

ADVANCING CHRONIC DISEASE PREVENTION AND MANAGEMENT PROGRAMS

Building a Third-Party Organization to Support
Managed Care Coverage of Services in
Community-Based Organizations in Illinois



Prepared for the Illinois Public Health Institute by the National Association of
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EXECUTIVE SUMMARY

Illinois has nearly 3 million Medicaid enrollees, more than two-thirds of whom are enrolled in Medicaid Managed Care Organizations (MCO). It is estimated that 175,000 Medicaid beneficiaries in Illinois have diabetes and 350,000 are obese or overweight, which is a risk factor for developing prediabetes or type 2 diabetes. Evidence-based chronic disease prevention and control programs, including the National Diabetes Prevention Program (National DPP) lifestyle change program and the Stanford Diabetes Self-Management Program (DSMP), have been shown to be effective tools for lowering the risk of developing type two diabetes in people with prediabetes or controlling the symptoms in participants who have developed the disease. These programs, which are increasingly in demand in Illinois, are often delivered at community-based organizations (CBO) and led by trained facilitators (rather than health care providers).

To fully meet the growing need for preventive and self-management programs serving the Medicaid population in Illinois, it would be helpful to establish a network of CBOs that offer evidence-based programs and are able to contract with Medicaid MCOs. Given that CBOs are generally not enrolled as Medicaid providers, nor do they usually offer services that are reimbursed by state Medicaid agencies, they encounter many challenges when providing services to program participants who are covered by Medicaid MCOs. CBOs may face challenges related to contracting with MCOs, following physician referral protocols, billing and reimbursement, and complying with patient privacy laws.

In response to these and other barriers, it may be beneficial for MCOs to have access to third-party organizations that can assist with the administration of DSMP, the National DPP lifestyle change program, and other chronic disease prevention and management programs offered by CBOs. These “third-party organizations” could manage networks of online or community-based programs and provide functions such as claims processing and billing.

To better understand the landscape of third-party organizations serving CBOs in Illinois, IPHI, NACDD, and Leavitt Partners conducted a series of interviews with third-party organizations providing services to CBOs, organizations providing services to more traditional health care providers, CBOs, and payers. Findings from these interviews identified key functions that need to be established between CBOs and MCOs in order to cover chronic disease prevention and management programs in Illinois. These functions include legal, data, financial, certification or credentialing, contract and network building, and network coordination and referral.

While all these functional areas are important, some lend themselves better to an Illinois-based third-party organization framework from both a cost and need perspective. Findings from the interviews also indicate that there are practices a third-party organization may want to incorporate to improve its ability to meet the needs of Illinois’ CBOs and, in turn, its overall success in the market. These include: using a high-touch approach with organizations; having the ability to provide knowledge, time, and resources; maintaining a sense of mission for the work; establishing access to start-up funds; and maintaining diversification of services.

INTRODUCTION

Illinois has nearly 3 million Medicaid enrollees, more than two-thirds of whom are enrolled in Medicaid Managed Care Organizations (MCO). It is estimated that 175,000 Medicaid beneficiaries in Illinois have diabetes and 350,000 are obese or overweight, which is a risk factor for developing prediabetes or type 2 diabetes. Considering these large numbers, medical providers alone do not have the capacity to address the preventive and self-management needs of these patients. Medical providers may also not be the best suited to provide this type of health education as research has shown that chronic disease prevention and management programs are effective and less costly when provided in a community setting.¹

To fully meet this growing need for preventive and self-management programs, it would be helpful to establish a network of community-based providers that offer evidence-based programs and are able to contract with Medicaid MCOs. Not only would this improve the health of Medicaid beneficiaries in Illinois, but it would promote health equity by increasing access to community-based programs for individuals who may benefit from them the most.

Numerous issues need to be addressed to establish such a network, including:

- Determining appropriate reimbursement models for evidence-based programs
- Ensuring community-based organizations (CBO) have a stable financial model
- Incorporating CBO programs into MCO networks
- Ensuring an adequate supply of trained providers to deliver programs within CBOs
- Identifying successful enrollment strategies for Medicaid beneficiaries

ROADMAP TO MEDICAID COVERAGE OF COMMUNITY-BASED CHRONIC DISEASE PREVENTION AND MANAGEMENT PROGRAMS

In April 2016, the Illinois Public Health Institute (IPHI) developed the “Bridging to Preventive Care: Roadmap to Medicaid Coverage of Community-Based Chronic Disease Prevention and Management Programs.” The Roadmap captures the essential elements required for MCOs to offer evidence-based programs for diabetes prevention and management to their Medicaid enrollees through partnerships with CBOs. The Roadmap defines the framework necessary to address barriers MCOs experience when contracting with CBOs and establish effective processes for collaboration between MCOs and CBOs.

