bypass Local Tx Providers
- Inpatient Detoxification: High Cost, Lacks Tx Continuum, ‘Spin Cycle’
- Residential Rehabilitation: High Cost, High Recidivism
- Intensive Outpatient / PHP: High Cost, Short Term
- General Outpatient Services: Lacks MAT, Low Engagement
Heroin use/dependence has risen by 150% between 2007 and 2013 (CDC)

75% of new heroin users first became hooked on prescription opiates (CDC)

In 2014 more than 30,700 Americans died from alcohol-induced causes, including alcohol poisoning and cirrhosis (CDC)

Nearly one-third (32.3 percent) of all hospital inpatient costs are attributable to substance use and addiction (CASA Columbia)

Substance abuse costs our Nation over $600 billion annually and treatment can help reduce these costs (NIDA)
“Longer treatment retention is associated with a greater likelihood of abstinence” (Harvard Review of Psychiatry)

“Mortality rate of opioid addicts (overdose being the most common cause) is about 6 to 20 times greater than that of the general population; among those who remain alive, the prevalence of stable abstinence from opioid use is low (less than 30% after 10-30 years of observation)” (Harvard Review of Psychiatry)

“The research evidence clearly demonstrates that a one-size-fits-all approach to addiction treatment typically is a recipe for failure.” (CASA Columbia)

“In 2008, less than half (42.1 percent) of discharges from formal addiction treatment services were of admissions in which treatment was completed.” (CASA Columbia)

“Successful treatment for addiction typically requires continual evaluation and modification as appropriate, similar to the approach taken for other chronic diseases.” (NIDA)

“Research show that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful. Medication assisted treatment (MAT) is clinically driven with a focus on individualized patient care.” (SAMHSA)

“Within a nationally representative sample of 345 privately-funded addiction treatment centers, only 24% used pharmacotherapy for alcohol dependence and 34% reported use of pharmacotherapy for opioid dependence.” (Journal of Substance Abuse Treatment)
BioCare Recovery

- Individualized Sustainable Treatment Program
- Exclusive use of Evidence-Based Treatment Protocols
- Outpatient Orientation – Recovery Starts at Home
- Medication Assisted Treatment (MAT)
  - Outpatient Detox whenever indicated
  - Partial Agonist and Antagonist Medications
  - Freedom from Substances is the Goal
- Outcomes-focused Accountable Care
- Comprehensive Continuum of Care
BioCare Recovery Stats

- 100% Receive Psychosocial Counseling
- 100% Offered MAT (FDA Approved)/ 96% Utilized
- 90% Complete Medically Managed Outpatient Detoxification
- Average Length of Engagement 13 Months
- Patient Utilization Ranges 4 to 18 Interventions Per Month
Aligned Incentives

- Payer
- Provider

Patient

Treatment Contract
Aligned Incentives

Patient
- Access to Treatment
- Low Financial Burden
- Quality Evidence Based Care

Payer
- Evidence Based Practices
- Case Management
- Decrease Recidivism

Provider
- Treatment Flexibility
- Lessen Administrative Burden
- Motivation
BioCare Recovery

- Contracting Methodology
  - Case Rates
  - Prospective Payments
  - Shared Savings
  - Combination

- Tiered Treatment

- Minimum Scopes of Work

- Aligned Incentives

- Accountable Care Provider
Lessons Learned

- Top Down and Senior Leadership
- Contracting Options
- Offer a solution to a problem
- Transparent negotiated risk/terms
- Outcomes and Metrics Driven care
- Speak their language and White Papers
- Persistence and Patience
301 Oxford Valley Rd
Yardley, PA 19067
(267) 392–5200
www.BioCareRecovery.com
Questions & Discussion
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