Business Planning for Integrated Programs for Older Adults and Disabled Adults

Presented To:

Vermont Department of Disabilities, Aging and Independent Living

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Topics

- Vermont Target Population
- Options for Consideration in Business Planning
- Review of Business Planning Components

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Vermont Target Population

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Goals of MyCare Vermont

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- Will provide person-centered care for individuals over the age of 18
- Will integrate primary/acute/LTC through an interdisciplinary team
- Will operate through community networks

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Vision of Integrated Care

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- Person-centered interdisciplinary care team
- Centralized comprehensive record
- Flexibility of covered services
- Integrated Medicare and Medicaid funding
- Program savings

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Target Population/Sub Groups

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- Older Adult Population
  - Dual eligibles, including nursing facility (NF) eligibles
  - Medicaid only, including nursing facility eligibles
  - Other older adults not receiving HCB or NF services
- Younger Disabled Population
  - A younger person with disabilities is a person under the age of 65 who qualifies for Medicaid coverage because of a disability
  - 3 broad categories
    - **Persons with physical disabilities**
    - Persons with developmental disabilities
    - Persons with mental illness

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Target Population
As Defined by MyCare Vermont Goals

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Highest Need

Individuals both financially and clinically eligible for long-term care services

High Need

Individuals both financially and clinically eligible for long-term care services but can be put on a waiting list

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Business Case for Integration

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Cost savings to the health care system

- Less use of inpatient care and emergency room
- Greater use of HCB services

→ Improved care and outcomes will lead to business success

More flexible service delivery including consumer-directed care

→ Consumer demands for choice will grow so new models are critical to future growth and financial viability

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MyCare Vermont Business Plans
Options for Consideration
From RFP

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PACE Model

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- Key Attributes:
  - Provider-based model, typically under 1,000 enrollment
  - Tightly controlled care management and utilization systems
- Results In:
  - Excellent care outcomes, high enrollee satisfaction, and low disenrollment rates
  - Established program with a proven track record
  - Serves exclusively a nursing-home eligible population in the community at the time of enrollment

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Medicare Special Needs Plan (SNP) Key Attributes

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- Key Attributes:
  - Insurance model versus provider model
  - Effective care management
  - Strong network development
  - Robust information systems
  - Scalability/size
- Results In:
  - *Evaluation pending*
  - Improved integration of acute/long-term care
  - Improved outcomes
  - Cost savings

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Current Relationships between PACE and SNPs

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- There are several existing relationships between PACE and SNPs
- Sponsoring organizations have both PACE and SNPs
  - Nonprofit HMO sponsor (Massachusetts)
  - Freestanding PACE sponsor (New York)
  - Demonstration Program (Wisconsin)
- Sponsoring organization has PACE and subcontracts with SNP (Massachusetts)
- *Experience so far is successful!*

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Going Beyond PACE to Achieve Vermont's Goals

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- Under current federal legislation, PACE cannot serve the entire population in the MyCare Vermont vision without legislative/regulatory changes
- Limited experience with under-65 disabled population has shown that PACE does not offer the flexibility sometimes desired by the younger disabled population
- Census/volume will reduce start-up costs and speed the time to achieving break even. Consideration should be given to using a single statewide PACE infrastructure to enhance the success of any integrated plan

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Nonprofit, Provider-sponsored Plans have a History of Success

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- Experience in a variety of risk-based, integrated care programs has shown a history of financial success:
  - PACE programs are sponsored by a variety of organizations
  - Wisconsin Partnership Plans are sponsored by community-based service agencies
- Other plans are county based (Arizona, Wisconsin Family Care, Minnesota)

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Option 1:
Expand PACE Statewide

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- Limited to population age 55 that is already NF eligible
- Cannot cover entire target population of older adults and younger adults with physical disabilities
- Can be accomplished in partnership with the existing PACE organization to achieve efficiencies
- Demonstration/legislative changes likely to be required in order to expand PACE to other populations
  - Under age 55
  - Not nursing home eligible

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Option 2: Develop Medicare Special Needs Plan