Implementation of the Roadmap consists of three phases. The first phase is the rollout of a pilot project to offer chronic disease management and prevention programs to adult Medicaid beneficiaries enrolled in Medicaid MCOs in Illinois. The second phase is collecting evaluation data from the pilot sites, and the third phase focuses on refining program operations based on the findings of the pilot.

The Roadmap’s pilot project is designed to capture best practices for recruiting and engaging Medicaid beneficiaries in community programs, demonstrate contracting mechanisms, and expand programs statewide. The pilot focuses on two evidence-based programs: the National Diabetes Prevention Program (National DPP) lifestyle change program and the Stanford Diabetes Self-Management Program (DSMP). Both the National DPP lifestyle change program and the Stanford DSMP are evidence-based programs that seek to improve patient self-care by focusing on behavioral approaches to provide participants with the skills and strategies necessary to make and maintain healthy lifestyle changes. The providers

participating in the pilot project, local YMCAs and AgeOptions, are certified to provide prediabetes and diabetes self-management programs across the state.

Successful implementation of this pilot project required support from the Illinois Department of Healthcare and Family Services (HFS), which made several accommodations. These accommodations include: allowing MCOs to attribute related costs to their Medical Loss Ratio, not requiring MCOs to have a Medicaid provider agreement, and not requiring MCOs to report detailed data back to HFS.

STANFORD DSMP

The [Stanford DSMP](#) helps individuals, along with their caregivers, learn how to control diabetes-related symptoms, engage in healthy eating and physical activity, and work more effectively with their health care providers. The DSMP is a 6-week program for people with type 2 diabetes and is led by trained leaders, at least one of whom has a chronic condition. It is offered in small group settings (often through CBOs) or online. The program is available in English or Spanish. DSMP has been found to be highly effective in improving general health and lowering hospitalization rates in people with diabetes.ⁱⁱ The Administration for Community Living offers Chronic Disease Self-Management Education (CDSME) grants to help build statewide delivery systems including increasing the number of workshop facilitators and supporting overall capacity. For additional resources on the DSMP and to learn more about coverage efforts, visit: <https://www.ncoa.org/>.

NATIONAL DPP LIFESTYLE CHANGE PROGRAM

The [National DPP lifestyle change program](#) is a year-long, evidence-based program that was developed by the Centers for Disease Control and Prevention (CDC) for people who have prediabetes and are overweight. The program is delivered in-person (often through CBOs), online, or through a combination approach. It consists of 16 weekly sessions held during the first six months and at least six-monthly sessions held during the second six months. The program is facilitated by trained lifestyle coaches who can be health professionals or non-licensed personnel. CDC has made the curriculum available in both English and Spanish. Studies have found that people who take part in this lifestyle change program can reduce their risk of developing type 2 diabetes by up to 58% (71% for people over the age of 60).ⁱⁱⁱ For additional resources on the National DPP lifestyle change program and to learn more about coverage efforts, visit the CDC's website: <https://www.cdc.gov/diabetes/prevention/index.html> or the online National DPP Coverage Toolkit: <https://coveragetoolkit.org/>.

CONTRACTING WITH COMMUNITY-BASED ORGANIZATIONS

As noted above, both the DSMP and the National DPP lifestyle change program are often delivered in a community setting through CBOs. However, given that CBOs are not traditional medical providers, these types of programs are usually unavailable to Medicaid recipients who could benefit from them. For states where Medicaid coverage exists, CBOs may have difficulty attaining enrolled Medicaid provider status (a process that certifies an entity to be legally authorized by the state to deliver health care services to Medicaid enrollees) and seeking reimbursement from Medicaid. Some of these organizations may not have experience working with Medicaid populations, and as a result may face challenges in enrolling and retaining participants, as well as helping participants overcome barriers to success such as physical or learning disabilities.

As experienced first-hand in the IPHI Roadmap pilot project, an MCO's contracting process and business structure may also create challenges for CBOs. One of the primary reasons why the pilot project has been delayed is the difficulty in finalizing contracts between the participating MCOs and CBOs. For example, MCOs' insurance requirements and data security and sharing standards are more rigorous than what many CBOs have in place. For many MCOs, clinical and management controls also require that services be prescribed by the primary care provider (PCP), rather than through the self- and community-referral strategies often used by CBOs. Billing and reimbursement can also present challenges. CBOs would need to comply with the Health Insurance Portability and Accountability Act (HIPAA) in order to exchange participant data with an MCO. However, many CBOs do not have the required security systems in place to transfer protected health information and the startup investment for creating such an infrastructure could be prohibitive. While CBOs are familiar with payment based on program enrollment, some MCOs may also prefer to use a claims-based system for reimbursement, which can present similar infrastructure issues for CBOs as this method requires a combination of ICD-10 and CPT codes for diagnostic and reimbursement determinations.

