Business Opportunity for Community-based Organizations:

MLTSS Care/Service Coordination

NASUAD
National Association of States United for Aging and Disabilities

Introduction

In a managed long-term services and supports delivery system, states have placed responsibility for care management and service coordination on the contracted managed care organizations (MCOs). However, MCOs face the decision on whether to 'buy' or 'build' the capacity to provide the type of intensive care management/coordination needed for individuals using long-term services and supports (LTSS). MCOs have acknowledged that traditional 'medical model' care management - which may be focused on specific diseases and is generally telephonic – is insufficient to meet the needs of individuals using LTSS. Further, since LTSS are almost exclusively public benefits, health plans do not have experience from their other lines of business to bring to this work.

The 'buy' or 'build' decision is keyed off many factors, unique to both the MCO and the state in which it is operating. There is great opportunity for community-based organizations (CBOs) to make their case to the MCO for a 'buy' decision for care management services in particular. Additionally, the other services that some CBOs – particularly Area Agencies on Aging (AAA) – have traditionally provided to LTSS consumers (transportation, nutrition, caregiver support and respite, and in- home chore services among others) may be equally valuable to an MCO which may have contractual imperatives from the state to meet.

State Case Studies

Below the experiences of CBOs in two states – Massachusetts and Ohio – are discussed. Each case study highlights the unique circumstances in each state which enhanced the CBOs' business opportunities, and offers lessons for CBOs across the country. It is important to note that in both states' financial alignment demonstration projects, a specific role for CBOs was mandated by the state.

Massachusetts

Elder Services of the Merrimack Valley (ESMV), a nonprofit, is one of the largest AAAs in Massachusetts, managing a network of 75 vendor contracts for over 120 different community-based services. With a staff of over 100 registered nurses and social work staff, ESMV also provides care management, care coordination, pre-

admission screening and level-of-care / functional assessments for HCBS and nursing facilities. [1]

The State of Massachusetts began implementing MLTSS, known as Senior Care Options, in 2004 and contracts between the MCOs and AAAs followed a couple years later. Between 2006 and 2013, ESMV saw its overall revenue double, and its income from grants and contracts increase nearly 600%.[2]

ESMV understood early on that the long-term care system had shifted irreversibly to a competitive, performance and outcome-based environment. The agency's long-term survival and growth would hinge on its ability to demonstrate that ESMV could add value to the work of hospitals, MCOs and Accountable Care Organizations (ACOs) to improve outcomes and hold down costs.

Achieving its objective of carving out a stable niche in the MLTSS marketplace, and establishing its credibility with payors, meant that ESMV's approach to care and service coordination would need to be evidence-based. The agency had to adopt an interdisciplinary perspective, blending clinical and social services skills, mirroring the MCOs' need to maximize both health care outcomes and quality-of-life outcomes for the MLTSS beneficiaries enrolled in their plans. The MCOs' responsibility for the health status of their enrollees dictated that their approach include a strong clinical focus. To be successful, ESMV had to do more than understand this clinical focus. Its products had to complement and support that aspect of the MCOs' work. Putting ESMV on a clinical footing also required that the agency invest in infrastructure to collect, analyze, and use data regarding the health care status of the consumers it served.[3]

ESMV's "adding value" strategy recognized that the agency would need to align its work with the priorities, and fiscal imperatives, of MCOs and the other players in the health care system with whom it wished to partner, such as hospitals and emerging ACOs. Understanding the fiscal incentives driving those organizations (capitation, pay-for-performance withholds, financial penalties for avoidable admissions) allowed ESMV to define its products and services to support the payors' needs. In general, these goals boiled down to

- Prevention and chronic disease management

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[1] http://nasuad.org/documentation/HCBS_2013/Presentations/MMLTSS%20Full.pdf, page 119.
[2] *Ibid*. at 120.
[3] *Ibid*. at 122, 126-8

- Patient activation and education
- Reduced unnecessary utilization of health care, including avoidable hospitalizations
- Improved access to care
- Improved overall patient experience and satisfaction[4]

With these work objectives in mind, ESMV began retooling its care management and service coordination so that the agency could measure and report the difference its efforts made in the health status of the consumers it managed. ESMV then focused on expressing this difference in terms of Return on Investment (ROI) based on the value they could add in a contract with one of the payors, and the resources ESMV expended to attain the desired health status and functional outcomes. [5]

ESMV concentrated on documenting the reduced incidence of avoidable events, utilization and reductions in chronic disease complications in the patients it managed, and quantifying the difference in dollars, making the case to payors that ESMV could reduce their costs well beyond the cost of the proposed care management contract.