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- Medicare SNP can be combined with Medicaid capitation to develop an integrated program
- Can cover all populations envisioned by MyCare Vermont
- Can be statewide
- Can include PACE population but is not limited to the PACE population
- No new SNPs can be developed unless legislative authority extended; this is under consideration in the House

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Option 3:
PACE Programs Can Develop SNP

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- Organizations now sponsoring PACE can also develop SNP programs; programs can be statewide
- SNP programs can be developed and can be operated as a separate business line/product
- Both programs can be offered to eligible populations with choice of program by consumer
- Economies of scale possible in infrastructure, such as:
  - Executive Director/CEO
  - Chief Financial Officer
  - Information Technology
  - Human Resources
  - Claims Processing/Data Submission

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Review of

Business Planning Components

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Business Plan Components

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- Integrated Care Model Description
- Integrated Care Financing
- New Business Entity
- Partner Organizations
- Environmental Analysis
- Market Analysis/Capture Rate
- Management Team

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Business Plan Components

- Legislative/Regulatory Issues
- Start-up Challenges
- Operational Plan
- Financial Pro Forma Projections/Sensitivity Analysis
- Risk Assessment
- Exit Strategy
- Timeline for Moving Forward

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Integrated Care Model Description

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- Describe your integrated model of care
  - Identify target population
  - Services provided
- Level of risk is being proposed for services provided
- Carve out of any services
  - For example, MSHO/Minnesota limits nursing home risk to 180 days

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Integrated Care Model Financing

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- Risk sharing with state
- Develop model starting with PACE and/or SNP or new demonstration model
- Consider if other waiver, demonstration, and/or legislation might be necessary

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New Business Entity

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- Create separate business entity
- Additional considerations:
  - Capitalization, including start-up funds
  - Distribution of gains/losses to partner organizations
  - Governance
  - Consider statewide efficiencies in administration on an integrated program

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Each Partner Organization

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- *Are the right organizations included in this partnership?*
- Describe each partner including:
  - Extent to which each organization has served the target population in the past
  - Current geographic reach of each organization and relationship between proposed service area and current service area (if different)
  - Each organization's specific contribution to the new organization/model, including capital and ability to accept proposed risk sharing arrangement
  - History of collaborative relationships among the organizations in this partnership

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Environmental Analysis

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- Describe and understand:
  - Types of providers currently serving your target population
  - Strengths and weaknesses of each program
  - Barriers to enrollment in the integrated program versus the current program
  - How this new integrated program will gain enrollment

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Market Analysis/Target Population

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- Describe your target population
  - PACE only (55+, NF eligible in community)
  - Other chronically ill older adults (not PACE eligible)
  - Disabled younger adults age18 through 65
    - Do you intend to phase in the target populations such as older adult population and then younger disabled population

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Market Analysis/Size of Market

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- Estimate the size of your total target population in the defined market area
- Review Vermont data prepared for this project; seek more recent Vermont data since CHOICES 1115 demonstration implemented
- Review each organization's historical service data
- Review other data sources (census, Claritas)
- Compare/validate all data sources
- Look at possible capture rates specifically from partners or survey referral sources

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Market Analysis/Capture Rate

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- Based upon environmental analysis, estimate percent capture rate of the target population/market
- These estimates are key to financial pro forma analysis
- Undertake sensitivity analysis of enrollment assumptions (critical)
- *If you develop the program, will they enroll?*

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Management Team

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- Consider the following:
  - Do the individuals have the necessary experience in understanding and managing a risk-based product?
  - Have you supplemented the “in kind” resources with sufficient staff?
  - Have you budgeted for additional expertise (e.g., legal, technical, actuarial) as needed?

