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

Webinar Tips

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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)

**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
Innovation Center Program

- Bundled Payments for Care Improvement Initiative: One of the new payment and service delivery models created by the Innovation Center
- Innovation Center – The Center for Medicare & Medicaid Innovation. Division of CMS that supports the development and testing of innovative health care payment and service delivery models.

- http://innovation.cms.gov/initiatives/map/index.html#model=
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

Is there a BPCI Near You?

Source: Centers for Medicare & Medicaid Services
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

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
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

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
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

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
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

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
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)

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
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

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
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

Model 3 - Retrospective

- Retrospective Post-Acute Care Only
  - Inpatient care in 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
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

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)
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

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
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)

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
Business Planning

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

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
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

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
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

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?
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)

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)
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”

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!
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

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
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

Upcoming Webinars

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

Follow link to register:
https://attendee.gotowebinar.com/register/5525350859508928513
Questions

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