



Welcome to

**“Positioning Your HCBS Program in the
Healthcare Market**

**Part 4: Developing a Strategy and a Business Model for Your
Organization”**

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Facilitator: Magda Hageman-Apol

The webinar will begin at 3:30 p.m. Eastern Standard Time



Webinar Tips

*We recommend that you listen to the webinar over your
computer speakers.*

*Your microphone or telephone will muted but you can ask
questions throughout the webinar, as shown on the next slide.*

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Type your questions and comments here and press send.



The Basics of Health Care and Health Reform – Webinar #4

Tim McNeill, RN, MPH

Key Concept Recap



- Medicare Eligibility
 - People 65 or older
 - People under 65 with certain disabilities
 - SSI
 - People of any age with End-Stage Renal Disease
- Duals are included in the Medicare Eligible category (Medicare + Medicaid)

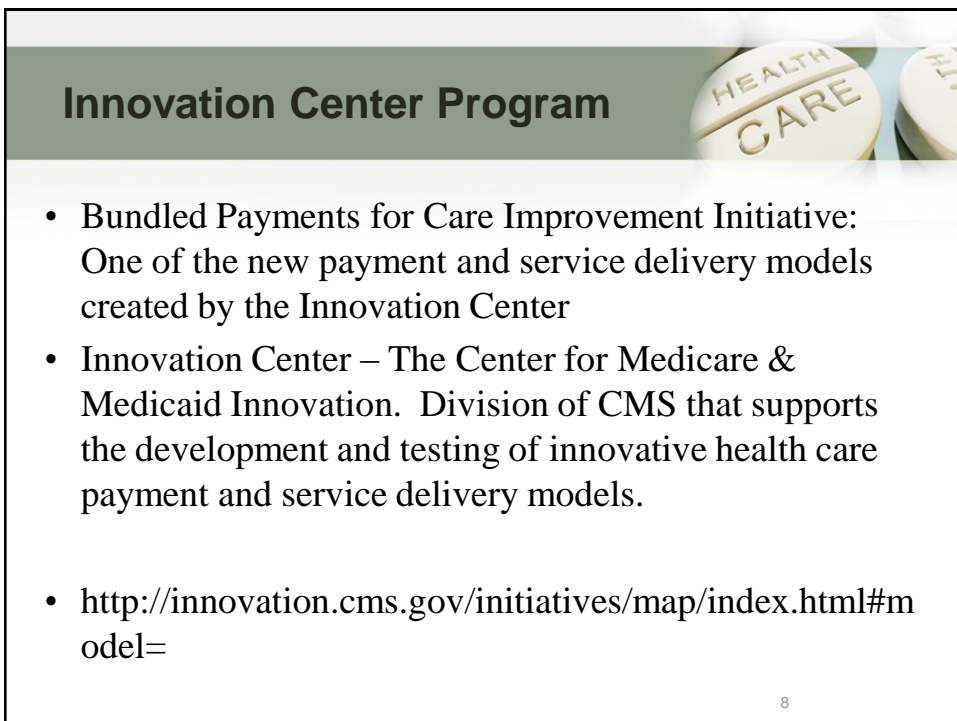
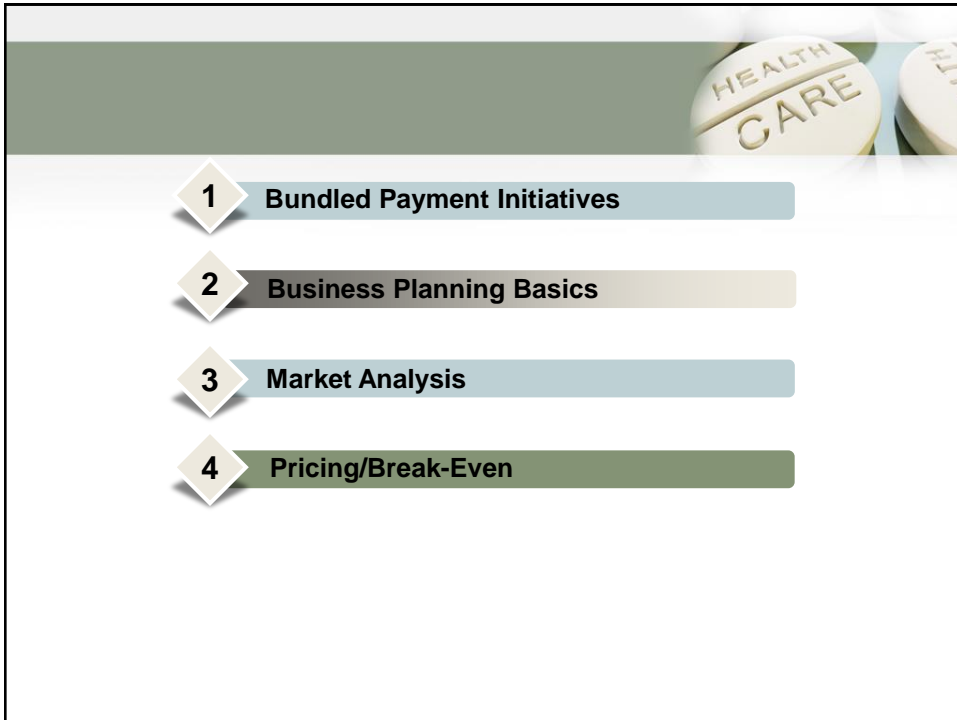
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Key Concept Recap (cont.)



