Montana Medical Association Annual Membership Meeting

The Brave New World of Value-Based Reimbursement: What Physicians Need to Know

September 2014
Overview of SSB Clients and Services

CLIENT CATEGORIES

Health Systems/Hospitals
- Regional non-profit systems
- For-profit hospital systems
- Community hospitals (urban/rural)

Physician Organizations
- Large groups
- Intermediate-sized groups
- National associations

Health Plans
- Commercial
- Medicare
- ERISA plans
- Healthcare exchanges

Healthcare Suppliers
- Healthcare IT
- Pharma/Biotech
- Medical Devices

STRATEGIC ADVISORY SERVICES

Clinical Integration Planning and Implementation
- ACOs, CIOs and Specialty CIOs
- Population health management
- Care management and clinical quality
- Shared savings and bundled payment Initiatives
- Governance and management
- Physician communications

Market-Driven Physician Alignment
- Physician employment
- Service line Co-management
- Specialty institutes and Centers of Excellence
- Professional services agreements

Payer Strategies and Contracting
- Transitioning to value-based reimbursement
- Risk analysis
- Performance assessment
- Network development

Strategic Partnering and Collaboration
- Introductions and assessment of strategic fit
- Due diligence
- Integration planning
- Leadership recruiting
- Post-integration advisory services
# SSB Client Projects Focused on Integration and Alignment

## Hospitals/Health Systems
- Adventist Health System (Florida)
- Alegent Health (Nebraska)
- Aspirus Health System (Wisconsin)
- Benefis Health System (Montana)
- Catholic Healthcare West (Arizona)
- Dean Health System (Wisconsin)
- Delta Dental Health Services

## Physician Organizations
- Alegent Health Clinic (Nebraska)
- Barrow Neurological Associates (Arizona)
- Dean Clinic (Wisconsin)
- Greeley Medical Clinic (Colorado)
- The Heart Center (Alabama)
- ProHealth Care (Connecticut)

## MONTANA CLIENTS
- Benefis Health System
- Bozeman Deaconess Hospital
- Community Medical Center
- St. Peters Hospital
- Dean Health System (Wisconsin)
- ProHealth Care (Connecticut)
Today’s Presentation and Discussion

- Mapping the Terrain: Understanding the Healthcare Landscape Today
- Understanding “Value”: Where You Stand Depends on Where You Site
- Value-Centric Reimbursement Models: What Physicians Need to Know

PROCESS

Questions
Perspectives
Exchange of Ideas
Interactive Engagement

GOAL

Informed
Consideration
of Changes on the Horizon
Mapping the Terrain: Understanding the Healthcare Landscape Today

Montana Medical Association Annual Membership Meeting
The Brave New World of Value-Based Reimbursement: What Physicians Need to Know
September 2014
A Brief History of Medicine

2000 BC “Here, eat this root.”
1000 BC “That root is heathen, say this prayer.”
1850 AD “That prayer is superstition, drink this potion.”
1940 AD “That potion is snake oil, swallow this pill.”
1975 AD “That pill is ineffective, take this antibiotic.”
1990 AD “Managed care will correct all that ails us.”
1995 AD “Managed care could be dangerous.”
2000 AD “Antibiotics are artificial; here, eat this root.”
2010 AD “Value is finally upon us . . . as are rules, regulations, requirements . . .”
2014 AD “Obamacare takes root… here, say this prayer!”
Navigating the Perfect Storm

U.S.S. Healthcare System

- Too much cost
- Too many patients
- Too little funding
- Too few professionals
US Health Spending per Capita

2002: $5,693
2004: $6,508
2006: $7,264
2008: $7,936
2010: $8,411
2012: $8,915
2014P: $9,697

70% increase 2002-2014

Notes: Health spending refers to National Health Expenditures. Projections (P) include the impact of the Affordable Care Act.
Breakdown of US Healthcare Expenditures

TOTAL SPENDING
$2.8 Trillion
Which Areas are Growing the Fastest?

