

Maternity Multi-Stakeholder Action Collaborative

Session 8: Contracting with Providers



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**PROMETHEUS Payment[®] Provider-
Payer Contract Amendment Template
Principles**

PROMETHEUS Payment[®] **Provider-Payer Contract Amendment Template Principles**

This document and the attached contract amendment template (the “Template”) have been created as a foundation for Payors and Providers to modify and customize for the purpose of creating an appropriate amendment to their existing Provider Participation Agreement. This document and the Template assume at least a passing familiarity with the basic principles of the PROMETHEUS Payment[®] Model (the “Model”) described at www.hci3.org. Set forth below are some of the predicates for the Template. For purposes of these Principles, “PPI” refers to PROMETHEUS Payment, Inc. and its successors.

1. The design and principles associated with the Model are more fully described in the documents posted on the HCI3 website from time to time (collectively, the “Program”). Some aspects of the Model and the Program are copyrighted and trademarked. Unless otherwise agreed, all parties are expected to comply with the Program as it evolves in order to assure the coherence and intellectual integrity of the Model and its design.
2. It is expected that each Payer will adopt specific policies that will guide the local implementation and operation of the Model. These policies, which are in the nature of a provider manual for the Program implementation and operation, are referred to as the “PROMETHEUS Payment[®] Policies” or “Policies”. They must be consistent with the Program.
3. There are various aspects of the local implementation of the Program which are flexible in accordance with the decisions collaboratively made by the participating Providers and Payors. These include the extent to which the dollars identified by the ECR[®] Analytics as falling into the Potentially Avoidable Complications funds (PAC allowances) are allocated to the ECR[®] Budget for each condition. In the original enunciation of the Model fifty percent (50%) of the PAC monies was allocated to Providers in the ECR Budget. However, in implementing the Model each Payer may choose to allocate more or less than fifty percent, depending on its goals. It may allocate all of these dollars, or it may allocate them differently, or variably among categories of Provider.
4. Another flexible element in the Program is the quality threshold above which Providers become eligible to be paid monies remaining in their PAC funds after claims have been paid. In the initial design of the Program, seventy percent (70%) of the Provider’s score turns on what that Provider does, thirty percent (30%) turns on what everyone else treating the patient for the ECR condition does; and there must be a minimum of a score of sixty-five (65) for the Provider to be eligible for any allocation of remainders in the PAC Pools. These percentages and thresholds may vary. These decisions would be set forth in the exhibit which is attached in the Template as Exhibit A.

5. The date upon which the final financial reconciliation regarding Provider payment is made for each ECR® (“Reconciliation”) turns on the scope of the ECR® and how long it extends. The process entails calculating the Provider’s Scores, deducting all claims paid for care from the ECR® Budget, and determining if the Provider qualifies. In order to accommodate “late” claims submission, meaning claims submitted close to the expiration of the ECR®, the ECR®s will be reconciled beginning ninety (90) days after their conclusion. The chart below shows the general scope of the various types of ECR®s.

Type of ECR	Trigger	Time Window
Chronic Medical	Outpatient Professional	One year from trigger
Acute Medical	Inpatient Facility	0 day look back; 30 day look forward
Inpatient Procedural	Inpatient Facility / Professional	30 day look back; 180 day look forward
Outpatient Procedural (i) With either inpt or outpt facility e.g. angioplasty (ii) With no inpt facility e.g. colonoscopy (iii) Pregnancy and Delivery	Outpatient Facility/Professional	(i) 30 day look back; 90 day look forward (ii) 7 day look-back; 30 day look-forward (iii) 294 days (42 weeks) look-back period, 42 days (6 weeks) look-forward period.

6. Not all funds in ECR Budgets will be paid to treating Providers. All monies, if any, remaining in ECR Budgets are to be paid in some measure to some proportion of top performing Providers. In the initial design, the top twenty-five percent (25%) of Providers would be paid this bonus. In local implementation, a different percentile could be used, or none.

7. Specific procedures for appeals to PPI are included in the Model set forth on the HCI3 website and in the Policies. PPI, Payer and each Provider shall each designate a contact person for appeals and all communications regarding appeals shall be conducted by such personnel.

A. The following issues may be appealed to PPI:

- (1) Whether an ECR has been triggered, terminated or concluded;
- (2) The allocation of payments among providers rendering services within an ECR Budget;

- (3) Whether severity adjusters have been properly applied to the Provider's ECR Budget;
- (4) Data discrepancies associated with the Scorecard;
- (5) Application of the Scores to the ECR Budget to produce the Scored Amount
- (6) Whether the provider was eligible for the ECR Bonus Payment

B. The following issues may be appealed to the Payor in accordance with the processes set forth in the Provider Participation Agreement:

- (1) Payments or denial of payments made pursuant to paragraph 3A of the Provider-Payor Contract Amendment Template;
- (2) The amounts remaining in the ECR Budget after payments are made pursuant to paragraph 3A of the Provider-Payor Contract Template;
- (3) The termination of Provider from the PROMETHEUS Payment program hereunder as set forth in paragraph 7 of the Provider-Payor Contract Amendment Template.

