***Disclaimer: These models are intended to provide possible starting points for final contracts that will need to be individually tailored and negotiated to reflect specific circumstances.***

**Bundled Payment Agreement – Employer and Health Plan/TPA**

**WHEREAS** THIS BUNDLED PAYMENT AGREEMENT (this “Agreement”) is made and entered into by and between EMPLOYER, a (“Purchaser”) who offers and pays for health benefits on behalf of its employees and their dependents, and

**WHEREAS**  HEALTH PLAN or THIRD PARTY ADMINISTRATOR (collectively “Plan”), is responsible for administering the health plan benefits, including claims payment on behalf of the Purchaser to this BUNDLED PAYMENT AGREEMENT, and

**WHEREAS** this Agreement sets forth the terms and conditions under which a Plan will administer a bundled payment arrangement (“Bundled Payment Program”), and

**WHEREAS** Planhas contracted with an appropriate network of providers to accept payment from Purchaser and Plan for services included under the bundle and a warranty for services within 90 days of the surgery, and includes professional fees, devices, inpatient, outpatient, rehabilitation, skilled nursing, home health and durable medical equipment services as defined in this agreement, and

**WHEREAS** both the Purchaser and the Plan (the “Parties”) wish to enter into this collaborative Agreement to form a BUNDLED PAYMENT PROGRAM for a period of three (3) years with an Effective Date of (DATE).

1. **Introduction**

The intent of this Agreement is to establish a bundled payment program which works in collaboration with the Purchaser and the Plan to improve the quality and cost effectiveness of care for the Purchaser’s Covered and Eligible Persons that require clinical services AND is a practical innovation that demonstrates alignment of value-based care delivery with payment.

The Bundled Payment Program includes:

1. Care Bundle: A *Care Bundle* of total knee or total hip replacement for patients with degenerative osteoarthritis that includes *Covered Services* appropriate for diagnosis, treatment, and follow-up care for *Reference Procedure*s, and includes related complications arising during the stay for *Care Bundle;*
2. Warranty: A performance *Warranty* for known and unforeseen clinical services related to the *Reference Procedure* for a period of 90 days following discharge from the affiliated facility.
	* The basic warranty includes rework for all complications related to repair, revisions, and modifications of the implant or original procedure and routine care follow up.
	* Provider and Plan may mutually agree to a full warranty service package beyond what is described in the basic warranty that includes all additional post-operative professional, facility, and ancillary, and transportation costs associated with skilled, inpatient rehabilitation, or home health care services (Post-Acute) for an additional negotiated fee;
3. Quality Metrics: The establishment of a set of *Program Performance* and *Provider Quality Metrics* that will serve as a guide for both parties to measure and monitor the overall quality, cost effectiveness, and performance of the Bundled Payment Program over the term of the agreement;
4. Transition in Benefit Design: A benefit model that provides value to all participants: to the purchaser in the form of lower costs, to the provider in the form of increased volume, and to enrollees in the form of information, support, improved clinical outcomes, and improved coverage for the services and procedures contained in the bundle; and
5. Transition in Payment Design: A transition in payment from fee-for-service for individual services to a bundled price. [Effect a transition in payment from fee-for-service for individual services to a target price payment in the first two years of the Agreement to an all-inclusive prospective payment at the beginning of the third year of the Agreement. Assuming there is a positive difference between the target amount and actual claims amount, the difference will be shared between the Purchaser and Provider during years 1 and 2. At the beginning of the third year of the Agreement, the payment moves to an all-inclusive prospective payment upon invoice with all claims attached with full procedure and financial risk borne by Provider.]

***Notes: The bracketed language in item 5 should be used if the Purchaser/Plan/Provider engages in a gain sharing arrangement. If the Purchaser/Plan/Provider engage in a bundle price with a warranty and no gain share (e.g. provider accepts full risk for any amount incurred over the bundle price in Year 1 of the Agreement), then the bracketed language should be removed from the contract.***

1. **Definitions**

***Acceptance or Non-Acceptance to Program –*** formal notification issued by Provider to Plan following clinical evaluation that Covered and Eligible Person meets or does not meet indications/contra-indications for Care Bundle and Warranty***.*** This notice would be shared with all subcontractors to Care Bundle and Warranty.

***Affiliated Providers –*** includes all providers that are affiliated with this Care Bundle that have subcontracted with Provider and signed sub-agreements that include the following elements: agreement to perform their respective service role consistent with standard of care; agreement to fully participate in clinical care coordination; agreement to participate actively in the quality review process; agreement to accept payment in full for services from Provider; agreement to administrative claims management consistent with terms of this Agreement; and agreement with Members to hold harmless and not seek additional payment from patients under services associated with this Care Bundle.

***Care Bundle and Warranty*** – includes all professional and facility and coordination services associated with clinical evaluation, treatment and care planning for the indicated clinical procedure for the *Covered and Eligible* *Person*. The *Care Bundle* is inclusive of the *Evaluation*, *Treatment*, and *Warranty* period (See Exhibit A).

***Claims Payment Agent -*** an agent of the Plan that coordinates the receipt, adjudication, claims payment and reporting of medical claims***.***

***Completed Episode –***consists of a *Care Bundle and Warranty* period that is 120 consecutive calendar days following date of discharge from the *Treatment* phase.

***Covered and Eligible* *Person* -** is considered an individual who is covered by Plan’s health benefit plan and meets administrative Eligibility requirements for coverage in that benefit plan at the time of the referral to the Provider for clinical evaluation for consideration to be a candidate for the Program.

***Covered Services*** – includes services, treatments, and supplies, including the implant, covered under members’ health benefit plan.

***Evaluation* –** all professional and technical services necessary to evaluate the *Covered and Eligible* *Person* for clinical indications and admission to *Care Bundle* program up to 60 days prior to the date of service for the *Treatment* phase of care. Services and associated costs include but are not limited to professional assessment, diagnostic imaging, and review of prior medical history and assessment of post-operative care and support capabilities that are consistent with *Provider’s* evaluation protocol.

***Health Coach -*** an agent of the Plan that facilitates and communicates to all parties (Member, Plan, and Provider) the determination of benefit *Eligibility*, any appropriateness review, authorization of benefit coverage approval, supports case management, and care coordination.

***Program Performance Metrics -*** set of defined metrics by Plan that measure program value and include cost, overall quality, frequency of services, patient satisfaction, and overall financial value.*Program Performance Metrics* will be shared between Provider and Plan to demonstrate transparent value to both parties (Exhibit C).

***Provider Quality Metrics -*** set of defined metrics that Plan and Provider agree upon that measure patient process of care and outcomes, including adverse events, system improvements as well as patient functional status and satisfaction. *Provider Quality Metrics* will be shared with Plan on a quarterly and annual basis and subsequently with enrollees of Plan as they assess selection of care providers (Exhibit C).

***Reference Procedure* -** list of procedures included in *Care Bundle and Warranty* by ICD9 CM code listed by rollup MS-DRG. (Exhibit A)

***Stop Loss Day Limit*** - a defined number of combined inpatient days during the *Treatment* or *Warranty* phases of care. Patients that require inpatient care beyond the *Stop Loss Day Limit* will be eligible for *Stop Loss Per Diem.*

***Stop Loss Per Diem -*** a single per diem payment to Provider for days of inpatient care beyond the *Stop Loss Day Limit* which is in addition to the *Care Bundle* payment, and which shall include all professional, technical, ancillary, and facility services necessary to evaluate, treat, and stabilize the *Covered and Eligible Person* for the indicated procedure on an inpatient basis during the *Care Bundle*.

***Treatment*** *-* includes all professional, technical, facility services necessary to evaluate, treat, and stabilize the *Covered and Eligible* *Person* for the indicated procedure. The *Treatment* phase includes pre-admission testing, surgery and implant cost, professional costs for all services including surgeon, anesthesia, pharmacy, and all professional clinical services called on to consult during *Treatment*, inpatient, outpatient, medical hotel, post-operative recovery, Intensive Care Unit (ICU), Critical Care Unit (CCU)(including all levels) care concurrent with the surgical procedure and prior to discharge from program and subject to a maximum *Stop Loss Day Limit.* (Exhibit A)

***Warranty* –** includes all professional, technical, inpatient, outpatient, and rehabilitative services necessary to repair, revise, and rehabilitate the *Covered and Eligible* *Person* for the indicated procedure following discharge from *Treatment* and up to and including the 90th day following the date of discharge.

* *Basic**Warranty* shall be considered a limited warranty and includes professional, technical, inpatient, outpatient services for normal patient post op follow up AND in the event, any repair, revisions, or re-admissions that are medically necessary for patient safety, such as hemorrhage, infection, implant mechanical repair, dislocation, or amendment of the functionality of the implant. Basic Warranty shall include a maximum *Stop Loss Day Limit;* or
* *Full Warranty* includes the services in the *Basic* *Warranty* and additional professional, technical, inpatient, outpatient services and costs including inpatient rehabilitation, skilled nursing facility, home healthcare skilled /rehabilitation during the Warranty period. Full Warranty shall include a maximum *Stop loss Day Limit*.
1. **Duties of Parties**
2. Duties of Purchaser

The Purchaser is responsible for the following:

1. Presenting a clear scope of the program, including the definition of the bundle, the time period of the program (e.g. 3 years), the savings expectations, the quality thresholds or improvement expectations;
2. Identifying a bundled payment based on previous payment data with defined payment limits with fixed payments on a prospective or retrospective basis in partnership with the Plan;
3. Offer a [COE or reference price benefit design] for hip/knee replacements.
4. Working with the Plan to present clear criteria the providers must meet to be considered eligible partners in the program;
5. Understanding the Plan’s readiness for implementing a program.
6. Preparing and disseminating employee communications in partnership with the Plan.
7. Monitoring the program results on an ongoing basis.
8. Evaluating the longer-term results in partnership with the Plan.

***Notes: Under A. 2., a Purchaser should insert the appropriate name of the benefit design it will use with the bundled payment program. The two most appropriate benefit designs for a bundled payment program are listed in brackets.***

1. Duties of Plan

The Plan isresponsible for the following:

1. Identifying a bundled payment based on previous payment data with defined payment limits with fixed payments on a prospective or retrospective basis in partnership with the Purchaser;
2. Referring to Provider with clear documentation for Covered and Eligible Person for Evaluation;
3. Ensuring the creation and maintenance of a list of facilities, surgeons, anesthesiologists, DME providers, and other Professionals that participate in Plan’s contracted network inclusive of National Provider Identifier (NPI), license, credentialing status, and current contract status with Plan;
4. Negotiating with a Provider a favorable list of exclusions for the Purchaser to maximize participation in the program (Exhibit B) ;
5. Administering a [COE or reference price] benefit for the Reference Procedures and communication strategy to membership in partnership with the Purchaser. The communication strategy will be supplied and updated annually to Provider;
6. Identifying Health Coach, case manager, care coordinator, or other type of Member navigator, and Claims Payment Agent to work with Provider in the implementation and operationalization of this program, including:
	* Defined referral process including authorization, documentation for systems (clinical, case, and claims);
	* Coordination of information (including data and reports) between parties to manage Program, including case summaries, case completion rates, warranty claims, outcomes and process of care measures; and
	* Claims flow and change management of transition from retrospective to prospective payment.
7. Establishing the credentialing standards necessary for Providers participating in the Program;
8. Processing bundled payment claims;
9. Assuring all providers of care that are party to this Care Bundle and Warranty meet and comply with Plan’s credentialing standards; Provider will supply to Plan evidence of compliance not less than annually;
10. Paying participating providers either through a prospective or retrospective bundled payment methodology;
11. Providing complete claims data for Covered and Eligible Persons treated by Provider to Provider on a quarterly and annual basis through a joint review of Program with Provider.
12. Participating in the quarterly and annual joint review of Program with the Purchaser, and Provider. The review process will include a review of the Program and Provider Quality Metrics.

***Notes:***

***Under B. 6., it is important in the vetting process that purchasers also understand concierge and/or patient coordination capabilities of a program. This includes understanding the details of patient intake, as well as coordination of ancillary services, including such things as travel needs, collection of records, surgeon selection, appointments, patient education, hoteling, transportation, etc.***

***Under B. 5., a Plan should insert the appropriate name of the benefit design it will use with the bundled payment program. The two most appropriate benefit designs for a bundled payment program are listed in brackets.***

1. **Transparency of Price and Quality**

During the term of the Agreement, the Plan agrees to provide the following information on a direct basis to members (e.g. through a searchable online portal):

1. provider name;
2. cost of the service to the member (i.e. member out-of-pocket cost);
3. quality and performance measures;
4. benefit coverage; and
5. steps the member has to take in order to be directed to the appropriate facility (e.g. access pathway)

At the beginning of the launch of the Program and at least annually thereafter, both Parties will review the price and quality information that are made available to the members, and update the aforementioned elements as necessary.

1. **Term of Agreement**

The initial term of this Agreement is three (3) years, unless either party fails to perform as outlined in Section 7.

# Fees

# Purchaser agrees to pay Plan [Insert payment arrangement – PMPM administrative fee, etc.] and [insert when the purchaser agrees to pay the plan].

1. **Termination**

Either Party can terminate this Agreement for cause upon 90 days following notice of the breach of duty. Grounds for termination include:

*By Plan*

* Purchaser fails to adequately establish and communicate a COE, reference price or adequate benefit differential to its members; or
* Purchaser fails to pay the fees to Plan for services.

*By Purchaser*

* + - The Plan terminates contracts with the providers participating in the bundled payment program;
		- There is a material change of clinical team composition (surgeons);
		- Loss of clinical privileges and failure to meet credentialing standards, that cause the contracted provider to not meet reasonable performance and access standards; or
		- Plan or Plan’s agents (Health Coach, case manager/care manager/navigator, Claims Payment Agent) fail to perform their respective duties.

Termination fees are not to exceed $50,000.00 if either Party meets the general terms of the breach and fails to remedy the breach during a 30 day process. During the first year of the Agreement the fees shall be due upon invoice receipt by the Party in default.

1. **Exclusivity**

Neither Party considers this Agreement exclusive with other parties. (See Term and Termination).

1. **Dispute Resolution and Indemnification**

Any controversy or claim arising out of or relating to this Agreement or breach hereof shall be settled as follows:

1. Dispute Resolution Process
2. First, the project managers or team leaders for the project shall attempt, in good faith, to negotiate a resolution.
3. Second, if they are unsuccessful, the highest level of management with responsibility for the project shall attempt in good faith to reach a resolution.
4. Third, if the dispute is not capable of being resolved without the intervention of a neutral third party, the parties agree to mediate the dispute pursuant to the then applicable mediation rules of the American Arbitration Association at a venue mutually agreed upon by the parties, and failing such agreement, in the nearest large city equidistant to the parties.
5. If good faith efforts at mediation fail, then either party may commence arbitration with one arbitrator in [INSERT CITY, STATE], in accordance with the rules of the American Arbitration Association then existing; provided, however, that the arbitrator shall have no authority to add to, modify, change, or disregard any lawful terms of this Agreement. The decision of the arbitrator shall be final and binding, and judgment on the arbitration award may be entered in any court having jurisdiction over the subject matter of the controversy. Arbitration shall be the exclusive final remedy for any dispute between the parties.
6. Indemnification- Standard Indemnification for Acts of the other party

Purchaser agrees to indemnify, defend, and hold Plan/TPA and their successors, officers, directors, agents, and employees harmless from any and all actions, causes of actions, claims, demands, cost, liabilities, expenses, and damages (including attorneys’ fees) arising out of, or in connection with, any breach of Provider’s warranties or obligations arising out of this agreement, including without limitation to breach of its tax obligations, or growing out of any act of Consultant or his/her agents or employees.

Plan/TPA agrees to indemnify, defend, and hold Purchaser and its successors, officers, directors, agents, and employees harmless from any and all actions, causes of actions, claims, demands, cost, liabilities, expenses, and damages (including attorneys’ fees) arising out of, or in connection with, any breach of Plan’s warranties or obligations arising out of this agreement, including without limitation to breach of its tax obligations, or growing out of any act of Plan’s agents or employees.

The Parties below hereby enter into the Agreement as outlined above and in all Exhibits.

Plan Name:

By:

Signature:

Date:

Provider:

By:

Signature:

Date:

**Exhibit A- ICD-9\* Procedure Codes Included in Care Bundle**

|  |  |
| --- | --- |
| **INPATIENT** | **OUTPATIENT** |
| **DRG:**Episode must map to one of these DRGs.* 469 – Major Joint Replacement or reattachment of lower extremity w/MCC
* 470- Major Joint Replacement or reattachment of lower extremity without MCC
 | **Index Procedure Code:**This procedure must exist to trigger the episode.CPT:* 27447—Arthroplasty, knee condyle and plateau, medical and lateral compartments

ICD-9 Px:* Knee- Replacement  - ICD9 Procedure Codes - Primary or Secondary - 81.54 (TKR) + 81.55 (Replacement Other) Combined
 |
| **DRG:**Episode must map to one of these DRGs.* 469 – Major Joint Replacement or reattachment of lower extremity w/MCC
* 470- Major Joint Replacement or reattachment of lower extremity without MCC
 | **Index Procedure Code:**This procedure must exist to trigger the episode. CPT:* 27130—Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft, or
* 27125—Hemiarthroplasty, hip, partial (e.g. femoral stem prosthesis, bipolar arthroplasty) (when performed for reasons other than fracture)

ICD-9 Px:* 81.51—Total hip replacement
* 81.52—Partial hip replacement (when performed for reasons other than fracture)
* 00.85—Resurfacing hip, total, acetabulum and femoral head
* 00.86—Resurfacing hip, partial, femoral head
 |

\*ICD-9 Codes should be used until such time as the ICD-10 Codes are in use (anticipated Fall 2015). At that time, codes should be updated to reflect the ICD-10 Code framework.

Attached is an Excel file that details the services included and excluded in the care bundle. The Excel file also includes a description of services included in the basic and full warranties.



**Exhibit B - List of Indications and Contra- Indications for Patient Acceptance to Care Bundle and Warranty Program**

Provider-supplied list of primary conditions that would include and exclude a patient from the Bundled Payment Program. Prior to executing the Agreement, this list will be discussed with and must be agreed to by the Plan.

**Exhibit C - Quarterly and Annual Reporting on Program and Provider Metrics**

Program Performance Metrics Dashboard

There are many ways to evaluate whether the program itself and provider partners are meeting or exceeding expectations. Using the measures below, CPR recommends that in the first year of the program, the target should be an improvement over baseline. In the second and third year of the program, the parties can decide if more specific or higher targets should be met.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Domain** | **Measures** | **Definition** | **Performance Target** | **YTD Performance** |
| Surgical Frequency/Volume | * Total procedures per 1,000 patients
 | * # procedures/1,000 patients
 |  |  |
| Utilization | * Average Length of Stay (ALOS)
* Readmission rates (30, 90 days)
 | * Average length of stay
* Number of patients readmitted within 30 and 90 days or less of hip or knee procedure performed at their facility (not revision of work completed by another facility)
 |  |  |
| Cost | * Case-mix adjusted total episode costs
* Total employer’s cost compared as a % of Medicare
 | * Total facility cost paid per mix-adjusted patient episode from 30 days prior to surgery (including imaging, labs, physicians services) through total joint replacement episode discharge and discharge through next 30 days (including inpatient and outpatient rehabilitation services, home-based rehabilitation, in home physical therapy, etc.) AND broken out by service category
 |  |  |
| Quality | * Mortality rate
 | * Measures the frequency of occurrence of death in a defined population during a specified interval.  The formula for the mortality of a defined population, over a specified period of time, is: Deaths occurring during a given time period divided by the size of the population among which the deaths occurred.
 |  |  |
| * Revision rate (one year)
 | * Measures whether patients had no redo procedures within one year after surgery.
 |  |  |
| * Post-surgical complication rate (90 day post)
 | * Measures whether patients had complications with surgery within 90 days post-surgery.
 |  |  |
| * Prophylactic antibiotic received w/in one hour prior to surgical incision
 | * Assesses the percentage of surgical patients who received prophylactic antibiotics within one hour prior to surgical incision. Patients receiving vancomycin or a fluoroquinolone should have the antibiotics initiated within two hours prior to surgery due to the longer infusion time required.

Numerator: # of surgical patients who received prophylactic antibiotics within one hour prior to surgical incision (two hours if receiving vancomycin or a fluoroquinolone) Denominator: All selected surgical patients with no evidence of prior infection |  |  |
| Coordination | * Physical therapy w/in 30 days
 | * Measures whether patients received at least one physical therapy session within 30 days after selected surgeries.
 |  |  |
| Functional Status | * Pre-op scores compared to 30 days post-op
 | Several accepted and proven tools exist. One functional gain metric from the following list must be selected and administered by contract provider:* Oxford Knee (14 questions)
* HOOS/KOOS (short)
* Activity of Daily Living
* SF 36 (pre vs. post)
* Patient satisfaction/ability to demonstrate access and team care from day one through end of the episode
 |  |  |
| Patient Satisfaction/Experience | * H-CAHPS Discharge Measure
* H-CAHPS Willingness to Recommend Hospital Measure
 | * Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.
* Patients who reported YES, they would definitely recommend the hospital.
 |  |  |

Provider Quality Metrics:

The domains and measure requirements listed below represent the minimum on which the Provider should report to the health plan/TPA/purchaser on a quarterly and annual basis. When used with the accompanying model contract language, failure to meet one, some or all of these metrics is grounds for termination of the agreement.

|  |  |  |
| --- | --- | --- |
| **Domain** | **Requirement** | **Met/Not Met** **(select one)** |
| Participation in Multi-Center Joint Registry | Provider must participate in a multi-center registry that provides benchmark performance reporting to provider at physician level, and includes patient demographic, implant, and functional outcome. The provider shall participate in at least one of the following registries: * California Joint Replacement Registry (CJRR)
* American Joint Registry (American Academy of Orthopaedic Surgeons)
 |  |
| Tracking Adverse Events and Rates | Provider will track and report to the Plan the following metrics for all Covered and Eligible Persons in the Program:* Percentage of patients with antibiotic prescribed within three days of date of procedure
* Average length of stay
* 30 day, 60 day, 90 day post discharge re-admission rate to hospital (includes transfers from rehabilitation facility/skilled nursing facility)
* Infection Rate – all noted surgically-related infections within 30 days
* Dislocations within 90 days of original procedure date
* Revision procedures within 90 days of original procedure
* DVT/Embolisms within 90 days of original procedure
 |  |
| Care System Improvement & Performance Based Compensation | Provider will demonstrate its care system and quality review through the following processes: * Providing the charter and membership of Provider’s Quality and Patient Review Process;
* Providing a summary of meetings and agenda and attendance of membership in Quality Review process; and,
* Outlining Quality and Performance Compensation & Incentives made available to Providers and Affiliated Providers under this program.
 |  |