THIRD-PARTY ORGANIZATIONS

In response to these and other barriers, it may be beneficial for MCOs to have access to third-party organizations that can assist with the administration of the DSMP, the National DPP lifestyle change program, and other chronic disease prevention and management programs. These "third-party organizations" could manage networks of online or community-based programs and provide functions such as claims processing and billing. Existing entities that offer similar services include third-party administrators (TPA), management service organizations (MSO), administrative services organizations (ASO), and provider integrators.

EXISTING ENTITIES THAT CAN SERVE AS A MODEL FOR THIRD-PARTY ORGANIZATIONS

TPAs are typically defined as companies that administer self-funded employee benefit plans (such as health welfare, workers' compensation, and retirement plans) on behalf of an employer or health plan sponsor.^{iv} That said, TPAs are used by multiple payers for a variety of service and network management needs. In Illinois, one example of a TPA is DentaQuest, which administers dental benefits for Illinois Medicaid beneficiaries. DentaQuest integrates dental and medical services by providing financial operations, certification, referrals, and data functions to the state. Pharmacy benefit managers (PBM) are also registered TPAs in Illinois. PBMs contract with MCOs and other health insurance plans to develop the pharmacy network, submit claims or invoices to payers and purchasers, and help with collecting, reporting, and evaluating data. They are generally paid a percentage of claims.

MSOs are businesses that provide nonclinical services to providers. MSOs are most commonly known for providing administrative services to physician practices, although the specific services they provide can vary widely. Some MSOs provide a menu of administrative services to providers. Others specialize exclusively in a certain type of service, such as Electronic Health Records (EHR) management.^v ASOs generally provide payroll, employee benefits, human resource guidance, and workers' compensation insurance coverage options.^{vi}

An integrator, or a provider integrator, is a new term that is used by some businesses to describe the services they offer. [Solera Health](#) describes itself as an "integrator" and plays a connecting role between

health systems, payers, patients or members, and the CDC-recognized organizations^{vii} offering the National DPP lifestyle change program. CDC-recognized organizations join Solera’s network, and Solera in turn contracts with payers to manage referrals and enrollment, claims submission and reimbursement, and data reporting. Solera is a nationally based company and provides services in markets across the United States. For more information on Solera Health visit: <http://soleranetwork.com/>.

THIRD-PARTY ORGANIZATION IN CONTEXT

Unless otherwise specified, the term third-party organization is used throughout this concept paper to reference entities that specifically serve CBOs. Functions offered by the third-party organization could include legal, data, financial (e.g., claims or invoice processing), certification or credentialing, contract negotiations, network building, and network coordination and referral.

CURRENT LANDSCAPE OF THIRD-PARTY ORGANIZATIONS SERVING COMMUNITY-BASED ORGANIZATIONS

Organizations both nationally and in other states are starting to recognize the need to support administrative functions for CBOs offering evidence-based programs to payers’ members. To better understand the landscape of third-party organizations serving CBOs in Illinois, IPHI, NACDD, and Leavitt Partners conducted a series of interviews (from which highlights have been shared throughout this paper), with third-party organizations providing services to CBOs, organizations providing services to more traditional health care providers, CBOs, and payers. Two national organizations operating in this capacity include Solera Health (mentioned above) and YMCA of the USA (Y-USA).

Y-USA MSO

Y-USA identified the need to provide administrative, business, and technology services support to local YMCAs (local Ys) to enable them to obtain reimbursement for evidence-based programs, and to ensure that Y-USA was able to keep the interest of local Ys at the forefront of any negotiations with payers. The creation of the Y-USA MSO allows the organization to leverage their national infrastructure to serve these needs and to better coordinate with athenahealth, which manages their EHR interface and billing and revenue cycle management.

The functions the Y-USA MSO provides include: 1) legal support for local Ys on HIPAA compliance; 2) clinical integration and compliance/risk management to assist local Y’s with integration with health care partners; 3) facilitating billing and claims-based reimbursement that allows for as much revenue as possible to transfer to the local Ys; 4) certification monitoring for HIPAA compliance, Medicare Diabetes Prevention Program (MDPP) supplier regulations, CDC-recognition status for the National DPP lifestyle change program, and lifestyle coach training requirements for the YMCA Diabetes Prevention Program (YDPP); and 5) management of data submission to the EHR system and to the CDC. Program recruitment and referral functions are managed at the local Y level, not through the MSO. Currently, the MSO only provides claims-based reimbursement for the YDPP, however Y-USA expects to expand to other evidence-based chronic disease prevention and management interventions as reimbursement opportunities arise.