- Four Parts of Medicare
 - Part A
 - Inpatient hospital, SNF, Home Health, Hospice
 - Part B
 - Doctor services, office visits, emergency care, ambulance services
 - Part C
 - Medicare Advantage
 - Part D
 - Prescription Benefit

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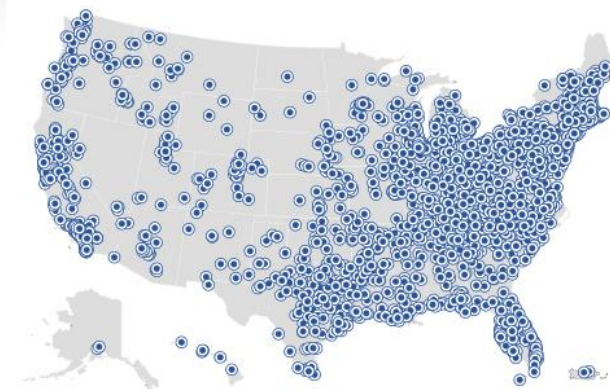
Bundled Payments for Care Improvement Initiative



- Initiative first awards were announced January 31, 2013
- Under this initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care
- Episode of Care
 - Key component of the initiative
 - All services rendered are bundled into one payment for an episode of care
 - Provides a financial incentive for the org. to keep costs down

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Is there a BPCI Near You?



Source: Centers for Medicare & Medicaid Services

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Background



- Original Medicare, Part A & Part B
 - Pays for services under a Fee-For-Service delivery model
 - Separate payments are made for each individual providing services to a beneficiary
 - Since each provider bills separately for services, each provider focuses on how to secure their individual payment
 - Has the potential to cause fragmented care as there is no incentive for providers to work together to provide more efficient care

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BPCI Financial Incentives



- Rewards providers for improvements in quality and efficiency of care
- No financial incentives rewarded providers for improving the quality of care in a similar manner
- Aligns incentives for coordinated care with the following provider types:
 - Hospitals, Post-Acute Care Providers, Physicians, and other Practitioners
 - CBOs – Post-Acute Care Providers

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BPCI Clinical Conditions List



- Organizations select clinical conditions to include as part of the initiative
- 48 Conditions to choose from -- Including
 - Amputation
 - AMI, Cardiac Valve, CHF, CABG
 - COPD, Diabetes
 - Orthopedic Surgery
 - Back and Neck Surgery
 - Hip and Femur fractures
 - Joint Replacement Surgery

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Why should we care?



- CMS has begun releasing payment data for providers and hospitals
- Data revealed a wide disparity in payments for the same services
- Average cost of a hip or knee replacement is \$50,000 per patient
- Cost for the same procedure shoots up to as much as \$200,000 in some facilities
- Top 10 hospitals charged 12 times more than 10 least expensive hospitals – for the same procedures

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BPCI Models



- Four Models – Each model links payments for multiple services serving beneficiaries
- Model 1 – Retrospective Acute Care Hospital Stay Only
- Model 2 – Retrospective Acute Care Hospital Stay Plus Post-Acute Care
- Model 3 – Retrospective Post-Acute Care Only
- Model 4 – Prospective Acute Care Hospital Stay Only

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Retrospective vs. Prospective



- Retrospective
 - All relevant ACTUAL expenditures are reconciled against a target price for an episode of care
- Prospective
 - A Lump sum payment is made to a provider for the entire episode of care

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Pre-BPCI Example



- 67 y/o female, Requires Knee Replacement Surgery
 - History of diabetes and CHF
 - Enrolled in Original Medicare – Part A & Part B
- Post surgery admission to SNF
 - Part A covers hospital care & SNF stay
 - Part B covers professional services
 - No financial incentive to coordinate between providers to keep costs down
 - What would make the most sense financially?
 - Pre-BPCI vs Post-BPCI