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Legislative/Regulatory Issues

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- Consider if the following are needed:
  - Modifications to federal regulations or new federal legislation
  - Modifications to state regulations or new state legislation
  - State licensure is needed as a risk-bearing entity
  - Timeline for obtaining regulatory guidance, including initial or working rates for financial analysis

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Start-up Challenges

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- Identify all start-up challenges including:
  - Access to capital necessary for start up and to sustain operations through break even/profitability
  - Ability to attract sufficient staff
  - Marketing compared to competitive programs
  - Organizational challenges of a new partnership

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Operational Plan

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- Administrative services:
  - Enrollment
  - Claims processing
  - Financial management
  - Customer service
- Staffing plan
- Consider statewide efficiencies in administration of an integrated program
- Care management/care coordination
- Network development
  - Services provided by risk sharing partners
  - Services provided by network partners
- Quality management

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PACE Example
Key Assumptions – Start-Up Staffing

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PHILADELPHIA HEALTH MANAGEMENT CORP
PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
STARTUP STAFFING ASSUMPTIONS

DEPARTMENT	POSITION NAME	Month 1-8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18
Transportation	Transportation Coordinator	-	-	-	-	-	-	-	-	-	-	0.50
Transportation	Van Driver	-	-	-	-	-	-	-	-	-	-	0.50
Nursing	RN	-	-	-	-	-	-	-	-	-	-	0.50
Nutrition	Dietician	-	-	-	-	-	-	-	-	-	-	0.50
Social Services	Social Work Director	-	-	-	-	-	-	-	-	-	0.50	1.00
Recreational Therapy	Recreational Therapist	-	-	-	-	-	-	-	-	-	-	1.00
Restorative Therapy	Physical Therapist	-	-	-	-	-	-	-	-	-	-	0.50
Restorative Therapy	Occupational Therapist	-	-	-	-	-	-	-	-	-	-	0.50
Center Support	Center Manager	-	-	-	-	-	-	-	1.00	1.00	1.00	1.00
Center Support	Personal Care Workers	-	-	-	-	-	-	-	-	-	-	1.00
Center Support	Receptionist	-	-	-	-	-	-	-	-	-	-	0.50
In-Home Services	Home Care Coordinator	-	-	-	-	-	-	-	-	-	-	1.00
Primary Care	Staff Physician	-	-	-	-	-	-	-	-	-	-	0.25
Primary Care	Nurse Practitioner	-	-	-	-	-	-	-	-	0.25	0.25	0.50
Administration	Program Director	-	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Administration	Medical Director	-	-	-	-	-	-	-	0.25	0.25	0.25	0.25
Administration	Intake/Referral Coordinator	-	-	-	-	-	-	-	-	0.50	1.00	1.00
Marketing	Director of Marketing	-	-	-	-	-	-	-	-	1.00	1.00	1.00
Medical Records	Clerk	-	-	-	-	-	-	-	-	-	-	0.50
Total		-	1.00	1.00	1.00	1.00	1.00	1.00	2.25	4.00	5.00	13.00

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PACE Example
Key Assumptions – Summary of FTEs

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PHILADELPHIA HEALTH MANAGEMENT CORP
PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
FTE ASSUMPTIONS