The process through which the MSO works with local Ys to support contracting with payers is relatively simple. The first step is for a local Y to sign a master service agreement (MSA) with the MSO. Once that

agreement is signed, the local Y would include the MSO in any contract negotiations with a potential payer for claims-based reimbursement. The local Y may choose to participate in those negotiations or leave it to the MSO to navigate. Following negotiations, the MSO would sign the contract with the payer. One Y-USA representative described it as “one voice, one contract, one contact.”

In the case of invoice reimbursement, it depends on the scope of the payer whether the MSO is involved in the process. If the payer is state-wide, regional, or national and the contract could cover multiple Y branches, then the MSO is involved; however, if the payer is local then the direct payment (invoice) contract could be signed between the local Y and the payer. The Y-USA acknowledged there could be a need for the MSO to be involved in supporting direct payment contracts if the local Y indicates that need.

Local Ys in Illinois expressed feeling supported by the Y-USA MSO and credited it with allowing them to retain their focus on successfully implementing programs and recruiting participants. The Y-USA MSO is still in its beginning stages of implementation and there will be new considerations to address as local Ys prepare to become MDPP suppliers and address the Medicare regulatory expectations around compliance and reimbursement. It is also important that connections continue to be made between non-traditional providers, like local Ys, and health care systems and health plans. IPHI’s Roadmap pilot project, discussed above, is helping to foster these relationships.

ANTHEM BLUE CROSS AND BLUE SHIELD

Anthem Blue Cross and Blue Shield (Anthem) acts as the TPA for the Kentucky Employees’ Health Plan (KEHP), a \$1.8 billion self-funded insurance plan with 262,000 employees, dependents, and retirees. Before Anthem was awarded the KEHP account in 2015, Humana piloted the National DPP lifestyle change program with state employees the previous year. Because the results of that pilot were so favorable, KEHP decided to launch the program as a full member benefit when Anthem came on board.

Given the importance of this program within KEHP, Anthem hired a full-time administrator to oversee the National DPP lifestyle change program for KEHP members. The administration of the program focuses on the “Four R’s” – recruitment, referrals, reimbursement, and reporting:

<i>“Four Rs” of National DPP Lifestyle Change Program Administration</i>	
Recruit and refer members	<ul style="list-style-type: none"> • Eligible members are identified through claims. • Referrals are made by zip code. • A team of nurses at Anthem make the referrals. They talk to members about the program and connect them to classes in their area. • These nurses track the members they have sent specific class information to determine if they enroll.
Recruit CDC-recognized organizations	<ul style="list-style-type: none"> • Business associate agreements (BAA) are signed between Anthem and the CDC-recognized organizations to allow for the exchange of personal health information (PHI). • Of the 58 CDC-recognized organizations in Kentucky, 49 have signed BAAs and are participating in the network.

<p>Reimbursement</p>	<ul style="list-style-type: none"> • Once a CDC-recognized organization has signed the BAA, it is eligible to receive reimbursement. • CDC-recognized organizations invoice Anthem once an employee has attended four classes. • For an individual claim, a CDC-recognized organization sends an invoice to the administrator at Anthem, and if the KEHP member attended at least four sessions the organization will be reimbursed the full program amount of \$429. • The Anthem administrator for the program reports an 80% retention rate between classes 5–16 and 50% after 16 weeks.
<p>Reporting</p>	<ul style="list-style-type: none"> • Each month, Anthem collects data from the CDC-recognized organizations to ensure KEHP members are meeting the standards for attendance, weight loss, and minutes of physical activity each week. • This data is aggregated by Anthem to determine how much weight KEHP employees are losing and the minutes of physical activity they are achieving.

KEHP does not release organizations from its network solely based on the loss of CDC recognition. They acknowledge that some of the organizations offering the program, including local health departments, are serving KEHP’s members in other important ways, such as through biometric screenings and referrals. The administrator at Anthem advocates for supporting these organizations and continuing to work together, and cites shared learning as a benefit of these relationships. Anthem allows their administrator to observe the classes and get to know the organizations in the network to better understand how to best support them. This one-on-one attention has been a key factor in making this network successful in Kentucky.

