



## IHA Bundled Episode Payment Pilot (BEPP) Frequently Asked Questions

### **Q1: Why bundle payment?**

A1. There is broad policy interest in testing new payment methods as alternatives to traditional fee-for-service reimbursement. Bundled or episode payments have long been cited as a payment strategy that would better reward physician and hospital efforts to improve care quality and efficiency. The Centers for Medicare and Medicaid Services are currently field-testing the concept through their Acute Care Episode pilot and the Patient Protection and Affordable Care Act of 2010 calls for both an expansion of the current pilot for Medicare beneficiaries and creation of a new episode of care demonstration for Medicaid beneficiaries. The expectation that episode payment may become a dominant form of payment in the public sector is driving many to experiment with the concept now in commercial populations, with an objective of testing their ability to price episodes appropriately and to build the contracting and administrative infrastructure necessary to administer these complex payment arrangements.

The Integrated Healthcare Association (IHA) is piloting bundled episode payment in California in cooperation with several physician organizations, health plans, hospitals and health systems, with the first group of participants anticipated to go live in late summer 2010. The IHA pilot will test the feasibility of bundling payments to hospitals, surgeons, consulting physicians and ancillary providers for patients undergoing inpatient procedures and acute episodes. The goals of the pilot are to:

- Encourage financial alignment that will support delivery system and process re-engineering to improve patient care quality and efficiency,
- Allow for shared savings among health plans, providers, employers, and patients to the extent bundled reimbursement improves quality and efficiency,
- Develop and test solutions to bundled payment implementation issues.

### **Q2: How is the pilot governed?**

A2: IHA has convened an executive steering committee with equal representation from hospitals, health plans and physician organizations to establish pilot principles and strategy. IHA has established common rules (e.g., episode definition and data methodology) for pilot participants. The episode price and the actual operations of the pilot are governed by the terms of confidential contracts between participating providers and between providers and health plans.

### **Q3: Who is currently participating in the pilot?**

A3: Aetna, Blue Shield of California and CIGNA are participating in the PPO pilot. HealthNet will participate for the HMO and Medicare Advantage mini-pilot that will go live late in 2010. Hospital participants currently include Cedars-Sinai, Hoag Memorial Presbyterian, Saddleback Memorial Medical Center, all Tenet-California hospitals, and the UCLA Health System. Monarch Healthcare is working with IHA to develop a model in which an Independent Practice Association (IPA) bills for and disperses the bundled payment. Healthcare Partners has also committed to working with the pilot later in 2010.

### **Q4: What episodes will the pilot target?**

A4: In the first phase, the IHA pilot focuses on major surgical procedures, beginning with total knee and hip replacement in 2010. In later phases, the pilot will expand into other clinical areas and into episodes of acute treatment that may include surgical procedures. The pilot will not include episodes of care for patients with

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chronic disease, a population for which a patient-centered approach to measurement or payment, such as medical homes, may be more appropriate. The planned expansion path is outlined below.

### Q5: What is the pilot timeline?

**A5:** The initial pilot participants in Orange and Los Angeles Counties will go live for selected orthopaedic procedures in the PPO population in late summer/early fall of 2010. Some initial participants are also working on a separate mini-pilot for HMO and Medicare Advantage populations that will go live late in 2010. IHA is currently recruiting additional participants for a second statewide cohort of the PPO pilot to go live at the end of 2010.

### Anticipated Project Timeline

2010	2011	2012
<ul style="list-style-type: none"> <li>• Statewide PPO orthopaedics</li> <li>• HMO mini-pilot (orthopaedics)</li> <li>• Medicare Advantage mini-pilot (orthopaedics)</li> <li>• Develop 3 new procedural episodes</li> </ul>	<ul style="list-style-type: none"> <li>• Implement new procedural episodes</li> <li>• Statewide for HMO, Medicare Advantage</li> <li>• Develop model plan designs (for 1/2012)</li> <li>• Develop acute episodes</li> </ul>	<ul style="list-style-type: none"> <li>• Implement new acute episodes</li> <li>• Add Medi-Cal Managed Care Plans</li> <li>• Implement plan design changes</li> <li>• Include shared-decision-making</li> </ul>

