Session 1
HCBO-Payer Relationship

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aidsunited.org

AIDS United

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AIDS United

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Community LEADERSHIP
BUILDING
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Grantmaking
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AIDS UNITED – Who We Are

AIDS United is a national, non-profit organization with a singular mission and focus to end AIDS in the US

AIDS UNITED – What We Do

- We lead the charge for responsive and effective federal, state, and local policies that benefit people living with and at risk for HIV
- We invest in innovative models to meet the needs of communities affected by HIV/AIDS
- We have given more than $104M in direct funding and leveraged $117M to increase capacity of communities and organizations responding to HIV in the US
- We inform the field with best practices and lessons learned

AIDS UNITED – How We Do It

- We advance advocacy based on sound public policy; strategic grantmaking to affected communities; targeted & tailored capacity building for organizations responding to the epidemic; and, research & evaluation to inform the field

- We work within a social justice framework that challenges the foundational issues of racism, sexism, homophobia and transphobia, socioeconomic inequality, gender discrimination, and stigma

Individual Coaching

Any HCBO interested in individual coaching by The Menges Group regarding establishing and strengthening relationships with payer organizations should reach out to Zach Ford and/or Paola Barahona at AIDS United's Sector Transformation email address, ST@aidsunited.org

After eligibility screening, HCBOs will be put in contact with The Menges Group to set up introductory meetings

Speakers

Joel Menges

Chief Executive Officer

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Vice President, Director, Government Contracting and Correctional Health Services

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Research Consultant

Session 1 Goals

- Attendees will achieve a baseline understanding of the payer environment and learn to assess their strengths and opportunities to strategically engage with the payer community
- Identify service gaps payers face that ASOs are ideally positioned to fill
- Discern which payers cover large populations of people living with, or at risk of, HIV, as well as other at-risk populations

Why Partner with Payers?

- The ACA has increased access to health coverage for PLHIV via the private market and Medicaid expansion
- PLHIV are increasingly covered by Medicare, and Medicare beneficiaries are increasingly enrolling in MCOs
- With grant funding diminishing, it is increasingly important for HCBOs to deliver services through contracts with MCOs and other payers
- This creates an additional path for reimbursement of HCBOs' existing medical services and non-medical support services – as well as opportunities for HCBOs to develop/deliver new services of value to the payer community and to PLHIV

Payer Environment

- Procurements – Medicaid MCO contracts are typically awarded through a competitive bid process
- Community Involvement – many payers are striving to partner with organizations to better address social determinants of health
- Financial Incentives – health plans experience higher costs for members with low health status – but also receive higher payments
- Pharmacy Costs: Rx represents a large share of HIV health expenditures – the average annual per person cost for HIV medication regimen exceeds $20,000. These costs will decrease considerably as patent expirations occur, which will change the health plans' economics of facilitating access to and adherence with HIV drug regimens.

Opportunities to Work with MCOs and Payers

- Procurements: MCOs need to favorably differentiate themselves against competitors – partnerships with HCBOs can achieve this
- Community Involvement: many states require MCOs to contract with FQHCs – HCBOs can help facilitate these partnerships
- Financial Incentives: to avoid poor health and increased medical dollars for members, MCOs are willing to spend additional administrative dollars
  - Every $1.00 investment made in HIV support services that lowers the MCO's medical costs by at least $1.00 is a welcome expense

Service Gaps in the Payer Community

- Establishing meaningful community connections
  - o Addressing social determinants of health is beyond the boundaries of traditional health benefits
- Finding and retaining members
  - o High-risk populations experience greater transiency and generate substantial health care costs via ED admissions
- High HIV drug costs and low adherence rates

High-Risk and At-Risk Populations

- People living with HIV
- People at-risk of contracting HIV
- Persons with multiple chronic diseases
- Persons with comorbid behavioral and physical health conditions
- Individuals transitioning back to the community from an incarceration

Payers Covering High-Risk Populations

- Medicaid: Many new PLHIV are now Medicaid eligibles via Medicaid expansion in 30+ states; most of these individuals are enrolled in Medicaid MCOs
- Medicare: many PLHIV qualify for Medicare via a disability, and a growing population of PLHIV are aging into Medicare. Many PLHIV on Medicare are also impoverished and are "dually eligible" for Medicaid
- Private Health Insurance: PLHIV covered through employer-based or individual private insurance (e.g., the health exchanges created by the ACA)
  - Blue Cross and Blue Shield entities often hold significant market share

SWOT Analysis

- Strengths: What are your differentiators? Describe your experience (length, populations, outcomes) and demonstrate your understanding.
- Weaknesses: Assess your weaknesses to better understand what you can offer payers
- Opportunities: Identify gaps in the continuum of care where your organization can have a role
- Threats: Does your model match your organization's capacity? Is there funding to support your mission?

Questions?

Upcoming Webinars in this Series

August 14th:	Reaching out to Payers
September 20th:	Establishing Effective Contracts with Payers
October 11th:	Creating the Pilot Program
November 15th:	Collaborative Learning
December 6th:	Next Steps

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