AGEOPTIONS

An Illinois-specific organization also developing ways to support the needs of CBOs offering evidence-based programming is [AgeOptions](#), an Area Agency on Aging (AAA) in Cook County, Illinois. AgeOptions implements the Stanford suite of evidence-based programs including DSMP and the Chronic Disease Self-Management Program (CDSMP). They have received federal grants from the U.S. Administration for Community Living (ACL) to develop, expand, and sustain the [Illinois Pathways to Health](#) (Pathways), an integrated statewide health program delivery system that is designed to provide multiple evidence-based interventions. The ACL funds multiple organizations throughout the country who do similar work, such as the Partners in Care Foundation in California and the Healthy Living Center of Excellence in Massachusetts. AgeOptions’ Illinois Pathways to Health is comprised of seven parts:

Illinois Pathways to Health

<p>Data Management, Evaluation, and Reporting</p>	<ul style="list-style-type: none"> ● Manages Workshop Wizard (an online data management system), processes referrals, and allows organizations to advertise workshops on the website. ● Provides online registration. ● Collects and reports evaluation data to funders.
<p>Network/Delivery System Development and Coordination</p>	<ul style="list-style-type: none"> ● Convenes partners from throughout Illinois such as social service providers, public health agencies, clinics, federally qualified health centers (FQHCs), and others. These partners implement the evidence-based programs, use the data management system offered by AgeOptions, and refer participants into programs within the network. ● Provides technical support to partner agencies and facilitators through phone calls, webinars, blogs, and online facilitator resource portal. ● Offers master trainer and facilitator trainings to ensure sufficient capacity to deliver evidence-based programs.
<p>Licensing and Quality Assurance</p>	<ul style="list-style-type: none"> ● Holds the program license (for the Stanford programs) used by most delivery partners. ● Ensures program quality throughout the system by conducting fidelity checks and reviewing evaluation data.
<p>Statewide Marketing and Branding</p>	<ul style="list-style-type: none"> ● Maintains a website (ILPathwaystoHealth.org) that displays evidence-based programs in Illinois and allows people to register. ● Ensures consistent branding by offering customizable brochures, posters, and other marketing materials for use by delivery partners across the state.
<p>Engagement and Referrals</p>	<ul style="list-style-type: none"> ● Offers secure methods for health care providers to refer their patients to evidence-based programs. ● In preference to relying on passive referrals from health care providers, AgeOptions: <ul style="list-style-type: none"> ○ Collects panels of eligible patients/members from health care providers (customers) in order to provide direct outreach through community health workers (CHW) using motivational interviewing techniques to support eligible patients/members' registration and attendance in programs. ○ Created a process for panel engagement and referrals that involves a large health care system, a fully-capitated primary and specialty care system, and ambulatory clinics where BAAs were put in place to support these functions.
<p>Sales and Contracting</p>	<ul style="list-style-type: none"> ● Approaches and sells to statewide and regional customers. ● Negotiates payment models and rates. ● Enters into contracts with statewide and regional customers to utilize delivery system.
<p>Reimbursement</p>	<ul style="list-style-type: none"> ● Submits invoices to regional and statewide customers. ● Pays delivery system partners for work completed.

AgeOptions recognizes the need for a third-party organization such as Illinois Pathways to Health to support CBOs with legal (contracting) and financial functions (billing and reimbursement). They note that CBOs may not have access to lawyers or staff who understand payers' contract reimbursement requirements or who can manage the communication with these payers. An interviewee from AgeOptions also speculated that this type of entity could help CBOs improve their processes and increase their capacity over time.

There was also a recognition that this type of work requires large up-front investment (staff, IT, contracting expertise, network development, etc.). As noted above, AgeOptions had a federal grant to support this investment in the Pathways project, but without the grant funding they likely would not have had the time or resources to invest in this infrastructure. Without upfront support through grants or federal funding to build these systems, a third-party organization seeking to recoup its investment may lead to price points that are out of reach for many CBOs. For more information on AgeOptions visit: <http://www.ageoptions.org/>.

CHW SOLUTIONS

An additional state-specific example of a third-party organization supporting evidence-based programing is [CHW Solutions](#) in Minnesota. CHW Solutions saw a need to support certified community health workers (CHW) serving the Medicaid population with administrative, billing, and evaluation functions. CHWs are Medicaid enrolled providers in Minnesota and, as such, have billing codes they can use for reimbursement of their services, including delivery of the National DPP lifestyle change program. CHW Solutions supports the interface of CHWs with large state-wide payers like Medicaid. For more information on CHW Solutions visit: <http://chwsolutions.com/>.