However, the agency needed to reevaluate how it approached care management and coordination, and the labor and capital costs it incurred in managing a patient's care, in order to determine how to price its services and negotiate reimbursement rates. ESMV required an intimate understanding of the cost of a unit of service:

- How much staff time would a unit of care coordination entail?

- What were ESMV's true labor costs and how much would they increase over the life of the contract?

- How much should the agency allow for administrative overhead and infrastructure investment?

- And, significantly, how much should the agency build into its rate for "investment growth", i.e., revenue that ESMV could then reinvest in new staff and infrastructure to expand its capacity and capabilities? [6]

ESMV has aggressively sought to expand its business beyond the care management and service coordination contracts it has with the MCOs. As ACOs take root in

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[4] *Id*. at 124.
[5] *Id*. at 126, 128.
[6] *Id*. at 128-9, 131

Massachusetts, ESMV has set its sights on contracting with hospital and physician-based ACOs, signing a contract with a large physician-based ACO in its region. The agency secured contracts with six area hospitals to provide "Transitional Coaching" to over 12,000 patients discharging from hospitals in the first 14 months of the program. ESMV's care transitions program, utilizing both clinical oversight and community-based support services, is designed to stabilize recently discharged patients in their homes and assist the contracting hospitals in avoiding Medicare penalties. [7]

ESMV is expanding its market presence in other areas as well: adapting its Transitional Coaching program for MCOs and developing a hybrid product for an ACO that bridges care transitions and care management. The agency also has expanded its work to new populations, contracting with an MCO to provide care management and service coordination for younger physically disabled dual eligible enrollees. [8]

ESMV's transition from a traditional case management agency to a rapidly growing innovator holds one last lesson for CBOs adapting to MLTSS. Among its earliest efforts to leverage its strength and expand its business beyond Medicaid waiver funding, ESMV proposed a no-cost pilot program with a neighboring hospital to provide care transition and care management / service coordination services, as a prelude to a possible longer-term contract. The no-cost pilot was a "proof of concept" venture, designed to build credibility with the payor and demonstrate ESMV's ability to bring value to the relationship. At the same time, the pilot allowed ESMV to fine tune its processes, gauge the adequacy of its data systems, calibrate its costs and staffing outlay, and refine its understanding of the payor's business needs. By the time the pilot ended and ESMV began negotiating a contract to continue the work, the agency had a proven track record and deep understanding of how to price the product. [9]

Ohio

In 2006, Council on Aging of Southwestern Ohio (COA) began seeing signs that the agency's world was about to change. The designated Area Agency on Aging for

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[7] *Id.* at 120.
[8] *Id.*
[9] *Id.* at 132.

Cincinnati and the surrounding suburban counties, COA is one the largest nonprofits in the region, serving more than 20,000 in-home services clients annually but COA's visionary CEO could sense change. Suzanne Burke noted

> Some of our staff said, "We're a nonprofit – why should we be concerned about being 'competitive' and having a 'market share?'" Our response was, "Aging is a hot market, with high demand and low supply, which translates into the potential for profit. Others believe they can do our job better than us. They believe that they can do it at a lower cost and they believe they can make money at it."[10]

By 2011-12, pressure on the state budget was so intense that the State signaled to CMS that Ohio intended to move the state's HCBS waiver (known as PASSPORT) into managed care and implement an integrated care delivery system as part of an application to CMS' Medicare-Medicaid Coordination Office (MMCO) for a financial alignment duals demonstration. [11]

As it contemplated how to respond to the imminent implementation of MLTSS, the first obstacle that COA had to overcome was its own mindset and culture. "We had this history of being a 'monopoly' with state and local funding. We were reimbursed for our costs and we received our funding without having to compete for it. We realized that we were going to have to rid ourselves of the "entitlement" mindset," remembers Burke. "By 2011, our questions changed to: 'Can we compete for business with managed care companies? What are the right products? How should we be positioning our organization for future relevance?'" [12]

Moving from an entitlement, sole source reimbursement mindset to a competitive, performance and outcome-based environment is a major challenge. The leaders of COA quickly realized that they would need to reinvent the entire organization. They undertook a complete restructuring in 2009, consolidating functions, flattening the organization and removing an entire layer of front-line supervisors. With the savings realized from the restructuring, COA started investing in technology, data systems, staff retraining, and streamlining organizational operations.

One aspect of streamlining was shortening the decision chain. COA initiated self-directed teams and gave both individual staff and the teams expanded discretion to

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[10] *Id*. at 187, 190.
[11] *Id*. at 186.
[12] *Id*. at 187, 191.

make operational decisions. The agency also focused on reforming its interactions with vendors and providers who delivered services to consumers– meals, transportation, etc. – as part of COA's service coordination portfolio.

The reforms included evaluating COA's provider network to "right size" it based on capacity. This yielded a decision to reduce the size of the provider network to allow providers to achieve economies of scale, improve quality, and drive down costs. Throughout this process COA's goal was to achieve the highest quality products, at the lowest possible costs, to serve as many individuals as possible with the tax dollar. Providing client satisfaction and quality reports to its provider network is part of COA's focus on improving the quality of services delivered by a responsive and client-focused provider network.

A unique aspect of the COA reorganization was creation of a new division -- Business Results and Innovation, currently comprised of the Quality Team, Project Team and Manager of Strategic Analysis. This new division drove the investments in technology and software to support "business intelligence", i.e., data analytics, that allowed COA to benchmark nearly every aspect of the agency: measuring response times; calculating costs and ROI; measuring their performance against contract expectations; comparing their products and performance to COA's peers and competitors; and comparing staff performance within the various teams and divisions. The tools developed by the division also supported strong internal project management that could monitor the progress of new initiatives and product development, and enforce project milestones.

 Early on, COA grasped that it would need more sophisticated tools to support care coordination in a capitated, integrated care environment where MCOs require case managers to possess real-time information regarding the health status of plan beneficiaries. The 2009 reorganization freed up capital for software development that COA would require to become a credible player in MLTSS, selling care and service coordination and care transitions services to hospitals and health systems, ACOs and MCOs. The data analytics developed by the Business Results and Innovation team is also supported by a major investment in data infrastructure that includes SAS Enterprise Guide, SQL server dedicated to a data warehouse, and data visualization software. These tools greatly enhance the team's data capabilities and provide a portal through which all staff can view data necessary for managing daily operations.

Similar to ESMV in Massachusetts, COA realized that it would need an intimate understanding of its costs in order to price its products and services appropriately. One of the earliest tasks assigned to the Business Results and Innovations division involved development of sophisticated cost and pricing tools. The agency uses these tools to calculate appropriate profit margins when negotiating contracts with payors and model alternate product offerings.

Just as important to the agency's cultural transformation to a performance-based organization, COA relies on its cost and pricing tools to understand the cost of its operations and relate those costs to the services the agency sells. Nonprofit human services organizations – with a history of attracting leadership and staff trained in social work -- often struggle to adopt a business-oriented mindset, but COA wanted department managers and staff to understand how their positions were paid for and needed the finance and accounting teams to understand the business operations.

The leadership of COA enthusiastically embraces the concept of "social entrepreneurship". In a fiscal environment where traditional funding streams have contracted or stagnated, non-profit organizations, such as COA, struggle to maintain services in the face of escalating costs and growing demand. Putting COA on a competitive "for-profit" footing, striving to earn a margin on its products and services and expanding its market share, allows the organization to reinvest those profits in expanding and improving its service offerings to seniors in the Cincinnati metro area, fulfilling its social mission.

Acknowledgements

To request technical assistance or to learn more about our work in MLTSS, please contact Camille Dobson, Deputy Executive Director, at cdobson@nasuad.org.

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