***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 “Plan” and Provider**

**WHEREAS** THIS BUNDLED PAYMENT AGREEMENT (this “Agreement”) is made and entered into by and between EMPLOYER, a (“Plan”) who organizes and administers a health benefit plan on behalf of its employees and their dependents, and

**WHEREAS**  Musculoskeletal Provider Entity (“Provider”), is an incorporated entity in the (STATE), responsible for providing direct care, organizing and coordinating a network of affiliated providers who provide key clinical services to this BUNDLED PAYMENT AGREEMENT, and

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

**WHEREAS** Provider has contracted with other Affiliated Providers to accept payment from Provider 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 Plan and the Provider (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 Plan and the Provider to improve the quality and cost effectiveness of care for the Plan’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 Plan 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 Plan/Provider engages in a gain sharing arrangement. If the 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 Plan

The Plan isresponsible for the following:

1. Referring to Provider with clear documentation for Covered and Eligible Person for Evaluation;
2. Establishing [Center of Excellence or reference price] benefit plan coverage for the Reference Procedures and communication strategy to membership. The communication strategy will be supplied and updated annually to Provider;
3. 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.
4. Establishing the credentialing standards necessary for Providers participating in the Program;
5. Processing bundled payment claims;
6. 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. The review process will include a review of the Program and Provider Quality Metrics.

***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 Provider

The Provideris responsible to Plan for the following:

1. Performing the services and procedures to the best of their abilities;
2. Creating and maintaining a list of facilities, surgeons, anesthesiologists, Durable Medical Equipment (DME) providers, and other Professionals that participate in Provider’s subcontracted network inclusive of National Provider Identifier (NPI), license, credentialing status, and current contract status with Plan;
3. Creating and maintaining a list of indications and contra-indications for patient acceptance to Program in agreement with the Plan (Exhibit B);
4. 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;
5. Providing summary of intake and workflows and communication to the Plan, including:
	* Patient intake and communication across all providers and subcontractors;
	* Documentation of patient care workflow from evaluation, acceptance, treatment through Warranty; and
	* Claims flow and change management of transition from retrospective to prospective payment.
6. Selecting and demonstrating compliance with Provider Quality Metrics;
7. Coordinating the care for the Covered and Eligible Person including the pre-care, acute care and post-acute phases of care for the Care Bundle;
8. [Aggregating all claims from Provider and affiliated providers into a single claim file and summary and invoice for Plan payment; and]
9. Participating in the quarterly and annual joint review of Program with Plan. (The review process will include a review of the Program and Provider Quality Metrics).

***Notes:***

***Under Item 5, 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, such as patient travel needs, collection of records, surgeon selection, appointments, patient education, hoteling, transportation, etc.***

***Item 7 in brackets is an ideal situation for filing and paying claims. However, not all providers will be in a position to aggregate all claims from the participating providers in Year 1 of the Agreement. CPR recommends starting the negotiations with this provision, but if the Provider is not willing or able to perform this function, the contract should reflect that this provision will occur at the beginning of Year 3 of the Agreement.***

# Payment Terms

# Year 1 & 2 of the Agreement– Fee-for-Service Payment Reconciled to Target Price [with Gain Share]

# Existing Fee Schedules - *Provider and Provider Affiliates* submit claims for *Covered and Eligible* *Persons* and are paid for *Covered Services* under existing payment terms in place between Plan and Providers. *Provider and Provider Affiliates* will accept payment under these terms as payment in full and are prohibited from balance billing the *Covered and Eligible Person* for expenses included in the *Care Bundle*.

# Additional Compensation Model – During Year 1 and 2 of the Agreement, additional compensation will be available to Provider based on meeting the following criteria:

# a. Provider has met baseline Program and Provider Quality Metrics, and

# b. [A surplus is available to Share between Provider and Plan according to Gain Share Methodology (Exhibit D)].

# 6 Month Reconciliation – Within 30 days after the end of the first six months of this Agreement and within 30 days after the anniversary of the Agreement, Plan will summarize all completed episodes that occurred during the measurement period and meet with Provider to review the cases.

# [A final Agreement between the Parties will require a Target Price and if relevant, Gain Share amounts and Methodology. See Exhibit D for an illustration of a Gain Share structure.]

# [Distribution of Gain Share – Provider will receive additional compensation consistent with calculation and meeting quality criteria above. In the event of a program deficit at the time of the 6 month reconciliation, Plan may elect to delay final calculation of surplus/deficit until the end of the Year 2, at which time all deficits in previous periods would be charged to any subsequent surplus, prior to any distribution to provider.]

# *Notes: The title of this section and items 2.b., 4, and 5 in brackets are to be included in the contract only if the Plan/Provider are engaging in a gain sharing model. If the Plan/Provider engages in a straight bundle price with warranty and no gain share (e.g. full risk by provider), these items should be removed from the contract.*

# Year 3 – Prospective Payment and Stop Loss with Outlier Per Diem

Claims for Covered Services included in the case rate for the *Care Bundle and Warranty* will be paid to *Provider* and will be paid pursuant to the receipt of an [invoice and bundled claims from Provider and Provider Affiliates.] Provider and its provider affiliates under the Bundled Payment Program will look solely to Plan for payment of all Covered Services rendered pursuant to this Agreement.

***Notes: Refer to notes in 3.B.7. This language will change if a provider is unable to invoice and bundle claims in Year 1.***

For illustration purposes only, an example of moving to prospective payment and stop loss with outlier per diem is as follows:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Care Bundle and Basic Warranty  | Care Bundle and Full Warranty | Stop Loss Limit Days included in Care Bundle | Stop Loss Per Diem |
| Total Knee Replacement | $25,000 | $29,000 | 10 | $2,000 |
| Total Hip Replacement | $27,000 | $35,000 | 15 | $2,000 |

## Payment Schedule

For cases paid pursuant to the Care Bundle Program, Provider will bill the Plan for the full Care Bundle and Warranty amount no more than sixty (60) days from the date that the applicable Covered and Eligible Person was discharged from the Participating Hospital for the Index Procedure. Plan will pay Provider within 30 days after receipt of the claim. For payment arrangements still based on fee-for-service in the first two years of the Agreement, plans will follow and comply with existing local prompt pay laws.

1. Stop Loss and Outlier

Additional payment will be made available to Provider for cases that become catastrophic in terms of complications and additional required hospitalization. Additional payment in the form of a per diem inclusive of professional and facility fees will be made if Inpatient Acute/Critical care patient days exceed the Stop Loss Limit during the Care Bundle and Warranty period. Provider will continue to manage these cases and coordinate with Plan case management.

***Notes: This document is drafted to be a standalone contract. The per diem payments referenced in 4. C. and D. do not reference any other per diem amount a payor may have contractually agreed to with the provider entity. If a separate contract for other services exists between the payor and provider, the parties can decide if any prior per diem amount should be used in this section or if the other contract should be cross-referenced in this section.***

## Payment for Non Acceptance to Care Bundle and Warranty

For Covered and Eligible Persons who are referred to Provider for Evaluation, and do not meet clinical indications (See Exhibit B), Provider will be paid a flat rate amount for the services associated with Evaluation. For illustration purposes only, an example of the non-acceptance payment to be negotiated is as follows:

|  |  |
| --- | --- |
| Procedure | Non-Acceptance Payment for Evaluation (For illustration purposes only. Sample payments) |
| Total Knee Replacement | $350 |
| Total Hip Replacement | $450 |

## **Refunds**

Provider will refund any overpayment to Plan within 30 days of Provider’s receipt of a notice from Plan, if such overpayment is not a disputed amount. In the event that the overpayment is disputed, the Parties will resolve such dispute pursuant to the terms of the Agreement.

***Notes: Providers may claim difficulty in providing refunds in 30 days of notice of the overpayment. Prompt pay laws are usually 30 days within receipt of the claims so it is not unreasonable to expect a refund within the same timeframe. CPR recommends starting with 30 days in negotiation and working from there.***

## **Referrals to Non-Participating Providers**

In the event that a participating hospital or other provider under the Bundled Payment Program knowinglyrefers a Covered and Eligible Person to another facility or provider not participating in the Bundled Payment Program (collectively, “Non-Participating Providers”) during the Care Bundle and Warranty period, and the participating hospital or other provider intends to continue treating such Covered and Eligible Person and does not relinquish ultimate responsibility for such Covered Person’s care, the payment for Covered Services provided by the Non-Participating Providers during the Care Bundle and Warranty will be the responsibility of Provider, and such amount will be included in the bundled payment made to Provider by Plan, and no additional payments will be made from Plan to Provider to cover such expense. In the event a Non-Participating Provider bills the Covered Person for any expenses not covered by the Provider, the Provider participating in the Program shall hold the Covered Person harmless for any expenses from the non-participating provider during the Care Bundle and Warranty period.

## **Premature Closure of Case**

No bundled payments will be made, and the payment terms under the Agreement will control, if:

1. A Covered and Eligible Person loses coverage with Plan during the Care Bundle and Warranty for any reason (e.g., due to death, becoming covered by Medicare, employer switching health plans.); or
2. A Covered and Eligible Person is transferred or referred to a Non-Participating Provider without the expectation that such Covered and Eligible Person will return to the Participating Hospital or other provider at any time during the Care Bundle and Warranty.

Note that readmission to a hospital other than the Participating Hospital during the Care Bundle and Warranty does not constitute a reason for premature closure of the case. Under such circumstances, a bundled payment will still be made to Provider pursuant to the terms of this Agreement. Except as set forth under Section 6 above, Provider assumes no liability for payments that may be due to Non-Participating Providers under the Plan’s contract with such Non-Participating Providers or the Covered Person’s benefit plan.

Additionally, the case will not be subject to premature closure if the Covered and Eligible Person leaves the Participating Hospital or otherwise discontinues Treatment during the Care Bundle and Warranty “against medical advice.”

1. **Transparency of Price and Quality**

For the Term the Agreement is in place, both Parties agree 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 values 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 10.

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*

* + - Termination of subcontracted Affiliated Providers;
		- Material changes of clinical team composition (surgeons); or
		- Loss of clinical privileges and failure to meet credentialing standards, that cause Provider to not meet reasonable performance and access standards

*By Provider*

* Plan fails to adequately establish and communicate a COE, reference price benefit to is members;
* 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 beyond the reasonable number of

Providers necessary to carry out the necessary duties (See Term and Termination).

***Notes: CPR recommends the purchaser engage in bundled payment programs with no more than two providers in a market in any concurrent Agreement period. The goal is competition among providers and more than two will likely dilute the program.***

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

Plan agrees to indemnify, defend, and hold Providers 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.

Provider agrees to indemnify, defend, and hold Plan 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.

The embedded file details the bundle by phase of care, provider, facility, prescription, patient accommodations and exclusions.



**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.
 |  |

**Exhibit D – Gain Share Methodology**

# *Note: Exhibit D will only be necessary and used if the Parties engage in a Gain Sharing arrangement in Years 1 and 2 of the Agreement rather than a bundled payment with full risk by the Provider.*

# Plan will aggregate all claims received, adjudicated and paid (allowed basis) for all Covered and Eligible Persons referred to Provider during the Care Bundle and Warranty period for the Covered Services and, which are *Completed Episodes (Observed Claims Paid) Plan and Provider agree to group and rollup all Completed Episodes according to MS-DRG classifications.*

# Mean Observed Case Costs are created for each MS-DRG class for Knee and Hip Completed Episodes. Observed Case Costs are compared to Target Price (above).

# If Observed Case Costs are lower than Target Price, a Program Surplus has been created. If Target Case Costs are lower than Observed, a Program Deficit has been created.

# For illustration purposes only, below is an example of the Gain Share and Methodology for Years 1 and 2:

|  |  |  |  |
| --- | --- | --- | --- |
| Year 1  | Target Price for Care Bundle and Warranty | % of Gain or Loss Shared By Provider  | Application  |
| Knee | $28,000 | 10% | Observed Claims Paid Less Target Price is at Surplus or Deficit |
| Hip | $30,000 | 10% |

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| Year 2  | Target Price for Care Bundle and Warranty | % of Gain or Loss Shared By Provider  | Application  |
| Knee | $26,000 | 20% | Observed Claims Paid Less Target Price is at Surplus or Deficit |
| Hip | $28,000 | 20% |