PATHWAYS COMMUNITY HUB

The Pathways Community HUB (HUB) is a care coordination model used to identify and address risk factors at the individual level; however, it can also impact population health through data collection and evaluation. The HUB model can be summarized in three steps^{viii}:

<i>Pathways Community Hub</i>	
Find	<ul style="list-style-type: none"> • Identifies individuals at greatest risk for poor health outcomes. • Conducts assessment of health, social, and behavioral risk factors.
Treat	<ul style="list-style-type: none"> • Assigns each identified risk factor to a Pathway that tracks the step-by-step intervention or resolution (may include enrollment in an evidence-based program such as the National DPP lifestyle change program or DSMP).
Measure	<ul style="list-style-type: none"> • Confirms completion of each Pathway. • Includes other outcomes that involve multiple risk factors (e.g. reduction in hospitalizations).

The Pathways Community HUB Manual describes the model, required infrastructure, and implementation approaches. For more information, visit: <https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf>

FUNCTIONAL AREAS PROVIDED BY THIRD-PARTY ORGANIZATIONS SERVING COMMUNITY-BASED ORGANIZATIONS

The key issues and challenges that need to be addressed between CBOs and MCOs in order to cover chronic disease prevention and management programs can broadly be categorized into six key functional areas:

- Legal
- Data
- Financial
- Certification or credentialing
- Contract and network building
- Network coordination and referral

Information on the six functional areas and the required resources to provide the services within each area is briefly summarized in the table below. The table also includes information on whether such organizations currently exist and if they provide services that cross other functional areas.

<i>Legal functions</i>		
<p>This includes ensuring that CBOs understand and comply with rules and regulations that pertain to contracting, insurance requirements, data sharing, becoming a Medicaid-enrolled provider, and the transferring of protected personal health information (PHI). This would include compliance with the federal HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH Act). CBOs providing chronic disease prevention and management programs may not be accustomed to working with PHI, and some may not have the insurance in place to comply with the standards that most MCOs or other payers require.</p>		
Required Resources: High	Existing Organizations: Yes	Cross-functional: No
Requires staff with legal degrees or equivalent, and certification or experience in the areas listed above.	Generally operate on a contract basis to provide legal expertise related to the areas listed above.	Unlikely to provide or specialize in the other functional areas listed unless contracted or employed by another organization.
<i>Data functions</i>		
<p>CBOs have also expressed a need for assistance with data storage and establishing processes to help ensure program and data integrity. Many MCOs require providers to sign a BAA or Data Use Agreement (DUA) to ensure data security and regulatory compliance. These types of agreements outline the MCOs’ standards regarding obligations for privacy and security breaches, data obligations upon contract termination, and required security controls (including data vulnerability scanning). A third-party organization could either help ensure the CBO has the processes in place to meet the BAA or DUA requirements, or act as a contracted entity that controls and monitors the data.</p>		

Required Resources: High	Existing Organizations: Yes	Cross-functional: No
Requires staff with experience in storing, monitoring, and securing data to ensure it meets contract requirements.	Generally operate on a contract basis to provide the expertise related to the areas listed above.	Unlikely to provide or specialize in the other functional areas listed unless contracted or employed by another organization.
Financial functions		
In this capacity, the third-party organization would operate more like a traditional TPA by performing administrative services such as claims or invoice processing, adjudication, or financial record-keeping.		
Required Resources: Med-High	Existing Organizations: Yes*	Cross-functional: Yes*
Required experience includes collecting, aggregating, and paying invoices. More specialized staff will be required for a claims system.	A growing number of national organizations offer these types of services to CBOs. Fairly limited to invoicing at this time. *A claims system will require more specialized staff.	Most likely to also provide some data aggregation or reporting functions. *A claims system will require more specialized staff.
Certification or credentialing functions		
Certain MCOs may require CBOs to become certified providers or meet credentialing requirements to participate in their network. If the chronic disease management and prevention programs being offered are Medicaid covered benefits, then the CBO will also need to become a Medicaid-enrolled provider. This type of certification or credentialing can be a burdensome process for any providers who are new to Medicaid or an MCO's network, and even more so for a CBO that is unfamiliar with a certification or credentialing process. Third-party organizations may be able to assist CBOs in understanding or completing certification or credentialing requirements.		
Required Resources: Medium	Existing Organizations: Yes	Cross-functional: No
Required experience includes understanding Medicaid, Medicare, or commercial insurance provider certification or credentialing function.	Generally operate on a contract basis to provide the expertise related to the areas listed above.	Unlikely to provide or specialize in the other functional areas listed unless contracted or employed by another organization.