### Q6: What types of organizations are eligible for participation in the pilot?

**A6:** Participation in the pilot is open to healthcare organizations operating within California, including national and regional health plans, hospitals and health systems, IPAs, medical groups, and other types of provider organizations (such as post-acute service providers). Participants should perform a significant number of the pilot procedures on an annual basis to balance the effort of developing bundled payment infrastructure with potential impact. Provider participants must be preferred with one or more of the participating health plans and must negotiate appropriate contracts with the health plans before accepting patients into the pilot.

### Q7: What benefits accrue to pilot participants?

**A7:** Participants will benefit as follows:

- **Physicians** remain in control of the treatment plan, and of decisions about length of stay and the use of consultants and ancillary services. They may increase revenue through gainsharing arrangements with the hospital. They may also benefit from new opportunities to collaborate on quality and service enhancements such as implementation of evidence-based care pathways.
- **Physician Organizations** benefit from the opportunity to work effectively with physicians and hospitals to develop new gainsharing and revenue opportunities.
- **Hospitals** will develop stronger partnerships with individual physicians and physician organizations. Some of the strategies being tested in this project such as clinical pathways, aligned financial incentives with physicians, joint vendor negotiations with implant vendors, and joint physician-hospital contracting with health plans will prepare hospitals to more effectively compete under Medicare's expected expansion of the bundled payment approach. Optimizing clinical and administrative processes for the commercial

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population may ultimately reduce costs and improve margins for all patients, including those currently reimbursed by Medicare on a DRG-basis.

- **Health Plans** can share in quality and efficiency improvements realized by the physician and hospital alignment through rate negotiations and pass these savings on to their customers and members. “Warranties” for the quality of treatment offered by the contracting provider groups place new incentives for providers to reduce avoidable complications and prevent certain readmissions. The inclusion of devices in the bundled episode rate provides incentives for providers to help control these rapidly increasing costs.
- **All Participants** gain an opportunity to better understand and test the contracting and operational infrastructure needed to manage episode-based payment mechanisms effectively.

### **Q8: What is bundled in the global payment for an episode of care in the pilot?**

**A8:** For PPO products, the episode begins on date of admission for the procedure and extends 90-days. The episode definition includes all physician charges, all inpatient charges (including the implant) for the initial procedure, routine follow-up care by the surgeon and the treatment of complications or related readmissions that occur during the episode period. There is an option for providers and health plans to include physical therapy and home health care visits during the 21-day period immediately following discharge for the index procedure.

For managed care products, the episode definition adds post-acute services provided during the 90-day episode period (e.g. physical therapy, home health care, skilled nursing facilities, inpatient rehab), and defined pre-surgical services.

Both definitions exclude outpatient prescription drugs and durable medical equipment (see FAQ Appendix A).

### **Q9: What makes the IHA pilot different from other bundled payment demonstrations?**

**A9:** The IHA pilot differs from and expands activities under current pilots and demonstrations in several ways:

- By focusing on common episode definitions, data methodologies, and contracting models, the pilot establishes an open framework that can be disseminated to multiple health plans and provider groups.
- The pilot extends the bundled payment with warranty and evidence-based care pathways approach (pioneered by Geisinger) to populations outside integrated delivery systems, testing the feasibility of disseminating the methodology across different forms of organizational and contractual relationships between physicians and hospitals.
- The pilot provides a demonstration of actual rather than virtual bundled payments within the commercial PPO population, and will expand payments to other populations not currently addressed under other demonstrations (HMO, Medicare Advantage and Medicaid).
- By including the cost of the implant as well as the 90-day warranty on complications and related readmissions, the pilot incorporates both upside and downside risk from inception.

### **Q 10: What are the key principles being following by the pilot participants?**

**A10:** The following principles are being followed by pilot participants:

- Develop consistent, standard methodologies and incentives applicable across the industry within an open contracting framework to reduce redundancies and complexity.
- Seek cost efficiencies that enhance, rather than restrict, access to medical care.

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- Pay for the procedures on an actual vs. virtually-bundled basis.
- Build the administrative and contracting infrastructure to bill for services on a bundled basis and to disperse payments among participating providers.
- Resolve operational issues collaboratively.
- Maintain participation in pilot episodes and populations on a voluntary basis.
- Share savings among providers, hospitals, health plans and patients.

### **Q11: What are the key operational issues and administrative processes participants must address during implementation of the pilot?**

**A11:** The operational model is for one provider organization (either a hospital or physician organization) to act as a general contractor. This organization will negotiate the governing contract with each health plan and execute subcontracts with physicians and other providers for all services included in the episode definition (see FAQ Appendices B and C).

Patients whose care will be reimbursed under the bundled rate are identified by the surgeon and hospital based on clinical criteria and contracting parameters. They are identified to the health plan during the standard pre-authorization and eligibility confirmation processes.

The general contractor assumes responsibility for gathering the usual bills of all subcontractors and submitting them as a bundle to the responsible health plan. The package is submitted at discharge for all services provided to that point. On receipt of this package, the health plans process the individual bills as no-pay (to capture service line detail) and pay the full negotiated bundled rate (net of patient cost-sharing) to the general contractor. The general contractor then disperses payment to the subcontractors according to the terms of the subcontracts. The general contractor submits a second package of bills to the health plan at the end of the episode period to provide information about all services provided during the post-discharge period, but no additional payment is processed.

The general contractor must therefore develop internal processes and infrastructure to:

- Identify patients to whom the bundled payment applies.
- Bill on an episode basis.
- Collect enrollee cost-sharing amounts and/or distribute these amounts appropriately among subcontractors.
- Pay subcontractors their negotiated rates.
- Track and report information as necessary to calculate and disperse negotiated gainsharing payments with subcontractors.
- Make gainsharing payments to subcontractors.

Health plans must develop the infrastructure to:

- Track patients for whom bundled payment applies once identified through their pre-authorization process and eligibility processes.
- Calculate employee cost-sharing against the episode price.
- Communicate cost-sharing and payment rules on the Explanation of Benefits.

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- Calculate and make payment on a bundled basis within regulated claim-payment timeframes, while still capturing service line detail.
- Isolate bills erroneously submitted by providers who should be paid directly by the general contractor,
- Pass identification of bundled payment and service line detail on individual payments from their claim system to their data mart to support future reporting.

FAQ Appendix D provides a high-level diagram of the process flow. Most initial participants have determined that these processes most closely mimic the model used to pay for organ transplants and intend to apply similar processes to bundled payment reimbursement.

### **Q12: Will existing contracts need to be amended for participation in pilot?**

**A12:** Yes, existing contracts between provider participants and health plans must be amended to outline the terms of participation and payment. New or amended contracts will also be required between the provider organization acting as general contractor and all physicians and ancillary service providers who subcontract to provide services and be reimbursed out of the episode payment.

### **Q13: How much effort and what types of resources will be required?**

**A13:** Each participating organization names an executive lead to coordinate its overall organizational response. Each organization must devote network contracting personnel to negotiate price and other aspects of the bundle that are governed by contracts between the health plans and providers. Each organization must also develop required billing, payment and reporting infrastructure. Additionally:

- Health plan participants commit to provide historical episode price data and on-going project reports using code developed by Ingenix Consulting under contract to IHA,
- Each provider organization acting as a general contractor must negotiate the subcontracts necessary to provide all services included in the episode definition,
- Physician organizations and hospital participants should expect to devote resources to working cooperatively on care pathways redesign and negotiation of gainsharing provisions around both quality and efficiency metrics.