Average Annual Growth, 1992–2012
- Hospital Care: 5.6%
- Physician and Clinical Services: 5.6%
- Prescription Drugs: 9.0%
- CPI: 2.5%

Notes: Health spending refers to National Health Expenditures. CPI is Consumer Price Index. See page 29 for more information on changes in prescription drug spending growth.
Health Insurance Spending Per Enrollee (2012 vs. 2014)

MEDICARE
- 2012: $11,519
- 2014P: $12,051

MEDICAID
- 2012: $7,535
- 2014: $7,565

EMPLOYER-BASED COVERAGE
- 2012: $5,128
- 2014: $5,664

Projected Growth,* 2012–2014
- Medicare: 2.3%
- Medicaid: 0.2%
- Employer-Based Insurance: 5.1%

*Projected growth calculations are average annual figures per enrollee. Note: Projections (P) include the impact of the Affordable Care Act. Source: Author calculation based on Centers for Medicare & Medicaid Services (CMS), National Health Expenditures, 2014 release (historical) and 2013 release (projections), www.cms.gov.
Escalation in Average Commercial Premiums

Average Annual Premiums: 1999 - 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Single Coverage</th>
<th>Family Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>$2,196</td>
<td>$5,791</td>
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<tr>
<td>2000</td>
<td>$2,471*</td>
<td>$6,438*</td>
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<tr>
<td>2001</td>
<td>$2,689*</td>
<td>$7,061*</td>
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<tr>
<td>2002</td>
<td>$3,083*</td>
<td>$8,003*</td>
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<tr>
<td>2003</td>
<td>$3,383*</td>
<td>$9,068*</td>
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<tr>
<td>2004</td>
<td>$3,695*</td>
<td>$9,950*</td>
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<tr>
<td>2005</td>
<td>$4,024*</td>
<td>$10,880*</td>
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<tr>
<td>2006</td>
<td>$4,242*</td>
<td>$11,480*</td>
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<td>2007</td>
<td>$4,479*</td>
<td>$12,106*</td>
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<tr>
<td>2008</td>
<td>$4,704*</td>
<td>$12,680*</td>
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<tr>
<td>2009</td>
<td>$4,824</td>
<td>$13,375*</td>
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<tr>
<td>2010</td>
<td>$5,049*</td>
<td>$13,770*</td>
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<tr>
<td>2011</td>
<td>$5,429*</td>
<td>$15,073*</td>
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<tr>
<td>2012</td>
<td>$5,615*</td>
<td>$15,745*</td>
</tr>
<tr>
<td>2013</td>
<td>$5,884*</td>
<td>$16,351*</td>
</tr>
</tbody>
</table>

The Growing Burden of Carrying Coverage

**Graph Description:**
- **Health Insurance Premiums**
- **Workers' Contribution to Premiums**
- **Workers' Earnings**
- **Overall Inflation**

- **X-axis:** Years from 1999 to 2013
- **Y-axis:** Percentage increase from 0% to 250%

**Key Points:**
- Health insurance premiums increased by 196% from 1999 to 2013.
- Workers' contributions to premiums increased by 182%.
- Workers' earnings increased by 182%.
- Overall inflation increased by 150%.

**Source:**
Decreasing Employer Ability to Provide Insurance

**Percentage of All Firms Offering Health Benefits: 1999-2013**

- **All Firms**
- **Firms with 3-9 Workers**

Grading Our $3 Trillion Delivery System

Overall performance of the U.S. health care system

Using a typical report card scale with grades of A, B, C, D, and F, with A being excellent and F being failing, how would you grade the overall performance of the U.S. health care system?

<table>
<thead>
<tr>
<th></th>
<th>Employers</th>
<th>Physicians</th>
<th>Consumers*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favorable “A” or “B”</td>
<td>33%</td>
<td>31%</td>
<td>21%</td>
</tr>
<tr>
<td>Average “C”</td>
<td>38%</td>
<td>44%</td>
<td>31%</td>
</tr>
<tr>
<td>Poor “D” or “F”</td>
<td>29%</td>
<td>25%</td>
<td>45%</td>
</tr>
</tbody>
</table>

Source: Deloitte Center for Health Solutions: 2013 Survey of U.S. Employers
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A Complex Story Simplified....Where We Are Today

Affordable Care Act

Market Pressures

Shift from Fee-For-Service to Fee-For-Value
Shift from Employer to Individual Plan Purchase (Public and Private Exchanges)

Intensified Focus on Price/Value Relationship in Healthcare Benefits and Services

MINIMIZE PRICE
Payers: Offer “Low” Premiums
Providers Pursue Population Health Mgmt.
Care coordination and management on top 20% of patients generating 80% of costs
Optimizing overall care continuum to ensure right service by right provider in right setting for all patients

MAXIMIZE VALUE
Provider Access
Quality of Care
Patient Outcomes
Level of Service

Systemic Synergy and Tension
Physicians at a Crossroads

**Eroding Practice Financials**
- Declining professional fees
- Decreased ancillary reimbursement
- Rise in practice costs
- Recruitment challenges

**Challenge of Pending Healthcare Reforms**
- Adapting to new clinical models
- Intensified emphasis on “value” and “quality”
- Increasing reliance on EMRs
- Increased payment risk

**Local Market Forces**
- Formation of narrow provider panels
- Increased demand for services
- Growing sophistication of competitors
Top Practice Challenges Today

Wolter Kluwer Health 2013 Physician Outlook Survey
In-depth interviews with 300 practicing primary care physicians

Top four areas most frequently identified as “Very Challenging” or “Challenging”

- **Shifting Reimbursement** (91%)
- **Financial Management** (90%)
- **Time with Patients** (88%)
- **Affordable Care Act** (84%)
Private Practice Exodus to Hospital Employment

Although the total number of physicians is increasing, the percentage that are truly independent is declining 2000 – 2013 (thousands)

Source: Accenture Analysis, MGMA, AMA

Source: MGMA
Private Practice Employment Shift by Specialty

Shifts in Major Specialties

Percentage of Respondents in Hospital/IDS Practices

- Cardiology
- Internal Med
- Neurology
- Pediatrics
- Hematology/Oncology
- OB/GYN
- Radiology
- Orthopedic Surgery
- Gastroenterology
- Urology
- Anesthesiology

Questions

1) To what degree are these changes and challenges reflected today in Montana market?

2) Which aspects of the reforms are moving most quickly?

3) Which delivery systems and provider groups appear most engaged?
Understanding “Value”: Where You Stand Depends on Where You Site
Value = Patient Outcome / Cost

“In any field, value should be defined around the customer, not the supplier. In health care, value is defined as patient health outcomes achieved relative to the costs of care. It is value for the patient that is the central goal, not value for other actors per se.”


(10.1056/NEJMp1011024).
Value: Patient’s Perspective

Value = \frac{Quality of Experience + Outcome}{Cost}

Achieving expected outcomes

Physician communication and interaction

Ease of access

Friendly, caring and responsive staff

Reasonable cost

Value: Patient's Perspective
Value: Clinician’s Perspective

Value = Quality of Experience / Cost

Value: Clinician’s Perspective

Value = Quality of Experience / Cost

Degree of autonomy

Purposeful and meaningful work

Trustworthy systems

Supportive, knowledgeable colleagues

Quality focused and committed support staff

Satisfactory compensation

Learning environment

Work/life balance
Value: Hospital/Health System Perspective

Value = \frac{\text{Quality of Service} + \text{Reputation}}{\text{Cost}}

- Highly productive clinicians
- Favorable payer relationships
- Financially sustainable operating model
- Engaged and committed employees
- Safe, quality-focused care
- High patient satisfaction
- Efficient, integrated care
- Market competitive prices
- Financially sustainable operating model
- Engaged and committed employees
- Safe, quality-focused care
- High patient satisfaction
- Efficient, integrated care
- Market competitive prices

Value = \text{Hospital/Health System Perspective}

27
Value: Health Plans

Value = \[
\text{Quality of Service} + \frac{\text{Reputation}}{\text{Cost}}\
\]

- Loyal clients
- Satisfied members
- Manageable financial risk
- High-performance networks
- Growing market share in key categories
- Brand respect
- Productive provider relationships
- Market competitive prices
- Brand respect
- Productive provider relationships
- Market competitive prices
The Promised Land?

Accountable Care

Value-based, data-driven, patient-centered care model that rewards quality over quantity

COLLABORATION IS KEY

Clinicians
share information to coordinate care and apply evidence-based medicine

Providers and payers
collaborate to align incentives and establish gain- or risk-sharing agreements

Patients
engage more actively with their care team

Population Health Management

An organized system of care that leverages multifactorial care coordination, technology and patient engagement to optimize the health outcomes and total cost of care for a defined population
Significant Transformation of Clinical and Financial Models

FEE-FOR-SERVICE MODEL

PRIMARY CARE

SPECIALTY CARE

ACUTE INPATIENT CARE

VALUE-BASED MODEL

PRIMARY CARE

SPECIALTY CARE

ACUTE INPATIENT CARE

PRIMARY CARE

SPECIALTY CARE

ACUTE INPATIENT CARE

FEE-FOR-SERVICE MODEL
Meeting the Needs of the Most Expensive

- **5%** - Polychronic
- **20%** - At-risk for major procedures (e.g., cardiology, oncology)
- **75%** - Healthy, minor health issues

**Patient Populations**

**Cost Breakdown**

- **45%** - ER visits, overutilization, high care variation, noncompliance
- **35%** - Infections, complications, rehospitalizations
- **20%** - Other costs
CareMore’s Integrated Care Management Model

Medicare Advantage and “Medi-Medi”

Risk-adjusted capitated payments

Clinical care centers
- Health/nutritional education
- Fall prevention clinic
- Diabetes care program
- Hypertension program
- Foot clinic

30 needs-based, intensified care platforms

Remote bio-monitoring
Rank top 5% clinical quality and patient satisfaction scores
Care for Patient with Single Chronic Disease

- **5%** Polychronic
- **20%** At-risk for major procedures (e.g., cardiology, oncology)
- **75%** Healthy, minor health issues

**Third largest health system in Wisconsin**

**Top preforming Pioneer ACO for CMS**
- 4.6% cost reduction on 20,000 beneficiaries
- $5.2M award to system

**Robust medical home network with embedded care managers**

**CQI pushed through LEAN model dozen years previous**
Innovative care delivery models leveraging technology and access aggressively pursuing traditional, office-centric primary care business

Fragmentation of Traditional Primary Care Marketplace

- **Polychronic**
  - 5%
  - ER visits, overutilization, high care variation, noncompliance

- **At-risk for major procedures (e.g. cardiology, oncology)**
  - 20%
  - Infections, complications, rehospitalizations

- **Healthy, minor health issues**
  - 75%
  - 20%

Tele-Consults
- Home/Worksites
- “House calls”

Minute Clinics

Innovative care delivery models leveraging technology and access aggressively pursuing traditional, office-centric primary care business
Questions

1) How are you defining “value” in your practice or large group?

2) Are you started to segment or stratify patients based on clinical condition and utilization patterns? If so, in what context?

3) Are you aware of new, non-traditional competitors emerging in the care delivery market? If so, who is most worrisome?
Value-Centric Reimbursement Models: What Physicians Need to Know
Next Generation Payment Focus

**Fee-for-Service**
- Reward volume over value of services
- Fail to distinguish differences in quality of care
- Spotlight inequities in access
- Limit physician/patient face time to deal with complex or challenging conditions
- Discourage coordination of care over time and across the continuum of care

**“Value-Based” Payment**
- Support engagement of patients in treatment decision-making process
- Pay for team-based care
- Focus on total/episodic care payment,
- Pay based on evidence-based care
- Reward providers for resource use tied to superior outcomes
- Tied to measurable standards clear to providers and consumers
- Rewards innovative approaches to care delivery

$=$
- Shared savings
- Bundles payments
- At-risk fees
VB Contracts Can Provide Significant Incentives to Physicians

PCP and Specialty Strategies that will be employed by the CIN should be structured to take advantage of all available revenue streams and payment methodologies.

**Premium Revenue**

Administrative Fees

- Admin Costs and Contingency

$ Premium Revenue

Medical Loss Ratio (MLR)

Fee-For-Service

- Value-Based Performance Payments
  - Shared Savings
  - Clinical Quality Targets
  - Patient Satisfaction Targets

- New revenue stream

- Qualifying Physicians (Usually PCPs)
  - Specialists
  - Hospitals
  - Ancillary Providers
  - Rx/Lab
  - Other
Evolution of Risk-Based Reimbursement for Providers.

- **2014**: Fee For Service
- **2015**: Population-Based Shared Savings—Upside Risk Only
- **2016**: Population-Based Shared Savings—Upside and Downside Risk
- **2017**: Episodes of Care Bundles—Upside and Downside Risk
- **2018**: Full Risk
  - Population Health Management (Global Risk)
Key Components of Integrated Clinical Care

ACO Clinical Model

OUTREACH AND ENGAGEMENT
- Health management
- Wellness promotion

OUTCOME MEASUREMENT
- Benchmarking and identification of best practices
- Reporting of accurate, actionable and timely information
- Patient and Provider Satisfaction measurement

PROCESS IMPROVEMENT AND INNOVATION
- Define new approaches to improve outcomes

PHARMACY MANAGEMENT
- Appropriate use of drugs
- Prevent inefficient drug utilization
- Prevent fraud, abuse and misuse
- Reconcile medications between care settings

CHRONIC DISEASE MANAGEMENT
- Disease management for patients with common health conditions
- Case management for patients with multiple diagnoses compounded by social and behavioral issues
- Catastrophic or complex case management

CARE TRANSITIONS
- Manage patient care post-discharge
- Coordination of care between providers and community resources
- Prevention of avoidable re-admissions

INPATIENT CARE
- Identify patients admitted to IP and observation status
- Use standard criteria for appropriate level of care and length of stay
- Intensify focus on discharge planning
ACO Organizational Model (Hospital/Physician Partnership)

System Level ACO Council
(Physicians/Hospitals)
- Strategic risk guidelines
- Strategic clinical and care coordination priorities
- Strategic IT guidance and support

Hospitals
- Standardization of clinical pathways
- Quality tracking
- Hospital cost savings

physician Orgs.
- Clinical integration
- Care coordination (Medical Home)
- Best practices
- EMR adoption

Physician/Hospital Management Councils
COUNCILS RESPONSIBLE FOR
- Clinical integration priorities
- Care coordination programs
- Cost reduction
- Implementation and tracking of quality metrics
FTC Clinical Integration Criteria for Risk-Based Contracting

- Clear integration and interdependence between providers
- In-network referrals of both primary and specialty physicians
- Development, training, promotion and tracking of clinical standards, benchmarks and protocols
- Integrated IT
  - Efficient exchange of clinical information across care continuum
  - Utilization data gathered, analyzed and shared with CIO provider
- Defined processes for tracking provider adherence to protocols
How the CMS ACO Program Works

**1. Identify ACO Members**
CMS identifies ACO members based on Medicare beneficiaries use of primary care services.

**2. Calculate Performance Score**
CMS calculates a performance score for the ACO which must exceed a minimum performance threshold for the ACO to share in saving.

**3. Calculate Benchmark Target Cost**
CMS calculates a benchmark/target cost level based upon historical cost and utilization.

**4. Compare Actual Costs to Benchmarks**
CMS compares actual costs to the benchmark costs to calculate savings/losses.

**Share Available Savings with ACO**

$$$$
ACO Success Tied to 33 Key CMS Performance Metrics

**Better Care for Individuals (13):**
- Preventative Health
- Patient/Caregiver Experience

**At Risk Population:**
- Diabetes
- Heart Failure
- Hypertension
- Ischemic Vascular Disease
- Coronary Heart Disease

**Better Care for Populations (20):**
- Care Coordination
- Patient Safety

At Risk Population: Hypertension
- Diabetes
- Ischemic Vascular Disease
- Coronary Heart Disease
CMS Shared Savings Calculation: One-Sided Model

An ACO must meet two key thresholds to participate in shared savings

**Threshold 1**

**Minimum Savings Rate Threshold**

Threshold varies with the number of members (to acknowledge the variability of smaller population costs)

Varies from a high of 3.9% for 5,000 members to a low of 2.0% for 60,000 or more members

**Threshold 2**

**Minimum Performance Threshold**

Must achieve 30th percentile on at least one performance measure within each domain

If these thresholds are met:

• ACO shares in first dollar savings

• ACO’s share of savings are capped at 10% of benchmark costs
Key Functional Requirements for ACO

ACO MUST HAVES...

- Network scaled to deliver care across all settings and specialties
- Legal framework and capabilities to enable joint contracting and single-signature authority
- Well-defined governance and decision-making structure
- Clear alignment of financial incentives among participants toward common objectives
- Capability of accepting common financial risk for performance and of internally distributing revenues and expenses.
- Sufficient numbers of patients to support comprehensive performance measure and reporting
ACO Typically Anchored by Medical Home “Ecosystem”

Patient Panel

- Primary care services
- Disease management
- Prevention/wellness

ACO

- Manage population health in partnership

Payers

- Care Management Fees
- Performance Bonuses
- Shared Savings

Hospitals and Specialists

- Clinical metrics and disease targets
- Clinical protocols
- Performance tracking

Community Resources

- Care management
- Patient communication and engagement
- Quality and safety
- Enhanced access

Clinical Resources

- Shared clinical data
- Care transitions

PCMH

- EMR
- Disease Registries

Attribution

Patient Stratification
# PCMH Payment Model Examples

<table>
<thead>
<tr>
<th>MODEL</th>
<th>CASE EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FFS with discrete new codes</strong></td>
<td>• BCBSMI: pays T-Codes for practice-based care management</td>
</tr>
<tr>
<td></td>
<td>• Horizon BCBS of NJ: pays for traditionally non-reimbursed care management services</td>
</tr>
<tr>
<td><strong>FFS with higher payment levels</strong></td>
<td>• BCBSVT: pays enhanced rates to qualifying practices for office-based E&amp;M, consultations, preventive medicine, and counseling codes</td>
</tr>
<tr>
<td></td>
<td>• BCBSMI: plans to pay 10% higher E&amp;M code rates to qualifying practices beginning mid-2009</td>
</tr>
<tr>
<td><strong>FFS with PMPM payment</strong></td>
<td>• Vermont Blueprint: three insurers and state Medicaid pay FFS with sliding scale PMPM based on achievement against NCQA PCMH standards and financial support/resources for embedded care manager</td>
</tr>
<tr>
<td><strong>FFS with PMPM and P4P</strong></td>
<td>• THINC RHIO: FFS with enhanced PMPM payment for PCMH structural measures and for performance on 10 HEDIS measures</td>
</tr>
</tbody>
</table>
Evolution of Risk-Based Reimbursement for Providers.

- **2014**: Fee For Service
- **2015**: P4P Incentive and Medical Home Payments
- **2016**: Population-Based Shared Savings—Upside and Downside Risk
- **2017**: Episodes of Care Bundles—Upside and Downside Risk
- **2018**: Population Health Management Global Risk

Full Risk
Fragmented delivery of medical services and provider payments

**Provider Services Today**

- **INITIAL INPATIENT STAY**
  - Part B Service

- **Post Acute Services** (Rehab, Psych, LTC, SNF, HH)
  - Office Visit

- **Other Part B Services** (Hospital Outpatient, Labs)

- **Readmission**
  - Part B Service

**Time**
Bundled Services Focused on “Episode of Care”

Coordinated delivery of services guided by evidence-based pathways

$ Single payment split in accordance with formula between participating parties

INITIAL INPATIENT STAY

Part B Service

Post Acute Services (Rehab, Psych, LTC, SNF, HH)

Office Visit

Readmission

Part B Service

Other Part B Services (Hospital Outpatient, Labs)

Office Visit

TIME
Bundled Payments Summary

- Provider reimbursement for provision of multiple health care services associated with a defined episode of care under one, all-inclusive payment
  - Includes payment for all of a patient services for a certain procedure or diagnosis over a set number of days (usually from 30-120)
  - Episode of care can be either acute or chronic

- Savings “delta” between the set payment and actual costs is shared

Calculating the Bundle

Base cost associated with typical care for covered services × Severity adjustment based on patient acuity + Allowance for potentially avoidable complications + Projected margin

DATA ANALYTICS

- Identify bundle components
- Discern patterns, variances and opportunities for efficiency
- Compare performance to benchmarks
- Determine potential for shared savings
CMS Bundled Payments for Care Improvement (BPCI)

- Significant number of hospitals, health systems and post-acute providers have embraced participation BPCI

- BPCI offers four participation models shown in table below
  - Model 1 covers all DRGs
  - Models 2-4 cover DRGs for 48 defined clinical episodes of care

<table>
<thead>
<tr>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All acute patients, all DRGs</td>
<td>Selected DRGs, hospital plus post-acute period</td>
<td>Selected DRGs, post-acute period only</td>
<td>Selected DRGs, hospital plus readmissions</td>
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<tr>
<td><strong>Services included in the bundle</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Part A services paid as part of the MS-DRG payment</td>
<td>All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>All non-hospice Part A and B services during the post-acute period and readmissions</td>
<td>All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions</td>
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<tr>
<td><strong>Payment</strong></td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
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</table>

CMS Bundled Payments for Care Improvement (BPCI)

BPCI Participants (All Model)

Ground Level View in Montana: Key Questions for Physicians

Montana Medical Association Annual Membership Meeting
The Brave New World of Value-Based Reimbursement: What Physicians Need to Know
September 2014
Key Questions for Consideration

1) How fast is the market in Montana moving in the direction of “value-base” care? How can you find out?

2) Are you seeing the impact of the reforms today (e.g., patients covered by state exchange products)?

3) Who are the “organizing forces” in Montana with respect to addressing market changes and challenges?

4) If employed by a hospital or multi-specialty clinic, who is driving transformation of delivery models to address new market realities? Is there an overarching or piecemeal strategy?

5) What specifically do you need to know to determine next steps?