Contract and network building functions

Some MCOs may prefer to contract with a single third-party organization rather than directly with multiple CBOs. CBOs would also benefit from being able to contract with a third-party organization that could help standardize and streamline the process when contracting with several MCOs. The third-party organization would serve as an intermediary, or “hub”, between MCOs and the CBOs by holding separate contracts with each CBO and allowing MCOs to contract with a single entity. The third-party organization could also help simplify the contracting process for CBOs and negotiate with MCOs and other payers to develop standardized contract terms. This could shorten the contracting time by leveraging the relationships, time, and resources the third-party organization has built with each MCO and CBO in its network. The third-party organization could also provide some basic data aggregation, evaluation, or reporting functions as well as help the CBOs make any required adjustments to their delivery practices to comply with requirements in MCOs’ contracts.

Required Resources: Medium	Existing Organizations: Yes	Cross-functional: Yes
Requires staff with some insurance experience as well as time and the ability to build a network of CBOs.	Both national and local organizations provide or are building this expertise, specific to CBOs.	Most likely to also provide some financial (invoicing aggregation and collection) and network coordination or referral functions.

Network coordination and referral functions

Third-party organizations can assist with network coordination and making referrals to CBOs within an MCO’s network. They can manage MCOs’ member lists, coordinate referrals from primary care physicians and other providers, manage self-referrals to the program, and guide to which CBOs those referrals are directed. This is coordinated through “centralized processes, systems, and resources to allow accountable tracking of those being served, and a method to tie payments to outcomes.”^{viii} As outlined in the Pathways Community Hub model highlighted in the Landscape section, some third-party organizations are effective at providing a care coordination role. In this role, third-party organizations identify individuals at greatest risk, provide assessment of health, social, and behavioral risk factors, and assign each identified risk factor to a “pathway” that guarantees it is addressed with an evidence-based approach. Some third-party organizations could even assist with marketing and promotion of the programs.

Required Resources: Low	Existing Organizations: Yes	Cross-functional: Yes
Requires staff with good organization and the ability to build connections between CBOs and other providers within MCOs’ networks. Must meet MCOs’ contracting terms.	Both national and local organizations provide or are building this expertise, specific to CBOs.	Most likely to also provide some contracting and financial (invoicing aggregation and collection) functions.

BUILDING A SUCCESSFUL THIRD-PARTY ORGANIZATION FRAMEWORK IN ILLINOIS

As noted above, there are organizations that currently provide services within each of the six functional areas. However, only a few organizations exist in Illinois, or nationwide, that provide services that are (1) specific to CBOs, and (2) cross other functional areas. This illustrates the need that exists in the Illinois market, particularly as the need for community-based programs expands and the demand from MCOs and other payers looking to contract with CBOs increases.

While all these functional areas are important, some lend themselves better to an Illinois-based third-party organization framework from both a cost and need perspective. For example, given the resources and specialty expertise associated with providing legal, data, and credentialing functions, it may make more sense for a CBO to contract with specialized organizations for these services on an as-needed basis, rather than for a third-party organization include them in a core package.

Findings from the interviews also indicate that there are practices a third-party organization may want to incorporate to improve its ability to meet the needs of Illinois' CBOs and, in turn, its overall success in the market. Information on these practices are summarized below.

HIGH-TOUCH APPROACH

Given that contracting with CBOs on a large scale is relatively new for Illinois' MCOs, it was noted that a high-touch approach may be necessary for a third-party organization looking to be successful in the Illinois market. This would include working with CBOs one-on-one to help them understand the process of becoming a Medicaid enrolled provider (if the program is a Medicaid covered benefit) as well as understand Illinois MCOs' contracting, data, and payment requirements. This would also allow third-party organizations to individualize the services they provide to best meet CBOs' needs. For example, some of the CBOs in Illinois may need more assistance with understanding required data security protocols, while others may need more assistance in the reimbursement process.

A high-touch approach would also allow the third-party organization to work with MCOs to help them better understand the benefits that CBOs can provide to their members as well as the constraints they face with contracting, meeting data and security requirements, and the credentialing process. Third-party organizations can help MCOs determine how they can adjust these processes to provide support and flexibility where possible in order to ensure their Medicaid members receive evidence-based services.

KNOWLEDGE, TIME, AND RESOURCES

The downside to this approach is that it requires a significant upfront investment in knowledge, time, and resources from the third-party organization, which makes it less sustainable and scalable over time. This in turn could increase the cost to both MCOs and CBOs in Illinois. It is possible that some efficiencies may be achieved over time, particularly through the standardization of contract requirements (i.e. a standardized scope of services) between the different MCOs and CBOs. For example, if a third-party organization can establish agreement from multiple MCOs on using the same reimbursement model for a particular program, then the third-party organization would save time, knowledge, and resources when negotiating and implementing processes around this reimbursement model in the future. This would also benefit participating CBOs as program reimbursement would be streamlined through the third-party organization.