### **Q14: How will bundled payment pricing be determined?**

**A14:** Prices are negotiated between individual participants (e.g. each hospital, IPA, or health plan). These negotiations are supported by health plan reports of historical allowed amounts calculated in accordance with the episode definition. IHA will not:

- Intervene in price negotiations between physicians, hospitals and health plans
- Attempt to identify or set a market price for the bundles
- Share charge or reimbursement information across competing health plans or providers

### **Q15: What data will we need to provide, and when will the data be required?**

**A15.** IHA has contracted with Ingenix Consulting to supply report specifications that allow health plans to develop historical episode costs for each participating provider group that are consistent with the episode definition for the pilot procedures. For health plans currently licensing a version of the Ingenix ETG grouper software, Ingenix Consulting also supplies SAS code that leverages the logic of that program. IHA does not receive or aggregate these data, and no historical price information is shared across health plans or providers

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(for example, Health Plan A reports information to Hospital B about the historical costs of episodes at Hospital B only).

Hospitals are expected to perform reasonability checks on these data, and to supply the health plans with various non-price statistics that are more reliable at the hospital level, e.g., length of stay and historical readmission rates for the target procedures.

Timelines are negotiated as part of the project work plans for each phase of the project.

**Q16: How will provider gainsharing work under the pilot?**

**A16:** Provider gainsharing details are negotiated between the participating provider organizations and remain confidential to those parties. The project expects that negotiated gainsharing agreements will include both quality and efficiency metrics. For Medicare Advantage products, gainsharing amounts should not exceed limits outlined in provider incentive regulations under Medicare.

**Q17: Does participation in the pilot present any regulatory concerns?**

**A17:** All pilot participants must ensure that their participation complies with existing laws and regulations. IHA has reviewed the pilot as currently designed for the PPO population (90-day episode, no plan design changes) with the Department of Managed Healthcare (DMHC) and received a non-binding opinion that the design does not trigger Knox-Keene licensure requirements. Health plans regulated by DMHC must still file usual paperwork describing the payment terms and ensure that participation does not adversely affect patient access to care. Regulatory issues affecting HMO and Medicare Advantage populations are still under review.

**Q18: What will it cost us? How is the project funded?**

**A18:** Each participating organization funds its own development and implementation expenses, including the effort to supply required historical claim data. IHA's work to develop the initial 2010 phase of the project has been funded jointly by the California Health Care Foundation and the Blue Shield of California Foundation. IHA is developing a funding plan for the second and third year of the pilot.

**Q19. How will the pilot be evaluated?**

**A19.** The objective for Phase I of the pilot is to prove concept. Initial pilot evaluation parameters include:

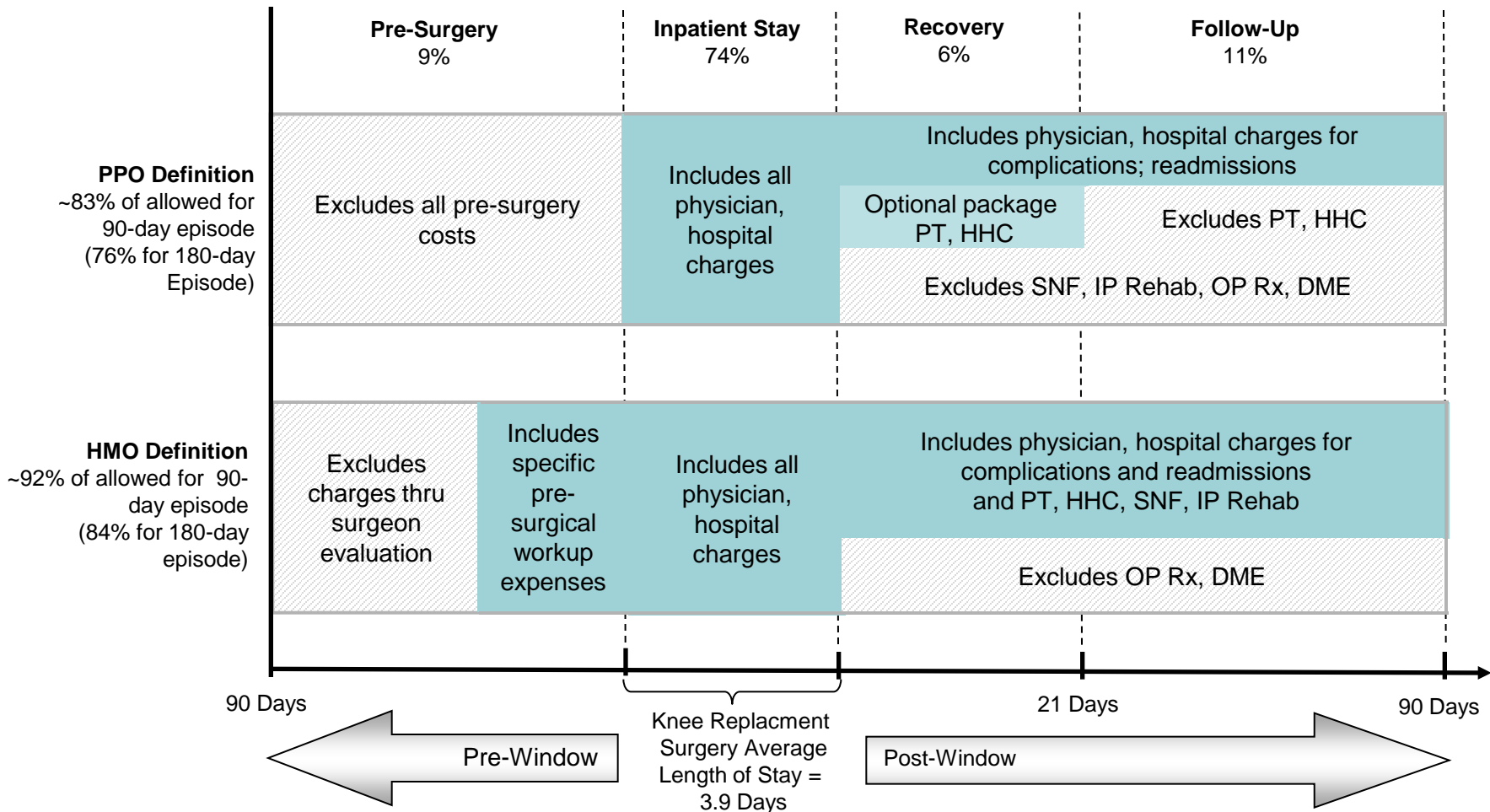
- Whether pilot participants agree on a common episode definition and can negotiate payment on a bundled basis
- Whether the financial incentives of episode payment are sufficient to induce providers to rethink care pathways in ways anticipated to improve both care quality and efficiency
- Whether episode payment is scalable beyond the first pilot participants

As the patient population included in the pilot increases over time, the pilot will begin to incorporate explicit measures of quality and efficiency. Another key evaluation point will occur when the initial bundled episode payment contracts renew: Did the pilot moderate the cost of targeted procedures in California and were savings shared across participating providers, health plans and consumers?



# Episode Definition: Knee Replacement

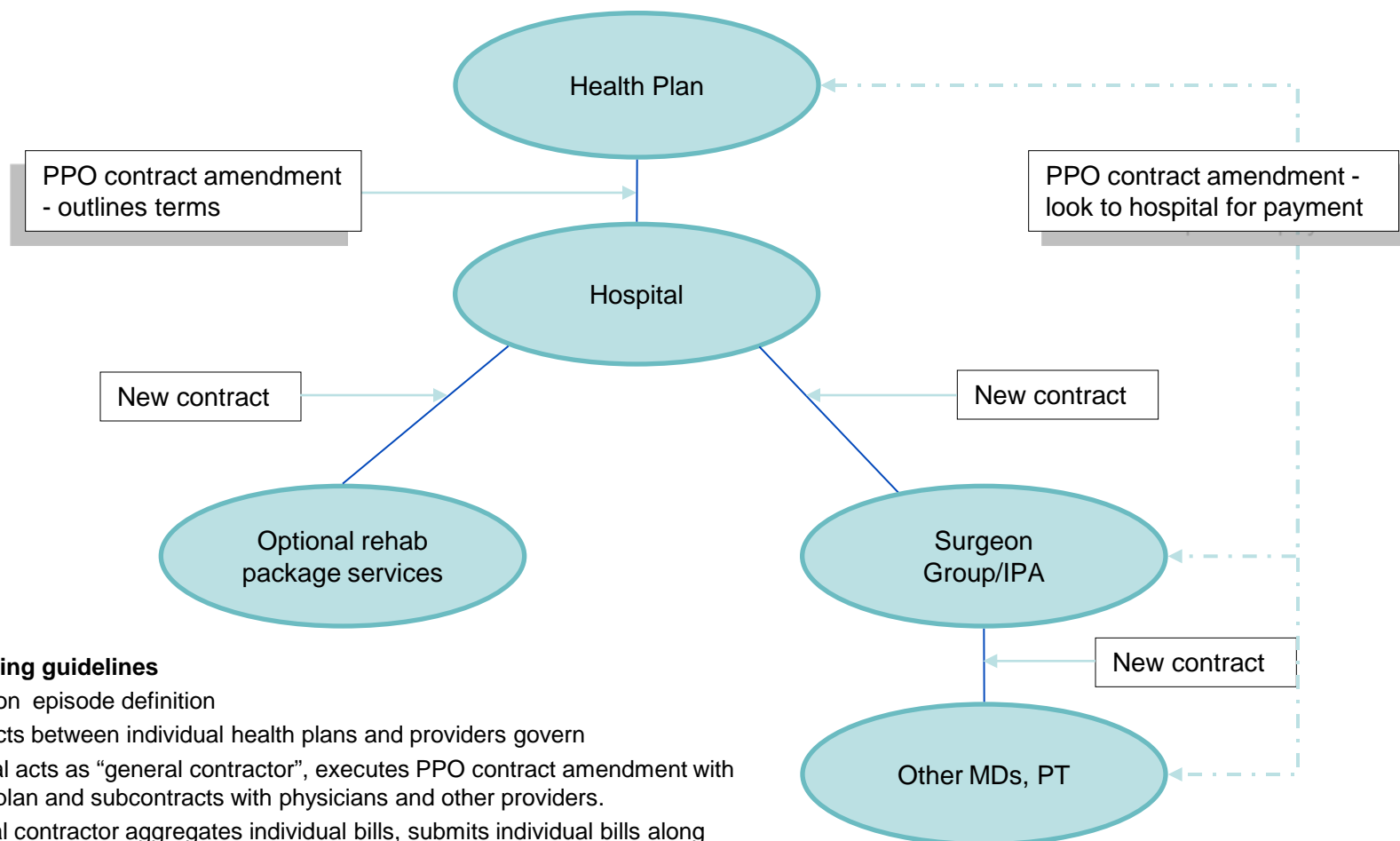
## Distribution of Contractual Allowed Amounts in Commercial Population<sup>1</sup>



<sup>1</sup>Source: Ingenix Claims Data – 7,632 complete episodes



## Contracting Model for PPO—Hospital as General Contractor

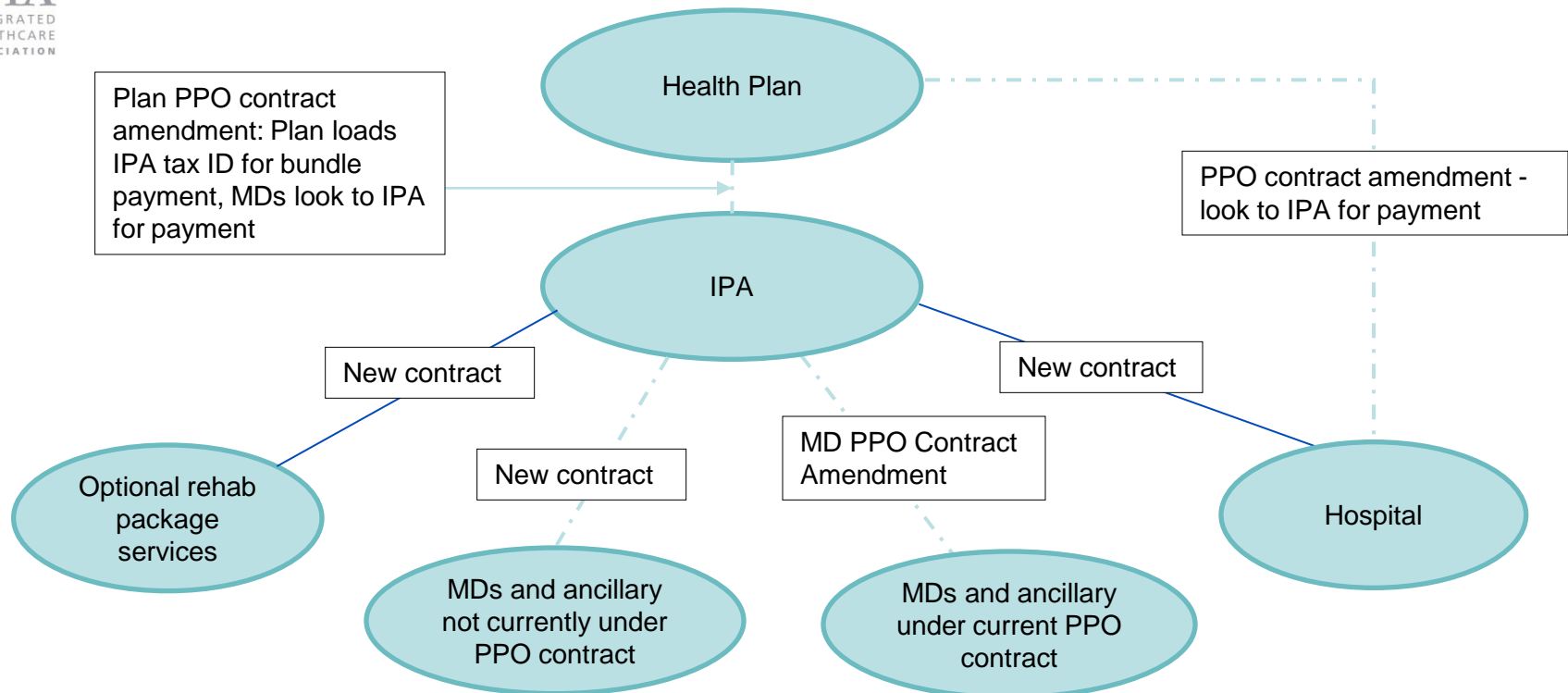


### Contracting guidelines

- Common episode definition
- Contracts between individual health plans and providers govern
- Hospital acts as “general contractor”, executes PPO contract amendment with health plan and subcontracts with physicians and other providers.
- General contractor aggregates individual bills, submits individual bills along with claim for full bundled rate at discharge.
- Plan pays full bundled amount to general contractor.
- General contractor disperses payment to sub-contractors
- General contractor aggregates bills for services post-discharge and submits to plan at end of episode to capture service line detail (no further payment due).



## Contracting Model for PPO—IPA as General Contractor



### Contracting guidelines

- Common episode definition
- Contracts between individual health plans and providers govern
- IPA acts as “general contractor”, executes PPO contract amendment with health plan (or if entering into PPO arrangement with health plan, new contract with bundled payment language)
- Amendment to existing IPA/MD PPO contract (or if entering into PPO arrangement with IPA, new contract with bundled language) to look to IPA for episode payment; IPA contracts with hospital and rehabilitation service providers
- General contractor aggregates individual bills, submits individual bills along with claim for full bundled rate at discharge.
- Plan pays full bundled amount to general contractor.
- General contractor disperses payment to sub-contractors.
- General contractor aggregates bills for services post-discharge and submits to plan at end of episode to capture service line detail (no further payment due).

### Key Bundled Payment Administrative Processes: Hospital as General Contractor