			Staffing Ratios					Purchased Service Indicator					Projected FTE's				
POSITION NAME	**Basis**		**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Transportation Coordinator	Fixed Per Program		1.00					N	N	N	N	N	0.50	1.00	1.00	1.00	1.00
Assistant	ADA	1:	174					Y	Y	Y	N	N	-	-	-	0.75	1.00
Van Driver	Census	1:	25					N	N	N	N	N	1.25	3.17	5.00	7.00	8.83
RN	Census	1:	100	100	100	85	90	N	N	N	N	N	1.00	1.33	2.00	2.83	3.00
LPN	Census	1:	120					Y	N	N	N	N	-	1.00	1.92	2.00	2.42
Clinic CNA	Census	1:	170					N	N	N	N	N	1.00	1.00	1.00	1.83	2.00
Dietary Aide	ADA	1:	80					N	N	N	N	N	-	0.75	1.08	2.00	2.00
Dietician	Fixed Per Program		0.50	0.50	1.00	1.50	1.50	N	N	N	N	N	0.50	0.71	1.00	1.42	1.50
Social Work Director	Fixed Per Program		1.00					N	N	N	N	N	1.00	1.00	1.00	1.00	1.00
Social Worker	Census	1:	50					Y	N	N	N	N	-	1.83	2.78	3.74	4.70
Recreational Therapist	Census	1:	170					N	N	N	N	N	1.00	1.00	1.00	1.83	2.00
Activity Aide	ADA	1:	45					Y	N	N	N	N	-	1.50	2.00	2.67	3.00
Physical Therapist	Census	1:	175	175	175	175	175	N	N	N	N	N	0.50	0.54	0.80	1.07	1.34
Physical Therapist Assistant	Fixed Per Program		0.00	1.00	1.00	1.00	1.00	Y	Y	N	N	N	-	-	1.00	1.00	1.00
Restorative Aides	Census	1:	150					Y	N	N	N	N	-	1.00	1.25	2.00	2.00
Occupational Therapist	Census	1:	175	175	175	175	175	N	N	N	N	N	0.50	0.54	0.83	1.08	1.34
OT Assistant	Fixed Per Program		0.00	1.00	1.00	1.00	1.00	N	N	N	N	N	-	0.42	1.00	1.00	1.00
Speech Language Therapist	Census	1:	300					Y	N	N	N	N	-	0.30	0.46	0.62	0.78
Center Manager	Census	1:	175	175	175	175	175	N	N	N	N	N	1.00	1.00	1.00	1.83	2.00
Personal Care Workers	ADA	1:	10					N	N	N	N	N	2.25	5.08	7.50	9.92	12.25
Receptionist	Census	1:	175	175	175	175	175	N	N	N	N	N	1.00	1.00	1.00	1.79	2.00
Home Care Coordinator	Census	1:	300	300	300	300	300	N	N	N	N	N	1.00	1.00	1.00	1.00	1.00
Staff Physician	Census	1:	125					N	N	N	N	N	0.34	0.73	1.12	1.49	1.88
Nurse Practitioner	Census	1:	100	100	100	100	100	N	N	N	N	N	1.00	1.33	2.00	2.25	3.00
Program Director	Fixed Per Program		1.00					N	N	N	N	N	1.00	1.00	1.00	1.00	1.00
Medical Director	Fixed Per Program		0.50	1.00	1.00	1.00	1.00	N	N	N	N	N	0.50	1.00	1.00	1.00	1.00
Intake/Referral Coordinator	Fixed Per Program		1.00	1.00	1.00	2.00	2.00	N	N	N	N	N	1.00	1.00	1.00	1.83	2.00
Director of Marketing	Fixed Per Program		1.00					N	N	N	N	N	1.00	1.00	1.00	1.00	1.00
Marketing Staff	Fixed Per Program		0.00	0.00	1.00	1.00	1.00	N	N	N	N	N	-	-	1.00	1.00	1.00
Clerk	Census	1:	175	175	175	175	175	N	N	N	N	N	1.00	1.00	1.00	1.75	2.00
Housekeeper	Census	1:	175	175	175	175	175	N	N	N	N	N	0.50	1.00	1.00	1.42	1.50
Maintenance Worker	Fixed Per Program		1.00	1.00	1.00	1.00	1.00	N	N	N	N	N	1.00	1.00	1.00	1.00	1.00
											Total FTE's		**19.84**	**34.24**	**46.73**	**63.12**	**72.55**
											Census		**38**	**91**	**139**	**187**	**235**
											ADA		**19**	**46**	**70**	**94**	**118**

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Financial Pro Forma Projections

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- Use best available data and revise as more accurate information becomes available
- Financial statements should include income statement, balance sheet, cash flow statements, break-even analysis, and start-up costs
- Sensitivity analysis should be undertaken on key assumptions
- Consider any necessary risk reserves as required by state or federal regulators

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Determine Financial Outcomes

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Financial Term	Definition
Break-even Census	The census level that created a break-even cash flow
Break-even Time Frame	Number of operating months before a break-even cash flow for the month
Payback Period	Number of months before the initial investment was recouped in cash
Current Operating Margins	Percent of operating profit to total revenues

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PACE Enrollment Growth Sensitivity Example

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Statistic	Experience	Minimum	Impact
Net Growth	1 to 12 per month	3 per month	Five year impact of achieving 5 instead of 3: **Doubling of Cash and operating income**
Initial Census	1 to 20 participants	5 per month	First year impact of opening with 20 instead of 8: **Break-even occurs 4 months earlier and operating losses drop by $500,000**

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Risk Assessment

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- Consider and identify all business risks, including:
  - Enrollment risk
  - Utilization risk
  - Payment Risk
    - Medicare payment risk
    - Medicaid payment risk
- Sustained state commitment
  - Providers are assured of Vermont's Commitment

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Enrollment Risk

- Enrollment is difficult to predict and critical to success
- Greater initial enrollment and growth results in accelerated break even

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Utilization Risk

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- Hospital
- Nursing Home
- Pharmacy

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Payment Risk

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- Medicare Payment Risk
  - Cannot be controlled by provider
  - Adjustments to Medicare payments are now being discussed in Congress
  - Payment systems are imperfect and do not predict risk-adjusted costs with precision
  - Need sensitivity analysis
- Medicaid Payment Risk
  - Seek risk sharing with state
  - Seek stable payment approach with refinement as needed

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Exit Strategy

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- A complete business plan should:
  - Identify the criteria upon which the organization would exit the business
  - Develop plans for ensuring that enrollees received needed care

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Timeline for Moving Forward with Business Plan for New Integrated Model

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PHASE I	PHASE 2	PHASE 3	PHASE 4
Planning and Conceptual Development	Initial Business Plan (Due to State)	Refine Model in Discussion with State State pursues necessary action steps	Refine Business Plan Consider collaborative business plans among regions

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Making the Decision to Proceed

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- This new integrated program fills an unmet need that is different than any other individual organization in the marketplace
- This new integrated program is a good fit with the sponsoring organization's current mission, strategic direction, and services
- This new integrated program is financially viable and offers a reasonable return on investment for a nonprofit health care organization

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Making the Decision to Proceed

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- The financial projections in this business plan are realistic and attainable. Sensitivity analysis has been undertaken which shows the range of financial performance
- The management team is capable of achieving the desired financial and operating results
- The organization can manage the identified risk, but has an exit plan that can be carried out if unforeseen circumstances arise

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Closing Thought

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"Even if you are on the right track, you'll get run over if you just sit there.

Will Rogers

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Supplemental Information on MSHO and Mass SCO Rates

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Minnesota Senior Health Options Rate Structure

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Rate Cell Category	Column 1 RCC-D	Column 2 RCC-C	Column 3 RCC-B	Column 4 RCC-A
	Nursing Facility (NF) Enrollees	**Community Nursing Home Certifiable (NHC) Conversions**	**Community NHC/ Elderly Waiver (EW) Diversions**	**Community Non-NHC**
Medicare	- 90% M+C Demographic Rate - 10% HCC Risk Adjustment	- 90% M+C Demographic Rate with PACE Risk Factor (2.39) - 10% HCC Risk Adjustment with Frailty Factor		- 90% M+C Demographic Rate - 10% HCC Risk Adjustment
Medicaid Acute Care/Ancillary Services	Institutional PMAP rate	Institutional PMAP rate	Non-institutional PMAP rate + NF Add-on	Non-institutional PMAP rate + NF Add-on
Medicaid Long-term Care Costs	180 day NF liability Present system	2 X average monthly Elderly Waiver payment	Average monthly Elderly Waiver payment	N/A

Medicare payments – Beginning in January 2004, 10% of the Medicare payment is based on the CMS-HCC (Hierarchical Condition Categories) model. Prior to 1/1/04, 100% of the MSHO Medicare payment was based on the demographic model.

Medicaid payments Payment for acute care services under MSHO consists of the same rates made for PMAP enrollees with the following modifications: (1) For Conversions (RCC-C), MCOs receive the institutional PMAP rate. They also receive 2 times the average monthly EW payment for a maximum of 12 months following discharge from the NF; (2) For Community NHC enrollees (RCC-B), Medicaid pays the average monthly EW payment and the NF Add-on, payment for the 180-day liability policy; (3) For Community Non-NHC enrollees (RCC-A), Medicaid pays the NF Add-on.

MSHO Risk Arrangements All MSHO MCOs participate on a risk basis.

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Statewide MSHO Average Rates for 2007

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Aged Institutionalized						
Age	**Sex**	**Basic Rate**	**NF Add-On Metro**	**NF Add-On Non-Metro**	**EW Add-On Metro**	**EW Add-On Non-Metro**
65-74	Female	$ 439.83	$ -	$ -	$ -	$ -
75-84	Female	$ 307.02	$ -	$ -	$ -	$ -
85+	Female	$ 221.24	$ -	$ -	$ -	$ -
No Medicare 65+	Female	$ 1,333.19	$ -	$ -	$ -	$ -
65-74	Male	$ 423.69	$ -	$ -	$ -	$ -
75-84	Male	$ 345.97	$ -	$ -	$ -	$ -
85+	Male	$ 271.68	$ -	$ -	$ -	$ -
No Medicare 65+	Male	$ 1,362.51	$ -	$ -	$ -	$ -

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Statewide MSHO Average Rates for 2007

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Aged Non-Institutionalized						
Age	Sex	Basic Rate	NF Add-On Metro	NF Add-On Non-Metro	EW Add-On Metro	EW Add-On Non-Metro
65-74	Female	$ 515.70	$ 52.14	$ 45.01	$ 847.41	$ 863.79
75-84	Female	$ 616.04	$ 123.92	$ 106.96	$ 989.45	$ 1,026.04
85+	Female	$ 616.04	$ 131.05	$ 113.12	$ 1,309.13	$ 1,333.32
No Medicare 65-74	Female	$ 1,105.80	$ 58.19	$ 50.23	$ 847.41	$ 863.79
No Medicare 75-84	Female	$ 1,105.80	$ 138.29	$ 119.37	$ 989.45	$ 1,026.04
No Medicare 85+	Female	$ 1,105.80	$ 146.25	$ 126.24	$ 1,309.13	$ 1,333.32
65-74	Male	$ 483.25	$ 61.36	$ 52.96	$ 935.56	$ 1,007.58
75-84	Male	$ 651.95	$ 129.07	$ 111.40	$ 860.03	$ 1,009.44
85+	Male	$ 651.95	$ 135.30	$ 116.79	$ 1,067.05	$ 1,150.79
No Medicare 65-74	Male	$ 1,092.00	$ 68.48	$ 59.11	$ 935.56	$ 1,007.58
No Medicare 75-84	Male	$ 1,092.00	$ 144.04	$ 124.33	$ 860.03	$ 1,009.44
No Medicare 85+	Male	$ 1,092.00	$ 151.00	$ 130.34	$ 1,067.05	$ 1,150.79

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Massachusetts
Medicaid Rates for Contract Year 2007

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	Community Settings of Care			Institutional Settings of Care		
	Other	AD/CMI	NHC	Tier 1	Tier 2	Tier 3
Dually Eligible	**RC 20**	**RC 22**	**RC 24**	**RC 26**	**RC 27**	**RC 28**
Boston	$161.49	$616.23	$2,738.59	$4,641.15	$6,604.95	$8,368.60
Dually Eligible, Non-Boston	**RC 21**	**RC 23**	**RC 25**	**RC 26**	**RC 27**	**RC 28**
Outside Greater Boston	$168.15	$654.75	$2,993.15	$4,641.15	$6,604.95	$8,368.60
MassHealth Only, Boston	**RC 30**	**RC 32**	**RC 34**	**RC 36**	**RC 37**	**RC 38**
Boston	$938.80	$2,468.46	$7,404.45	$4,641.15	$6,604.95	$8,368.60
MassHealth Only, Non-Boston	**RC 31**	**RC 33**	**RC 35**	**RC 36**	**RC 37**	**RC 38**
Outside Greater Boston	$771.16	$2,083.47	$6,578.59	$4,641.15	$6,604.95	$8,368.60

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