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Model 1 - Retrospective



- Retrospective Acute Care Hospital Stay Only
- Episode of Care: The entire inpatient stay in the acute care hospital
- Includes: All Part A Services
- Medicare pays a discounted amount based on an established payment rate
- Medicare continues to pay physicians according to the Medicare Fee Schedule
 - Physicians and hospitals are permitted to share gains arising from redesign efforts

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Model 1 - Example



- 67 y/o female, Requires Knee Replacement Surgery
 - History of diabetes and CHF
 - Enrolled in Original Medicare – Part A & Part B
- All **Inpatient** care, related to care included in ***ONE*** bundled payment
 - Hospital
 - OR
 - Device
 - Post-surgery therapy (during inpatient stay)

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Model 2 - Retrospective



- Retrospective Acute Care Hospital Stay Plus Post-Acute Care
- Episode of Care: Inpatient stay plus related Post-Acute Care
 - 30 days
 - 60 days
 - 90 days
- Includes: All non-hospice Part A and Part B services
- Participants must select from 48 different clinical conditions

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Model 2 Example



- 67 y/o female, Requires Knee Replacement Surgery
 - History of diabetes and CHF
 - Enrolled in Original Medicare – Part A & Part B
- One payment covers 30, 60, or 90 day episode of care
- The Longer the period, the higher the bundled payment
- One Payment covers:
 - Inpatient Care
 - Post Acute Care

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Model 2



- To SNF or Not to SNF?
- Financially, we do not want to SNF
- One payment for 30 – 90 days
- Limiting high cost, post acute care reduces the potential profits in a bundled payment scenario
- If no SNF?
 - Coordinate support services in the home
 - Ensure coordinated post acute care and follow-up
 - Regular monitoring to advert complications

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Opportunity for increased payments for Model 2 BPCI



- Average Knee and Hip Surgery costs \$50,000
- Under Model 2, a flat rate (Negotiated) is paid
- Using \$50K as an example, the total cost of care for the full period must be managed and below \$50K
- Every dollar below \$50K is potential profit
- Cost drivers
 - Complications
 - Readmissions
 - Extended SNF stays
 - Rehab

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Model 3 - Retrospective



- Retrospective Post-Acute Care Only
 - Inpatient care is not included in the Model 3 bundled payment
- Episode of Care: Post-Acute Care Services with a participating skilled nursing facility
- Range of time: 30, 60, or 90 days
 - The longer the episode, the higher the payment
- Includes: All non-hospice Part A and Part B services
- Example: Rehab facility, long-term care hospitals, home health, and community support services

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Model 3 Example



- 67 y/o female, Requires Knee Replacement Surgery
 - History of diabetes and CHF
 - Enrolled in Original Medicare – Part A & Part B
- One payment covers 30, 60, or 90 day episode of care
- The Longer the period, the higher the bundled payment
- One Payment covers:
 - Post Acute Care Only
 - Payment is initiated when post-acute care starts

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Model 4 – Prospective



- Acute Care Hospital Stay Only
- Physicians and other practitioners submit “No-Pay” claims to Medicare
- Includes: All non-hospice Part A and Part B services
- Any related readmission for 30 days post discharge is included in the bundled payment amount
 - ER (Already paid)
 - Readmission (Already Paid)
 - Complications (Already Paid)

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Model 4 Example



- 67 y/o female, Requires Knee Replacement Surgery
 - History of diabetes and CHF
 - Enrolled in Original Medicare – Part A & Part B
- All Physicians, Inpatient care, OR, etc. all covered by one bundled payment
- Everyone must be interested in keeping costs down and reducing readmissions
- Distribution of payments generally made after the 30-day period

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Opportunity for CBOs



- A BPCI that includes post-acute care provides maximum incentives to reduce the cost of care after admission
- Reduce readmissions
- Limit SNF stays
- Transition to community as fast as possible
- Close monitoring in the home for potential complications

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For-Profit Community Provider approach



- Partner with BPCI Organizations
- Include their costs in the bundled payment rate
- Provide ongoing feedback to the providers on services provided in the community
- Track outcomes and provide ongoing feedback to show the Return on Investment (ROI)

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Mitigating the Threat of a For-Profit



- Are you a Meals Delivery Service or a Comprehensive Nutrition Program?
- Comprehensive Nutrition Programs will:
 - Demonstrate the value-added benefit of your services
 - Submit regular feedback to providers, about the status of each participating beneficiary
 - Provide alerts when complications arise
 - Coordinate the transfer from higher cost post acute care service providers to community

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Business Planning



- Key Elements of a Business Plan
 - Market Analysis
 - Market Strategy
 - Competitive Advantage
 - Price
 - Break-Even
 - Potential for Growth

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Business Model



- Always approach your plan with the worst case example in mind
- Think Murphy's Law when preparing your budget
- Preparing for the worst scenario, ensures that your program will survive turbulent times
- Begin with your program expenses and then move to your income projections

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Program Budget



- Begin with expenses because revenue is fixed per client. Only expenses and participant volume can be adjusted
- Expenses should be tied to productivity. Staff must have productivity projections that must be reported regularly.
- Ongoing productivity must be tracked
 - A drop in productivity is a reason to be concerned
- Remember: Revenue = [Volume x Reimbursement] – expenses
- If volume decreases, your profitability drops
- If expenses increase, your profitability drops

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Break Even



- Break-even point is the point at which costs or expenses and revenue are equal
- Usually calculated on an annual basis
- Income and expenses are spread over an annual basis to calculate break even
- In order to break even, you should increase income or reduce expenses
- Plan for attrition
- Plan for the number of completers that are required to cover your annual expenses

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Break Even Questions



- Can you realistically meet the break-even numbers?
- If your projected volume of clients is not realistic, what can you do to increase the volume?
- What can you do to decrease the expenses?
- What is your current demand for services?
- You should have an agreement with your Medicare provider partner about acceptable expenses
- Ensure that your prices cover expenses plus some margin that can be used for program development

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Opportunities



- Identify the types of insurers in your area
- Investigate to see if providers and hospitals are taking risk in your market
- Review how to become a contractor to provide services to the provider or health plan
- You should know how to price your service before beginning negotiations
- Be Prepared to Define your Value Proposition
 - What is the ROI that one gets by buying your services?

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Market Analysis



- Define the Potential Market for your Services
- Know the Universe of beneficiaries in your area
 - Medicare Beneficiaries in Original Medicare
 - Medicare Advantage
 - ACOs
 - Bundled Payment Participants
 - Medicaid Managed Care
 - Medicaid Managed Long-Term Services and Supports (MLTSS)

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Competition Example



- Tim's Meals vs. Anywhere, USA Community Meals
 - Tim's Meals
 - Located out of State
 - Drop ships meals in 5 and 10 day shipments
 - No connection with the community
 - Provides a low-cost option with national distribution range
 - Heavily markets benefits of meals and low-cost services
 - Website, Marketing Materials, Vendor Fairs
 - Continually meets with Health Plan Case Managers
 - Accepts electronic referrals nationwide (24/7)
 - Provides ongoing feedback electronically (24/7)

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Anywhere USA Meals



- Established community meals program
- Unaware of the market changes
- Doesn't market to health plans
- Cannot receive electronic referrals
- Cannot provide feedback on quality of services to health plan
- Value Proposition
 - “Everyone Really Likes Us”

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Are you Formidable Competition for Tim's Meals?



- Tim's Meals Value Proposition
 - Low Cost
 - Electronic referrals
 - Electronic feedback on quality of services
 - Large, Nationwide service area
 - No limits on who can be served or where services can be provided
 - Motto – If you are paying, We ARE Shipping!

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Anywhere, USA Community Meals



- Value Proposition
 - Comprehensive Meals Program
 - Able to assess nutritional needs
 - Accepts Electronic referrals
 - Provides feedback on quality of services
 - Provides ongoing assessments of consumer on a regular basis
 - Alerts provider/health plan of deterioration in status
 - Able to access additional community services
 - Adult Protective Services
 - Community Assistance Programs
 - OAA Programs
 - Veteran Programs

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Which Program would you buy services from?



- “Toto, I’ve a feeling we’re not in Kansas anymore...”
 - We are in a market driven healthcare environment
 - OAA requirements do not apply in a market driven environment
- Tim’s Meals provides more value to the payer
- More ROI is demonstrated for tangible benefits
 - You have to prepare to compete
 - Everyone Likes us is not a Value Proposition
- If you want to compete with Tim’s Meals, YOU Must define your value and continually demonstrate the ROI for your program

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Prepare to Compete!



- Know Your Market
- Define Your Value
- Demonstrate Your Value

- Tim's Meals is Swinging for the Fence.
 - Who will Own your Market
 - You have the Advantage to Own Your Market
 - Plan and Prepare to Compete

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Upcoming Webinars



- Webinar #5
 - SWOT Analysis
 - Strengths
 - Weaknesses
 - Opportunities
 - Threats

Follow link to register:

<https://attendee.gotowebinar.com/register/5525350859508928513>

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Questions



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