Positioning Your Program in the Market

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Affordable Care Act
Changes in Medicaid
Knowing your market
Self-Assessment
Changes to the Healthcare Landscape

• The Patient Protection and Affordable Care Act
  – Health Reform. Commonly called the Affordable Care Act or ACA
  – Signed into law by President Obama on March 23, 2010
  – On June 28, 2012, the Supreme Court rendered a final decision to uphold the law
• MACRA: Medicare Access and CHIP Reconciliation Act
The Evolution of the System

• Understanding the changes coming to the health care delivery system requires understanding how the current system evolved.
• You have to understand the financial incentives in the market to track where there are opportunities.
Older Americans Act

• Important but…
• Medicare and Medicaid are much larger payers
• Which one has the greatest impact on the market
• Managed Care is a commercial, market-driven enterprise
• Market-driven enterprises are moved by financial forces
• Which financial driver will have the biggest impact on commercial payers?
1915(c) Home & Community-Based Waivers
- Goal is to support consumers in the community that are at-risk for institutional placement
- Incentives are aligned with Value-Based payment models for Medicare
- This creates more opportunity for this target population
Federal Funding Trends: 2004 – 2014 (Billions)

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Shift Toward Value-Based Purchasing

- The current system is changing from Fee-For-Service to payment for outcomes.
- A Value-Based Purchasing system provides financial incentives for outcomes (Value)
- MACRA legislation provides direct incentives to Physicians and Hospitals to move towards a system that pays for outcomes.
- In the past, there were real financial incentives to providers, when complications occur.
The target population of many of the current changes in Healthcare are Medicare Eligible Beneficiaries. These changes are dramatically impacting the actions of providers that serve this population. Providers Impacted by Reform are targeting:

- People 65 or older
- People under 65 with certain disabilities
- People of ANY age with End-Stage Renal Disease (ESRD)
Where are there costs in the system

- A system that pays for value will focus on where the highest cost drivers are.
  - Reduction in Institutional Care
  - Readmissions
  - Nursing Home Placement
  - Preventable Primary Admissions
Emphasis on Duals

- The population that is most vulnerable to cost increases
- Eligibility generally requires
  - Aged (65+) or;
  - Disabled AND
  - Meets means testing for Poverty status
- Both Public Payers are impacted
  - Medicare
  - Medicaid
What is the Role of Medicaid for Duals

- Medicare is the primary payer for Healthcare services for Duals
- Medicaid becomes the secondary payer
  - Operates in a manner as the Medigap policy
- When a Dual has both
  - Medicare pays for health services
  - Medicaid pays supplemental costs
  - *Medicare is most often the primary
Reform impacting Duals

- Value-Based Payment Reform
  - ACOs
  - Bundled Payment (BPCI)
  - CJR
- Medicaid Managed Care
- MLTSS
- Health Homes
- Duals Demonstrations (high opt-out rates)
- D-SNP/C-SNP/I-SNP plans
Alignment of Initiatives

• Physician Value-Based Purchasing evaluates the following
  – COPD, Heart Failure, Coronary Artery Disease, Diabetes

• Readmissions Penalties evaluate the following conditions
  – Heart Failure, Acute MI, Pneumonia, COPD, Hip/Knee
Value-Based Purchasing Opportunities

- Disease self-management programs that can address the cost of care, reduce readmissions, and improve outcomes address key issues facing the healthcare system
  - Improve Physician Value-based purchasing
  - Reduce Readmissions Penalties
  - Improve Hospital Value-based purchasing
- Health Systems and industry will create programs to address this problem if good options are not presented

- ROI must be clearly defined and measured
What about Medicare Advantage

- Sometimes called “Part C” or “MA Plans”
- Medicare Advantage plans are required to cover all Medicare Part A and Part B benefits
- When a beneficiary elects Medicare Part C (Medicare Advantage) they have elected to have their Part A and Part B benefits managed by a Private Health Insurance plan that is approved by CMS to operate a Medicare Advantage Plan
Medicare Advantage Enrollment

- Kaiser Family Foundation Report (Jan, 2015)
- In 2014, the majority of the 54 million people on Medicare are in the traditional Medicare program
- 30% are enrolled in a Medicare Advantage Plan
  - There has been consistent growth in the number of Medicare Advantage enrollees over time
  - Enrollment in Medicare Advantage varies by State and Markets within a State
MA Plan Enrollment Map

Exhibit 2
Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2014

NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.
How are For-Profits from out of State beating me in my Market?

• Managed Care has completely commercialized the delivery of Medicaid services
  – HCBS
  – Long-Term Services and Supports
• You must be able to compete
• Medicaid Managed Care does not have to comply with Title III (OAA) requirements
• Opens the door to For-Profit entities
What is your competitive advantage

• You have to mobilize quickly
• The window of opportunity will not remain open indefinitely
• SOMEONE will fill the need
• No one should be able to mobilize faster in your community than you
Which Population has the most chronic disease?

- Most chronic conditions were more prevalent for dual-eligible beneficiaries
  - 72% of dual-eligible beneficiaries had two or more conditions
  - Dual eligible beneficiaries were 1.7 times as likely to have 6 or more chronic conditions
  - 1.7 times more likely to have COPD
  - 1.6 times more likely to have heart failure
  - 1.4 times more likely to have diabetes
- 98% of readmissions, in 2010, were for Medicare beneficiaries with two or more chronic conditions

What are the characteristics of Duals?

- According to the CBO, in 2009, there were 9 million dual eligibles and they cost Federal and State governments more than $250 billion in healthcare benefits.
- Medicaid provides health care coverage to low-income people who meet requirements for income and assets.
- All Duals qualify for full Medicare benefits, but they differ on the Medicaid benefits they qualify for.
• Full duals are twice as likely as non-dual Medicare beneficiaries to have at least three chronic conditions.

• Duals are nearly three times as likely to have been diagnosed with a mental illness, including chronic depression.
  – Many more have undiagnosed or untreated chronic depression.

• In 2009, total average healthcare spending:
  – Nonduals - $8,300 per year
  – Full Duals - $33,400 per year
LTSS for Duals

- Less than 0.5% of partial duals are institutionalized.
- 15% of full duals are institutionalized.
- Partial duals often transition to a full dual after completing the spend down period after a SNF/nursing home admission.
- Full duals are five times as likely to use LTSS as non-duals.
- Full duals are twice as likely to use LTSS as the non-dual ABD population.
Managed Long Term Services and Supports

- The delivery of long term services and supports through capitated Medicaid managed care programs
- States that elect to adopt MLTSS often use this as a strategy to expand HCBS to eligible beneficiaries
State Adoption of MLTSS

- 2004 – 8 States participated
- 2012 – 16 with many more States in the process of adopting some form of MLTSS initiatives
- States have wide discretion as to the implementation of MLTSS
  - Target Population
  - MCO participation
  - Incentive and risk models for participating MCOs
MLTSS Implementation

• State Division of Medicaid meets with applicable Stakeholders to design a proposed MLTSS model

• Medicaid MLTSS programs can be operated under multiple Medicaid Managed Care authorities
  – 1915a
  – 1915b
  – 1115

• State approves Medicaid Director to submit a State Plan Amendment (SPA) to CMS
• State Division of Medicaid and CMS work together to develop an acceptable MLTSS program that is acceptable to both parties
• SPA accepted along with an implementation timeline
• If MCOs are participating, CMS requires two or more plans to allow for consumer choice
• MCOs selected through open bid process
CMS requires that States that implement MLTSS provide consumers with a choice in MCO providers.

State Division of Medicaid issues a RFP.

Most States have a bidders conference to explain the proposal submission requirements.

Two or more MCOs provide consumers with a choice in each MLTSS approved market.