MISSION

Given the strain a high-touch approach can place on its resources, third-party organizations that truly know and are committed to the mission of Illinois' CBOs, and the chronic disease prevention and management programs they provide, will likely be more successful. Third-party organizations in Illinois need to be committed to the CBOs' missions even though efficiencies may not be achieved until the CBOs they work with are fully integrated into an MCO's or other payer's network. Successful third-party organizations in Illinois should also hire staff who are committed to the same mission and able to spend the time providing one-on-one consultation to the state's CBOs. Third-party organizations need to acknowledge that new providers will need to be added to MCOs' networks as the demand for the chronic disease prevention and management programs expand. New CBOs will need a high-touch approach as well, although the third-party organization will have likely developed a streamlined process to this approach.

START-UP FUNDS

The fact that only a few third-party organizations in Illinois currently provide services that are specific to the needs of the state's CBOs, and cross other functional areas, not only illustrates the need that exists, but potentially points out how difficult it is for these types of organizations to break into the market. Unless an investment is made by a parent organization or other entity, the upfront costs required of these organizations could make it difficult for them to scale and sustain their model in Illinois over time. Most of the organizations that currently exist in Illinois are a subsidiary of a larger organization or have received federal grants to support their work.

An upfront investment would also help lower the costs to Illinois' CBOs using third-party organizations. Third-party organizations are generally paid a percentage of claims or some type of fee by the CBO for their services. This cost can be prohibitive for some CBOs that are operating under tight margins due to the difficulty of enrolling and retaining individuals in chronic disease management and prevention programs as well as the increasing use of pay-for-performance models. Until this market becomes more sustainable, an upfront investment may be needed to ensure that there are enough third-party organizations in Illinois to drive competition and meet market needs.

DIVERSIFICATION OF SERVICES

One approach a third-party organization entering the Illinois market may want to consider to assist with sustainability and scaling is to diversify the portfolio of programs it administers. For example, a third-party organization could provide program administration for both the National DPP lifestyle change program and the Stanford DSMP. This would increase the number of CBOs the third-party organization is working with in the state, which would hopefully place downward pressure on the cost per CBO to contract with a third-party organization. This in turn would have the positive effect of increasing Medicaid beneficiaries' access to community-based programs.

Additional efficiencies could hopefully be achieved by focusing on evidence-based chronic disease and prevention programs that are similar in nature (e.g., provided by non-licensed personnel, focused on behavioral change, delivered in-person, online, etc.) or address a common disease or condition (e.g., diabetes, weight loss, hypertension, etc.). One consideration for third-party organizations, however, is whether they want to start administering these additional programs before payers, like Medicaid or Medicaid MCOs, agree to cover them in Illinois.

CONCLUSION

Establishing an effective third-party organization framework in Illinois can offer MCOs a turn-key solution for contracting with CBOs and provide CBOs with the assistance they need to serve Medicaid recipients covered by MCOs. This work could also provide the foundation and infrastructure for broader coverage of these evidence-based programs, such as through commercial insurers and self-insured companies. Such a solution will save Illinois' MCOs time and resources and allow them to more rapidly expand access to community-based programs for the Medicaid members that need them the most. As Illinois' health care market increases its focus on preventive health and health education, the demand for CBO-based services will increase. A successful third-party organization framework can best meet this demand and the needs of the state's CBOs by providing a high-touch, mission-focused approach and proactively seeking the diversification of services over time. Fortunately, there are a few organizations, both nationally and in Illinois, that meet these criteria, and as evidenced by the preliminary learnings from IPHI's Bridging to Preventive Care pilot project, the need is great.

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ⁱ http://healthyamericans.org/assets/files/NYAM_Compodium.pdf

ⁱⁱ <https://www.selfmanagementresource.com/programs/small-group/diabetes-self-management/>

ⁱⁱⁱ <https://coveragetoolkit.org/>

^{iv} <http://pginsurance.com/the-role-of-third-party-administrators/>

^v https://www.healthlawyers.org/Events/Programs/Materials/Documents/PHY13/B_anderson_grey.pdf

^{vi} <http://www.businessadministrativeconsultants.com/aso/>

^{vii} CDC-recognized organizations are organizations that offer the National DPP lifestyle change program and have received either pending, preliminary, or full recognition from the CDC's Diabetes Prevention Recognition Program (DPRP).

^{viii} <https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf>