

# MANAGING AND NEGOTIATING MCO CONTRACTS

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## INTRODUCTION

In recent years, Texas Community Centers have become key players in the managed care delivery system. As more and more populations and services move to managed care, Community Centers must be able to manage and negotiate contracts effectively.

The Managed Care Steering Committee (MCSC) developed this guide to help Community Centers operate in managed care environment. Because Centers already contract with managed care organizations (MCOs) for indigent care and other programs, the guide starts with tips for managing existing relationships. It also includes suggestions for preparing for and entering into negotiations with MCOs.

The MCSC encourages Centers to form their own managed care committees to review this guide. Include program leaders who are familiar with MCO contracting, credentialing, utilization management, and billing processes. Determine which sections are most important to your contracting strategy, and set goals for completing these sections. At the end of the process, the Committee should be able to provide Center leadership with recommendations for increasing revenues and developing stronger partnerships with MCOs.

## PART 1: MANAGING MCO CONTRACTS

Before changing or expanding your managed care contracts, it is helpful to review existing managed care practices. There may be ways to enhance MCO relationships and increase collections before you start negotiations.

### START WITH THE "BIG FISH"

Focus initial efforts on your top three MCO payors.

## REVENUE CYCLE MANAGEMENT

Before negotiating with an MCO, review your revenue cycle management processes to determine whether you are billing for and collecting on all available services.

### Recommendations:

- **Analyze your billed and collected charges.**
  - Start by focusing on your top services -- those that generate the most income and utilization. For example, you can start by reviewing services that account for 80% of your revenue in each managed care program.
- **Review your revenue cycle management processes.**
  - **Payor & Client Mix** -- how many clients are enrolled in each MCO? Within each MCO, how many clients are enrolled in each managed care program (STAR, STAR+PLUS, STAR Health, STAR Kids, CHIP, Duals Demonstration, Medicare Advantage, and commercial?)

- **Denial Rate** -- what are the most common reasons for claims rejections? Are rejections based on MCO or Center errors? Are you able to track denials by category? Are claims rejected for untimely billing? Clean claims generate faster payment, so ensure your billing staff is well trained and billing systems are programmed correctly.
  - **Collection Rate** – how much are you collecting from each MCO, and what is your collection rate after considering denials and adjustments? Have you explored ways to improve collection? For example, does your front-office staff always verify insurance coverage and collect co-payments when applicable?<sup>1</sup> Can you determine how many claims are written off or adjusted?
  - **Payment Disputes** -- Is the MCO meeting standards for timely claims processing and paying in accordance with your contract? Medicaid and CHIP MCOs must adjudicate most claims to paid or denied status within 30 days (18 days for pharmacy claims filed electronically, 21 days for paper pharmacy claims). You should have written policies for handling disputed denials, including deadlines for informal resolution and filing formal appeals.
  - **Attachment A** is an excellent guide to revenue cycle management. If your Center is not using this format or a similar format to track net revenues from MCOs on a routine basis (e.g., monthly or quarterly), consider making this your goal.
- **Are you maximizing revenues by contracting with all of the MCO's corporate "arms"?** If you are only contracted with an MCO's subcontracted BHO, you may be missing out on opportunities to bill the MCO for other Medicaid or CHIP covered services (e.g. primary/acute care).

## PART 2: PREPARING FOR NEGOTIATIONS

### UNDERSTANDING YOUR TRUE COST

Understanding the true costs of services will help inform decisions during rate negotiations, and will give you the flexibility to quickly establish a cost for new services that may be of interest to the MCO.

#### Recommendations:

- **Define true costs of services and required reserves.**
  - Consider the following "layers of cost" when determining your true costs: direct salary/benefits, non-direct program costs, administrative costs, non-billable service activities, productivity, and reserves.<sup>2</sup>
  - Remember that MCO rates are negotiable, so negotiations do not need to be tied to Medicaid rates.
- **Are there ways your Center could lower costs and gain efficiencies?**<sup>3</sup>
  - Are you using productivity standards to improve efficiency?

<sup>1</sup> See p. 35 of the *Community Center Readiness Guide (Readiness Guide)* for examples of good collection protocols.

<sup>2</sup> *Readiness Guide*, p. 32.

<sup>3</sup> *Readiness Guide*, pp. 27-30.

- Can you reduce client “no-show” rates through appointment reminder calls/texts, centralized scheduling, open access to walk-in appointments, backfilling, or other methods?
- Are you maximizing the use of technology to improve productivity (e.g., electronic health record (EHR) systems, telemedicine and telehealth)?
- Are you using mid-level practitioners to expand capacity?
- **Review and update your Charge Master.**
  - Does it include the full cost of providing services? This is especially important for physician, E&M, ECI and other services where negotiated rates may not cover your full costs.
  - The Charge Master should not be set at Medicaid FFS, Medicare FFS or contracted rates unless these rates cover the full costs of service.
- **Develop a payor profile.**
  - Create a spreadsheet with rates for all contracted MCOs. Include a side-by-side comparison of your contracted rates for Medicaid, CHIP, Medicare, and commercial payors.

## REVIEW THE MCO’S FINANCIAL PERFORMANCE

Understanding the MCO’s financial position and motivators will also help you prepare for negotiations. As described below, you can find valuable information about the MCO’s financial performance from readily available sources.

### Recommendations:

- **Review the MCO’s financial reports.**
  - Is the MCO reporting a profit (% of net income to revenues) in the programs and service area(s) where you operate?
  - Is the MCO reporting an overall profit for all Medicaid/CHIP programs and service areas?
    - Copies of Medicaid and CHIP MCO financial reports are available on HHSC’s website at: <https://hhs.texas.gov/services/health/medicaid-chip/provider-information/medicaid-chip-financial-statistical-reports>
- **Review HHSC’s rate setting documents.** These documents provide information on factors the HHSC rate setters considered when setting the MCO capitation rates (e.g. cost trends, service utilization, program growth, etc.). Copies are available on HHSC’s website at: <https://rad.hhs.texas.gov/managed-care-services>. Click on the program links on the left side of the page (e.g. “STAR+PLUS Managed Care.”)
- **Review TDI filings.** You can request copies of MCO financial filings by submitting an open records request to the Texas Department of Insurance.
- **Consider the MCO’s past performance.**
  - Did the MCO generally meet its payment obligations on time?
  - Scrutinize denials. Was the number of denied claims excessive? Are there patterns that need to be addressed?
  - Survey operational staff. They should be able to tell you whether the MCO representatives are knowledgeable and responsive when problems arise. Can most issues be resolved without a formal appeal or HHSC intervention?

## ANTICIPATED UTILIZATION

If you are already contracted with the MCO, consider your current net revenues and how often the MCO's members are accessing your services. If you are not contracted with the MCO, try to determine whether becoming a network provider will positively impact your business.

### Recommendations:

- If you are contracted with the MCO, are there ways that you can increase net revenues through new contract terms? For example, you may be able to increase referrals to your Center if you have "gold" or preferred provider status.
- If you are not contracted with the MCO, are you tracking how often clients or potential clients are enrolled in the MCO?
- You can ask MCOs for enrollment information, or you can submit an open records request to HHSC or the Texas Department of Insurance (TDI) for enrollment information by MCO service area.
- The Kaiser Family Foundation also publishes information on Medicaid MCO enrollment at: <http://kff.org/data-collection/medicaid-managed-care-market-tracker/>

## ACCESS STANDARDS

State and federal programs require MCOs to comply with network adequacy standards. For the Medicaid and CHIP programs, these standards have historically been based on TDI travel distances and wait time standards; however, in March 2017 HHSC revised the access standards for the Medicaid and CHIP programs to align more closely with CMS standards for Medicare plans. HHSC added new standards measuring travel time in minutes, and in many cases shortened the travel distance standards.

Knowing the TDI, HHSC and Medicare access standards will help you understand your position in the MCO network.

### 1. MILEAGE AND NETWORK UTILIZATION STANDARDS

**Standards:** Commercial insurers must comply with TDI standards by providing access to PCPs and general hospitals within 30 miles, and specialists and specialty hospitals within 75 miles.<sup>4</sup>

Access standards for Medicare plans vary by region and provider type, and are available on the CMS website.<sup>5</sup>

<sup>4</sup> See Texas Insurance Code §843.082 and 28 T.A.C. §11.1607.

<sup>5</sup> Information on the 2018 access standards for Medicare Advantage plans is found at the following links: <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html>; [https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/HSD\\_Reference\\_File\\_01-10-2017.zip](https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/HSD_Reference_File_01-10-2017.zip)

Medicaid and CHIP MCOs must comply with the following access standards:

Medicaid and CHIP Provider Type	HHSC Standard as of March 2017					
	Distance in Miles <sup>6</sup>			Distance in Minutes		
	Metro	Micro	Rural	Metro	Micro	Rural
Acute Care Hospital	30	30	30	45	45	45
Psychiatric Hospital	75	75	75	NA	NA	NA
Mental Health Rehabilitation (Medicaid)	75	75	75	NA	NA	NA
Outpatient BH Provider	30	30	75	45	45	90
Outpatient PT, OT, SLT	30	60	60	45	80	75
PCP	10	20	30	15	30	40
Pediatrician	20	35	60	30	50	75
Psychiatrist	30	45	60	45	60	75
Rehabilitative Day Treatment (CHIP)	75	75	75	NA	NA	NA
Most Physician Specialties	30	60	75	45	80	90

Adults and children must be able to access at least two PCPs within the mileage and minute requirements. For all other provider types, access to one provider within each standard is sufficient.

Additionally, at least 80% of all Medicaid and CHIP outpatient services must be provided by network providers. MCOs may be penalized for exceeding this out-of-network threshold.

#### Recommendations:

- **Do a market analysis.**
  - How many providers do you bring to the MCO's network?
  - Are there other providers in the area that do the same work? Are there workforce shortages in your area (e.g. psychiatrists)? The fewer area providers, the greater your negotiating position.
  - Is it likely that the MCO will exceed the 20% out-of-network threshold if your Center is not part of the network?
- **Check the MCO Provider Directory.**
  - Is the closest provider farther away than the HHSC distance standards (e.g., an outpatient BH provider who is more than 30/75 miles away)?
  - Consider conducting "secret shopper" calls to see if the providers are still enrolled in the network and accepting new patients.
- **Check the HHSC website.** Has the MCO recently been cited for network deficiencies? See: <https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-organization-sanctions>
- **Ask HHSC for copies of the MCO's network adequacy reports.** If the MCO is not meeting access standards, has HHSC granted any special exceptions?

<sup>6</sup> HHSC defines the terms "metro," "micro" and "rural" based on both total population and population density per mile. See Attachment B-5 of the HHSC Uniform Managed Care Contract for county designations.

- **Think about what’s motivating the MCO.**
  - Is the MCO entering a new market? Facing critical deadlines to enter a marketplace?  
Are there other external factors influencing the MCO?
- **Are there ways you can work with the MCO to build capacity?** If you cannot meet the access standards, consider options you can present to the MCO for building capacity. For example, would increasing the rate for certain provider types help ensure availability?

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## 2. WAIT TIME STANDARDS

**Standards:** Medicaid and CHIP MCOs must demonstrate their networks comply with the following wait time standards:

- Emergency services – provided upon presentation
- Urgent care – provided within 24 hours
- Initial outpatient behavioral health – within 14 days
- Outpatient behavioral health follow-up after psychiatric admission – 7 days after discharge

**Recommendations:**

- **Compile data.**
  - Do you have data showing that you consistently meet the wait time standards?
  - Do you have member satisfaction surveys showing that clients received needed care on time?
- **Can you demonstrate better access?**
  - Do you offer walk-in appointments?
  - Can you provide designated slots to the MCO’s members, or other assurances that members will receive timely/priority access to care?
  - Can you show how higher payment rates help improve MCO member wait times?
- **Make sure your staff is trained on wait time standards.** Staff should be familiar with these standards and prepared to correctly respond to “mystery callers” or “secret shoppers” from HHSC and MCOs.

## QUALITY MEASURES

State and federal programs generally monitor MCO compliance with quality measures and outcomes. Like access measures, knowing quality metrics will help you understand what is important to the MCO.

The following section will help you communicate how your Center can help the MCO meet or exceed performance expectations. Although the measures are specific to the Texas Medicaid and CHIP programs, they are also helpful in demonstrating value to Medicare and commercial plans.

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### 1. QUALITY METRICS

**Standards:** Medicaid and CHIP MCOs must participate in several quality improvement strategies. See the [Medicaid and CHIP Quality and Efficiency Improvement page](#) of the HHSC website for additional information about quality improvement programs, including:

**Pay-for Quality (P4Q)** – the P4Q program places 4% of the MCO’s payment at risk for meeting quality outcome measures. For 2018, the measures focus on:

- Hospital Potentially Preventable ER Visits (PPVs) – STAR, STAR+PLUS, CHIP
- Diabetes HbA1c Control <8 – STAR+PLUS
- High Blood Pressure Controlled (CBP) – STAR+PLUS
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotics (SSD) – STAR+PLUS

**Performance Improvement Projects (PIPs)** – MCO must develop two PIPs per program. These projects last for two years, and must be designed to achieve improvements in clinical and non-clinical care through ongoing measurements and interventions. Examples of 2017 PIP topics:

- Diabetes control
- Behavioral health
- Behavioral health/family support services to caregivers
- Asthma
- Access and continuity of care for MDCP members
- Increase utilization of ECI for members younger than 3 years old with developmental concerns

See HHSC’s website for the complete list of PIP topics: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement>

**Performance Dashboard** – HHSC’s external quality review organization (EQRO) also monitors a number of key performance metrics. The 2017 behavioral health metrics are:

- 7 and 30 day Follow-up after Hospitalization for Mental Health (must be performed by a licensed provider to meet HEDIS requirements. Keep in mind this metric is not limited to patients released from State Hospitals) (FUH)
- Antidepressant Medication Management (AMM) (Acute and Continuation Phases)
- Follow-up Care for Children Prescribed ADHD Medication (ADD) (Initiation and Maintenance)
- Initiation of Alcohol and Other Drug Dependence Treatment (IET)
- Engagement of Alcohol and Other Drug Dependence Treatment (IET)

See [UMCM Chapter 10.1](#) for more information on Performance Dashboard metrics. In addition, the Texas Healthcare Learning Collaborative website includes a portal where the public can access performance data by Program (STAR, STAR+PLUS, CHIP, FFS, etc.), MCO, and service area. See: <https://thlcportal.com/home>

**Super-utilizer Program** – MCOs must establish programs to address the needs of “super-utilizers,” or members with excessive utilization patterns for whom typical disease management approaches are not effective. The programs must include specialized intervention strategies, including options for in-person interaction outside of standard clinical settings.

Note that quality improvement topics and measures can change each year, so check to the HHSC website for the latest information.

### Recommendations:

- **Coordination and savings:** Describe the ways that you can help the MCO improve care coordination and/or generate cost savings through:
  - Better management of BH or SUD clients, including medication management
  - Identifying undiagnosed BH conditions or SUDs
  - Engaging clients in alcohol or SUD treatment programs
  - Reducing potentially preventable hospital visits or admissions
  - Diversion programs, such as mobile crisis outreach
  - Providing alternatives to inpatient care, such as crisis respite or residential services (not covered by Medicaid, but MCOs have more flexibility to provide these services as “case-by-case” or “in lieu of” services)
  - Wellness programs
  - Super-utilizer programs
  - DSRIP programs, processes, and outcomes
  - Partnerships with hospitals or other providers in your area
- **Tailored projects.**
  - Check the HHSC website for the MCO’s PIP topics. Can you help the MCO meet outcomes for existing PIP projects? Help them develop new PIP projects?
  - Find out about the MCO’s super-utilizer programs. Are there ways you can partner on these projects?
- **Provide data.** If available, provide data that demonstrates your ability to meet HHSC quality metrics, generate positive outcomes, or create savings. Having data will significantly improve your ability to negotiate higher rates or value-based payments.
  - Do you have data generated through DSRIP projects that demonstrates positive outcomes?
  - Are you using the Texas Council’s endorsed measures and tracking data for these metrics?
  - Are your billing systems set up to help the MCOs meet performance metrics (e.g., billing codes consistent with HEDIS specifications)? If so, this will help MCOs receive credit for your service.
    - Example: HEDIS requires licensed providers for the 7 and 30 day follow-up after mental health hospitalization. If the follow-up is provided by a licensed provider, work with the MCO on a process that will capture this information (e.g., use a procedure code modifier to identify the provider type, or include the provider’s NPI on line 24J of the claim).
  - How many MCO clients do you have the capacity to impact through your super-utilizer, disease management, wellness, crisis respite, or other programs?
  - Can you identify how many of the MCO’s members have high costs or utilization? If not, consider asking the MCO to collaborate on care coordination and share this data.

## CARE COORDINATION & SERVICE MANAGEMENT

Your Center may be able to negotiate additional compensation, such as higher rates or a monthly fee, for helping the MCO fulfill its Service Coordination requirements or for serving as a Health Home.

### 1. DISTINCT MCO SERVICE COORDINATION FUNCTIONS

**Standard:** MCO Service Coordination is a specialized care management function for STAR+PLUS and STAR Kids members. Service Coordination can be performed by MCO employees, subcontractors, or providers that meet program qualifications. Service Coordination involves identifying the member's unique health care needs, developing a service plan, and helping ensure timely and coordinated access to both the covered and non-covered services the member needs. Service Coordinators coordinate care through member "touches." These visits can be face-to-face or telephonic, depending on the MCO Program and member's need level.

Service Coordination Teams provide a member-centered support network, and enhance the coordination provided by a Service Coordinator. Team members are selected based on the member's needs and preferences. Teams must include or have access to individuals with expertise in behavioral health, IDD, medically complex conditions, substance abuse, long term services and supports, local resources, and other areas specific to the member's needs.

#### Recommendations:

- **Qualifications:** Service Coordination requirements vary by MCO program and member need level.
  - Check the "MCO Service Coordination" chapter in the Quick Reference Guide to see if one or more of your providers meet the qualifications.
  - Are your providers willing to serve on Service Coordination teams?
- **Touch Requirements:** Describe how your Center can help the MCO with "touch" requirements.
  - Explain how you locate clients and reduce "no shows."
  - Explain how you could incorporate MCO Service Coordination scripts into scheduled visits.
- **Community Resources.** Be prepared to explain your relationships with community organizations.
  - How do you help clients access local resources (e.g., housing programs, civic and religious organizations, consumer groups, and advocates)?
  - Are there ways you can improve coordination and communication about local resources with the MCO?
- **Ask whether the MCO is willing to delegate Service Coordination functions.** Some MCOs prefer to keep these functions in house. Before building a proposal, ask the MCO whether it is willing to consider other approaches to Service Coordination.

### 2. HEALTH HOMES

**Standard:** HHSC defines a "Health Home" as a primary care provider practice, or a specialty care practice if appropriate, that provides comprehensive care coordination, family-centered care, and data management. Health homes should focus on improving outcome-based quality of care and increasing

patient and provider satisfaction. Refer to the chapter on Health Homes in the *Quick Reference Guide for Medicaid and CHIP Managed Care* for more information on qualifications for each MCO program.

**Recommendations:** Can your Center serve as a primary or specialty care Health Home?

- **Team-based.** If your Center has a team of primary and specialty providers, be prepared to describe the data management and other tools you use to coordinate care and ensure clients can access services more easily. If you do not provide primary care services, do you have relationships or partnerships with other providers to coordinate care?
- **Person-centered.** Describe your Center's person-based approach to care. How do you holistically address the needs of clients with multiple chronic conditions, or serious and persistent conditions?
- **Patient engagement.** Explain your approach to patient engagement. How do you locate clients and keep them engaged in services? What steps do you take to reduce "no shows?"

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### 3. SERVICES NOT COVERED IN THE MCO CONTRACT

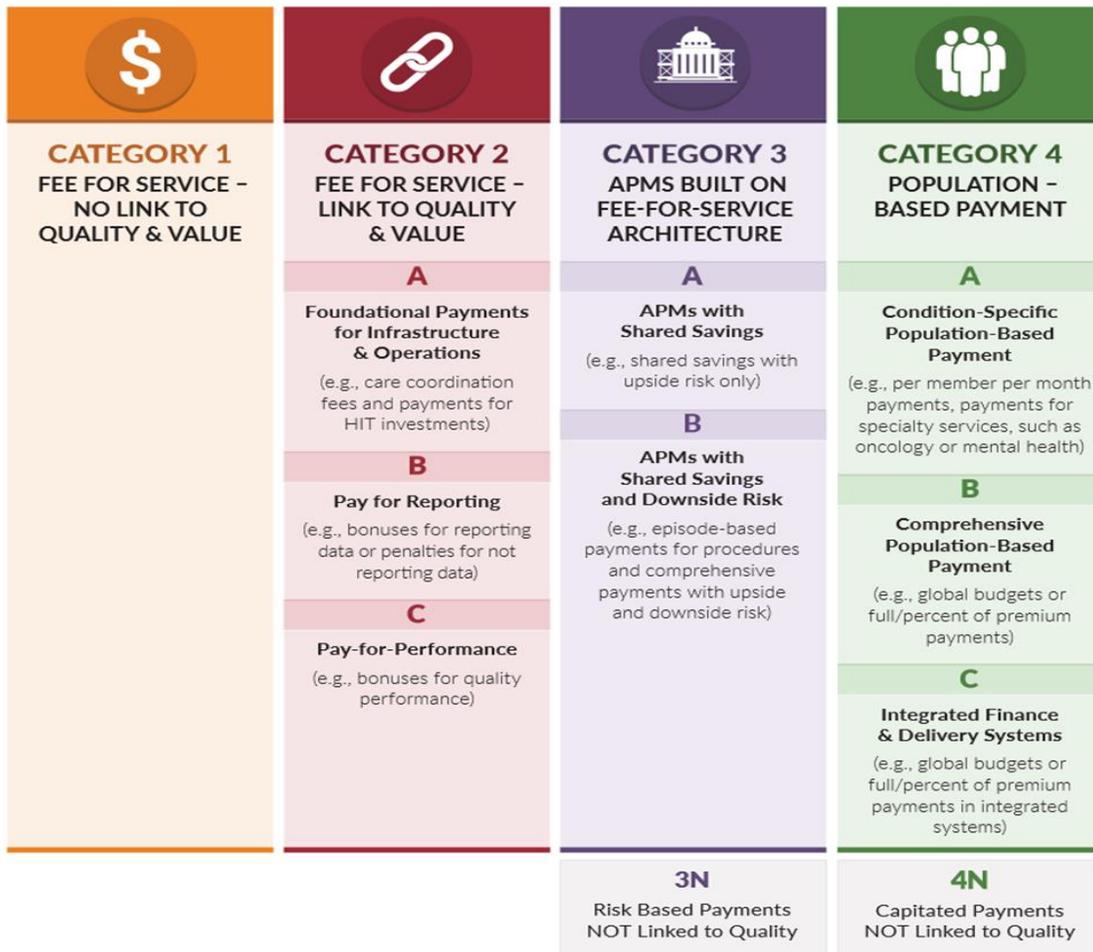
You might be able to contract with the MCO/BHO to include additional covered services (e.g., primary care services), or even services generally not covered by Medicaid, CHIP or commercial insurance (e.g., crisis respite or residential services). If cost effective, MCOs may have flexibility to pay for these services as "case-by-case" or "in lieu of" services.

## ALTERNATIVE PAYMENT MODELS/VALUE-BASED CONTRACTING

The last step when preparing for MCO negotiations is to determine whether your Center is willing and able to participate in value-based payments (VBP).

HHSC contracts require MCOs pay providers using VBP or "alternative payment models" (APMs). For calendar year 2018, at least 25% of provider payments must be tied to APMs, and 10% must be risk-based. Percentages increase over four years, reaching 50% APMs and 25% risk-based APMs in 2021.

HHSC outlined its goals for APMs in the August 2017 "Value-Based Purchasing Roadmap:" <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/draft-texas-vbp-apm-roadmap-august-2017.pdf>. As described in the Roadmap, one of HHSC's main objectives is to transition MCO provider payments from traditional fee-for-service models to population-based payments. The Roadmap includes the following VPB continuum. It describes four provider payment categories, ranging from the lowest to highest risk:



For additional information on the VBP continuum, see the *Quick Reference Guide's* chapter on "Alternative Payment Models and Value-Based Contracting."

**Recommendations:** Focus on the "MIMI" keywords when presenting VBP proposals:

- **Measures** – Can you help the MCO with access and quality metrics? It is extremely helpful to have supporting data.
- **Integration** -- Service integration becomes increasingly important when moving from low to high risk VBP models. If your Center provides integrated primary and specialty care (e.g., MH and SUD), or has arrangements to coordinate care with other providers, be prepared to discuss your model.
- **Money** – Describe how your Center can help improve efficiency and reduce costs. Show how you can impact hospital PPEs; better manage client care and medication adherence; substitute non-covered services like crisis respite for more costly inpatient services; etc.
- **Innovation** – Describe how your Center uses technology, best practices, or other innovative approaches to improve health care. Do you have DSRIP projects or collaborations with other providers/community partners that could benefit the MCOs members?

## PART 3: NEGOTIATING THE CONTRACT

### REVIEW THE CONTRACT

#### Recommendations:

- **Form a Contract Review Team.**
  - Include subject matter experts from different parts of your organization (financial, clinical, operational, executive staff).
  - Consult with legal advisors if you're not familiar with the laws, rules, and regulations cited in the contract.
- **Review the contract carefully.**
  - Do you understand all of the terms and conditions (T&Cs) and MCO requirements (including those stated in the Provider Manual and other policies and procedures referenced in the contract)?
  - Are there T&Cs that disadvantage your Center from a financial, clinical, operational or legal perspective?
  - Are both parties' responsibilities clear?
  - Are all attachments included?
  - If the MCO has agreed to roster-based credentialing, are the requirements and timelines clear?
  - Does the contract reflect sound business judgment?
- **Look for problematic clauses.** Look for risk-shifting and other problematic clauses. Examples:
  - Clauses that require you to pay attorney's fees;
  - Audit, take-back or offset provisions that extend for a long period of time or indefinitely;
  - Binding arbitration;
  - "Evergreen" contracts with static fee schedules;
  - Indemnification clauses;
  - Professional liability insurance (not required for Centers in Medicaid or CHIP);
  - Silence as acceptance of contract amendments; and
  - Heavy responsibilities after termination.
- **Check the HHSC Provider Contract Checklist.** This document includes clauses that all Medicaid and CHIP MCOs are required to include in their network provider contracts. If the clause is italicized, the MCO has to use HHSC's required language. See Uniform Managed Care Manual Chapter 8.1 at: <https://hhs.texas.gov/services/health/medicaid-chip/provider-information/contracts-manuals/texas-medicaid-chip-uniform-managed-care-manual>.

### PRIORITIZE ISSUES

#### Recommendations:

Prioritize risk into the following three categories:

- High = requirement creates unacceptable risks, must be changed to move forward.
- Medium = clause creates potential risk, needs clarification or change to move forward.

- Low = change or clarification would be “nice to have,” but is not necessary to move forward.

## FOCUS ON COMMON GOALS

Focus on goals that foster a long-term partnership and a positive working relationship.

### Recommendations:

- Educate the MCO about your concerns.
- Ask questions and listen to the MCO’s concerns.
- Voice options for mutual gain.
- Include objective and clearly articulated standards and methodologies.
- Emphasize the importance of maintaining ongoing relationships.
- Do not:
  - Take extreme positions, assuming the MCO will have room to bargain.
  - Win the battle to lose the war.
  - Saturate the contract with red ink – focus on top priorities.

## COMMUNICATE YOUR VALUE

During negotiations, you must be able to explain your Center’s value to the MCO. Value proposition answers the question: “What does my Center bring to the table to meet the MCO’s program objectives and goals.” You should also be prepared to answer tough questions or explain any weaknesses (e.g., higher costs, longer wait times for appointments, etc.)

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### 1. TELL YOUR STORY

MCOs may not fully understand Community Center operations, so you will likely need to educate them about your Center, including any unique characteristics or services.

### Recommendations:

- **Explain your role in the community as an Authority, and your status as a governmental entity.**
  - Do not assume that the MCO knows your full service array.
  - Addressing governmental entity status will help the MCO understand why you cannot agree to contract provisions that are standard for private providers.
  - Describe your reach – number of clinics, locations, staff by license, years in business, people served.
- **Explain your care delivery models.** As applicable, discuss your:
  - Staffing models – include a breakdown of licensed and other providers. Do you employ or contract with other providers for telemedicine, telehealth, or other services?
  - Best practice and evidence-based protocols.
  - Ability to provide integrated primary care.
  - Ability to provide substance use disorder (SUD) services.
  - Innovative care or payment models.

- Approach to person-centered care.
- Ability to provide care coordination services, and ways you can help the MCO with its distinct service coordination functions.

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## 2. FOCUS ON QUALITY

Describe your quality improvement processes and performance on key quality and performance metrics.

**Recommendations:** As applicable, explain how your Center:

- **Engages in continuous quality improvement.**
  - How do you identify and resolve issues?
  - Share your performance on key quality measures (client surveys, timely follow-up after inpatient admissions, etc.).
- **Can help the MCO meet its key performance metrics** (mileage standards, wait times, ER diversion programs, quality measures, etc.)?
- **Can apply best practices and lessons learned through DSRIP to managed care.**
- **Can use technology to improve care coordination and access.**
  - If your Center has an EHR, share dashboards on quality outcomes.
  - Describe how you use telemedicine and telehealth to improve access and client satisfaction.

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## 3. COSTS AND REIMBURSEMENT

Describe how your Center can provide cost effective care with better client outcomes.

**Recommendations:** Describe the:

- **Steps you have taken to provide cost effective care.**
- **Services you can offer as cost effective alternatives to inpatient care** (generally on an “in lieu of” or “case-by-case” basis).

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## 4. PARTNERSHIPS

Describe your partnerships with hospitals, primary care and specialty providers, and community supports.

**Recommendations:** Discuss your current or past partnerships:

- **Describe your DSRIP partnerships,** and how you can put these relationships to work in a managed care environment.
- **Do you have care transition processes with local hospitals?** Describe how you ensure these clients receive timely access to care.
- **Describe how you have used partnerships to improve client care or outcomes.**
- **Are grants available through MCO foundations or companies that support testing new approaches to care delivery?**