State selects MCOs based on an objective proposal evaluation methodology.
It is important to note that persons in a Medicaid MLTSS plan must first qualify for Medicaid

- Medicaid Waiver participants DO have Medicaid or else they would not qualify as a Medicaid Waiver participant
- This is separate and distinct from the State option to expand Medicaid
- *Common misconception – “My State is not accepting Medicaid expansion or “Obamacare” so we don’t have adults on Medicaid”*
Application of Medical Necessity

• Consumer admitted to the hospital
• Discharged with prescriptions
• Reports to CVS Pharmacy to fill the prescriptions
• CVS Pharmacy submits to the MCO proof that medical necessity is met based on an approved prescription from a physician
• The MCO pays CVS the contracted rate for dispensing this medication
Prescriptions vs Meals

• We can all relate to the Medical Necessity example in the previous slide
• Would you expect that Meals would be treated differently?
• The MCO must cover all medically necessary services to include HCBS
• The provider must understand the MCO requirements for establishing Medical Necessity and then advocate for your consumer
Those most at-risk for institutional care originates from how the healthcare system pays for institutional care in a Skilled Nursing Facility:

- Must have Medicare Part A
- Must have a qualifying hospital stay (3-Days)
- Medically necessary
Alignment of Payment Incentives

• Medicare
• Medicaid (Medicare Supplemental Coverage)
• Managed Long-Term Services and Supports
  – Medicaid Waiver
Role for Nutrition Programs

- Malnutrition and Unintentional weight loss are direct contributors to functional decline and increase risk of mortality
- Direct correlation with these cost drivers
  - Increased length of stay in hospitals
  - Increased likelihood of institutional care placement
Comprehensive Nutrition Program Svcs

- Nutritional Assessment
- Plan developed to address nutrition needs
- Implementation of the plan
- *Quarterly reassessment to determine if plan is meeting the needs of the consumer
  - **Performed monthly in institutional settings
- Tracking outcomes at the consumer and population level
Who is the Payer under Reform

- It Depends
  - Medicare
  - Managed Medicaid
  - Managed Medicaid Long-Term Services and Supports

- Providers react according to the changes impacting the payment model
- Opportunities are created resulting from this disruption
In order to seize the opportunity…

- CBOs must understand how they bring value
  - What are my strengths
  - What are my weaknesses
  - What is the target population that I can impact
  - How do I define the ROI for my services
  - What is my value proposition
  - What are the external and internal threats
  - What relationships do I have that increase my market potential
What is the Impact in my Market

• What is my market
  – Geography
  – Target Population
  – Demographics of target population
  – Location of target population

• What are the changes being implemented in my market

• How are providers reacting to these changes in my market

• How can my strengths overlay with the needs in the market
New Business Opportunities Abound

• The shift towards financial incentives that align with preventing costs has created new business opportunities

• Population Health
  – Identification of populations that are most at-risk for increasing costs
  – Stratification of the highest risk population
  – Need for programs and services that can address the factors that will lead to increased costs
Challenge for CBOs

- Understanding how your business brings value to the system
- Defining your return on investment (ROI)
- Implementing the required culture change to realize the opportunity
- Implement systems to drive change and document your impact
  - Continually reinforcing your ROI to your customer
Success will require

- Full understanding of the changes impacting the market
- Vigilance to ensure that you stay aware of the current changes and pending changes
- Model your program to meet the needs of your CUSTOMER
  - Who is the customer?
  - How does the customer differ from the beneficiary?
  - Can you meet the needs of both the Customer and the Beneficiary?
Where is the Opportunity

- Medicare and Medicaid
- Know who is the payer and how has financial risk
- Provide services like the Burger King slogan
  - Have It Your Way
  - Customer needs may force internal change
    - OAA requirements do not apply
    - Traditional State requirements do not apply
    - Geographic boundaries do not apply
    - Total Market driven system change
Aligned Incentives

- Providers need to shift towards financial incentives that pay for outcomes.
- Reduced costs and improved health outcomes are rewarded.
- Institutional Care provides:
  - Increased Costs
  - Lower Quality
  - Lower Consumer Satisfaction
- The Money Ball is now in the home.
Change at the Provider Level

- Each of the Programs impacting providers mandate a change in care delivery models
  - Most are focusing on highest cost drivers
    - Duals
    - At-risk for institutional care
- Key Market Drivers Today
  - Accountable Care Organizations
  - Readmission Penalties
  - Bundled Payment Initiatives
Know Your Market

- Medicare Population
- Those at-risk for Institutional Care
- Target services to those impacted by change
- Define how your services will lead to cost reduction and improved health outcomes
- Drive value and continually document the ROI that your provide
MLTSS Risk Pool

- Managed 1915 Waiver
- Target Population for 1915 Waiver
  - Beneficiaries at-risk for institutional care
  - Support them in the home to prevent premature institutionalization
- Target services to this target group
- This group may also have Medicare and will be subject to Medicare reform initiatives
Medicare Coverage

• Medicare Part A covers the following services:
  – Inpatient hospital care
  – Skilled Nursing Care
  – Home Health Care
  – Hospice Care

• Medicare Part B covers the following services:
  – Preventive Health Services
  – Doctor visits
  – Ambulance Services
  – Supplies/DME (wheelchairs, walkers, etc.)
Medicare Part B and the Dual

- Medicaid pays for the supplemental costs for all Part B services
- Providers can support a reduction in Medicare costs by maximizing prevention covered by Medicaid
- Medicaid is responsible for all supplemental costs
- When Medicaid Managed Care is implemented, the MCO is responsible for the supplemental costs
Questions

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How do we prepare for the market?

• Now that we have a better understanding about the dynamic healthcare market, what do we do next?
• It is important to prepare and know your market before seeking contracts
• Know who your customer is
  – Customer is the entity that buys your services
  – Beneficiary is the recipient of the services that are paid for by your customer
  – BOTH the Customer and Beneficiary needs must be met
Alignment of Initiatives

- **Physician Value-Based Purchasing** evaluates the following:
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Customer Vs. Consumer

- The new marketplace requires that you meet the needs of the customer and the consumer
- Customer – Managed Care Plan
- Consumer – Beneficiary receiving services paid for by the Managed Care Plan
What does the Consumer Need

- Consumer requires services that meet medical necessity to support the consumer in meeting their healthcare goals in the least restrictive environment as possible.
What does the Customer need?

- Data
- Data
- More Data
- Integrated Care Organizations have performance goals to meet
  - Financial and Quality Risks
- How do you contribute to improving quality and reducing financial risk?
  - If you are not, why should they contract with you?
Other Needs of a Large Mult-State Payer

- Vendors that have a clearly defined ROI
- Vendors that can access the consumer
- Vendors that can cover the MCO coverage area
- Vendors that make it easy to submit referrals
- Vendors that help meet quality metrics
- Vendors that submit data showing improved outcomes
Example

- I am a Managed Care Plan
  - Universal HCBS Health Plan
- I am covering a large service area that includes 10 Counties
- Demographics
  - Caucasian, Latino, African American, Asian, LGBT
• Do I want to execute a separate contract with 15 different meals providers for 1 coverage area?
• Do I want to incur an increased workload for my case managers and staff time to coordinate services with 15 different vendors in 1 service area?
For-Profit Appeal to Universal HCBS

• 1 Call Does it All.
• We cover the entire service area
• Case managers can submit electronic referrals 24/7
• We will provide electronic reports on services and quality in multiple formats
Which would you choose if you were Universal HCBS?

• **For-Profit:** 1 Call does it all
  – 24/7 Electronic referral process
  – Quality and Cost reports automatically submitted weekly
  – Coverage for the entire service area

• **25 Different non-profits**
  – Wide variation in the referral process
  – Wide variation in service area and populations served
  – Limited access to data
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• Know who your customer is
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What Should You Do NOW

• Understand the changing landscape in your community
• Assess the opportunities
• Define the Return on Investment (ROI) for your services
• Assess your IT capacity to meet the needs of the customer
Strategic Planning

- Market Analysis
- SWOT Analysis
- GAP Analysis
- GAP Mitigation Implementation Strategy
- Contract Capture
Some areas find strategic advantages to establishing a network of providers to serve a target population of beneficiaries.

A Network or Coalition may have a strategic advantage in meeting the needs of the customer.

Customer may find greater value in buying services from a network that can meet their need.
Potential Advantages of a Network Approach

• Customer geographic coverage area
• Individual Agency capability to serve the entire customer coverage area
• A Network of providers that ban together may bring strategic advantages to meet the needs of the customer
• Customer advantages
  – Central Referral process
  – Single Contracting process
  – Uniform quality standards
SWOT Analysis Elements

- SWOT should be performed for the individual agency and/or the Network
- SWOT
  - Strengths
  - Weaknesses
  - Opportunities
  - Threats
• In order to prepare for completing a SWOT there are key elements that should be completed first
• If a network will jointly complete a SWOT, then an individual agency assessment should be completed as part of the SWOT
• Pre-SWOT should begin with a Market Analysis
• Market Analysis can also drive the need for a Network strategy
SWOT Goals

- Closely assess potential customers
- Identify the point of pain for the customer
- Implement strategy to address the Customer’s point of pain for the customer
- Customers have more desire to buy services that specifically address a current Customer’s point of pain
  - Identify the point of pain
  - Understand how your services specifically address the customer point of pain
  - Present how you bring continual value to fix the customer point of pain
Pre-SWOT Market Analysis

- Know the current Health Reform Activity in your target area
- List each by topic area
- Define each of the entities that are engaged in these activities in your defined region
  - Medicare vs. MA Population
  - Medicare Advantage Plans
  - Medicaid Managed Care initiatives
  - ACOs
  - Bundled Payment Initiatives
Next Steps

- Know Your Market
- Know Your Competition
- Study Your Customer
- Organize and Execute
Application of the Concept

• Bundled Payment for Care Improvement Initiative
  – Target Population – Medicare Beneficiaries
  – Duals are included if they still maintain their Medicare benefit
  – Medicare Advantage plans are increasingly embracing Bundled Payment
  – Focus of Bundled Payment includes
    • Hospital Care
    • Post-Acute Care cost reduction
      – SNF
Bundled Payments for Care Improvement Initiative (BPCI)

• 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
Medicare Basics

- Medicare (2015) consists of 4 parts
  - Part A
    - Inpatient hospital, SNF care, home health, hospice
  - Part B
    - Doctor services, office visits, screenings, therapies, preventive services, outpatient services, emergency care, ambulance care, medical supplies, & durable medical equipment
  - Part C
    - Medicare Advantage
      - Must cover all Part A and Part B benefits
  - Part D
    - Pharmacy benefits
BPCI Financial Incentives

• Rewards providers for improvements in quality and efficiency of care

• Aligns incentives for coordinated care with the following provider types:
  – Hospitals, Post-Acute Care Providers, Physicians, and other Practitioners
  – Post-Acute Care Providers
  – Home Health Agencies
  – CBOs
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
Eligible Beneficiaries

- Must be enrolled in Medicare Part A and Part B
- Must not have End Stage Renal Disease
- Must not be enrolled in any managed care plan for Medicare benefit coverage
- Beneficiary participates by selecting a participating provider for 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 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
Example

- 68 y/o female admitted to a SNF after knee replacement surgery
- National Range for Knee Replacement surgery
  - $16,500 to $33,000 (90 days Acute + Post Acute Care)
- National Median SNF rate (Private room):
  - $240/day = $7440/mo.
  - $7,440/mo. @ 90 days ($7,440 X 3 = $22,320)
- PT, OT, MD care in addition to the SNF rate
- Post Acute Expense is already +$25K
CBO Partner Example

- 68 y/o female admitted to a SNF after knee replacement surgery
- SNF Stay is limited to 30 days = $7440 (Median SNF Expenditure)
- Day 31, beneficiary is transferred to home
- CBO provides home delivered meals, personal care aide and transportation at a fraction of the cost of the SNF stay
- Bundled Payment facility pays the CBO for services and achieves significant cost savings
CBO Partner Example is a Win – Win for All

- SNF reduces their costs and EARNs savings from the bundled rate
  - If the SNF bundled rate is $25,000, for 90 days
  - Through improved support in the community, the total costs equate to only $18,000, then the SNF retains the additional $7,000 as a BONUS
- SNF is able to free the bed and fill it with another paying customer – while collecting the savings from the bundle ($7,000)
• To SNF or Not to SNF?
• Financially, we do not want to SNF
• Target Price 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
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
Next Steps

- Assess Your Market
- Complete a SWOT
- Mitigate Your Risk to External and Internal Threats
- Network with Others as needed
- Develop a contract capture strategy
- Set a timeline for deliverables
- Execute and Track your success
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