PROMETHEUS PAYMENT® CONTRACT AMENDMENT TEMPLATE

This Amendment to the *[Provider]* Participation Agreement between *[Provider]* and *[Payor]* is effective as of _____, 20__.

WHEREAS, Provider and Payor have entered into a Provider Participation Agreement (the “PPA”) providing for Payor’s payment to Provider for services rendered for which coverage by Payor is available in accordance with such Agreement; and

WHEREAS, Provider and Payor seek to amend the PPA with respect to specified Covered Services as defined in the PPA, which Payor is willing to pay using the PROMETHEUS Payment® model for services which are eligible for payment based upon Evidence-informed Case Rates® (“ECRs”) and the performance of which is scored in accordance with PROMETHEUS Payment principles as set forth more fully herein.

NOW THEREFORE, in consideration of the mutual promises set forth herein and other good and valuable consideration the receipt and sufficiency of which is hereby acknowledged and intending to be legally bound, the parties agree as follows:

1. Definitions

A. “ECR” means the clinically defined constellation of medical, facility, pharmacy, and other clinical services which are included in the ECR Budgets set forth on Exhibit A which is incorporated herein by reference, which ECRs are triggered by the Provider’s submission of claims with codes as set forth in the PROMETHEUS Payment Policies and are terminated or expire in accordance with such Policies.

B. “ECR Bonus Payment” means the additional funds, if any, which remain from unpaid ECR Budget amounts associated with other providers’ delivery of ECR-based care which are available to pay the top *[quartile]* of providers whose scores qualify them for an additional payment above the ECR Budget amounts for which they have already qualified. *[Note: Payors and providers may negotiate a different percentile of qualifying providers.]*

C. “ECR Budget” means the total dollar amount which Payor has allocated for a single ECR to extend no longer than a Plan Year for the delivery of the services of all providers treating a patient whose care is paid under an ECR.

D. “ECR Remainder” means the amount remaining in the Provider ECR Budget after payment of claims pursuant to paragraph 2 hereof.

E. “HIPAA” means the Health Insurance Portability and Accountability Act of 1996 as amended.

F. “Intellectual Property” or “IP” means all inventions, discoveries, ideas, processes, algorithms, methodologies, software, designs, models, works of authorship (whether in tangible or electronic form), any derivative works with respect to a work of authorship, data and data sets, know how, trade secrets, unique and innovative uses of an existing invention and Marks or other designations of origin, whether or not protected by patent, copyright, trade mark or trade secret or similar law.

G. “IP Rights” means patents, trademarks, service marks, trade names, copyrights, design rights and trade secret rights and all rights or forms of protection of a similar nature or having equivalent or similar effect to any of them which may exist anywhere in the world with respect to any or all of the IP, whether or not any of such IP Rights are registered, and including applications for registration for any of them.

H. “Marks” means any and all trademarks, trade names, service marks, logos and other identifying information of either Party or its services that exist during the Term including all IP and IP Rights related to any of the foregoing. Marks of PPI include, without limitation, PROMETHEUS Payment®, PROMETHEUS, PROMETHEUS Payment, Inc., PPI, PROMETHEUS Model, ECRs®, PROMETHEUS ECRs®, Evidence-informed Case Rates® and any variant of the foregoing.

I. “Plan Year” means the 365-day fiscal year of financial account delimiting the beginning and end of eligibility for participating plan beneficiaries and the funding pools calculated to pay for health care claims arising from that period, as determined by rolling renewal dates; e.g., January 1st to December 31st, or any other fiscal-year period as determined by Payor, e.g., June 1st to May 31st.

J. “PROMETHEUS Payment Materials” or “Materials” means all data, information and other material provided by or made available to Provider or Payor by PPI or its agents or subcontractors in connection with this Agreement or otherwise, including without limitation, the PROMETHEUS Payment model, the PROMETHEUS Payment Program, the ECRs (including the ECR base materials and the ECR analytics), all confidential or proprietary information of PPI related to the Program, all playbooks, manuals, policies prepared for the implementation of the Program and all materials posted during the Term on the PPI website, including all IP and IP Rights related to any of the foregoing.

K. “PROMETHEUS Payment Policies” or “Policies” means the documents which set forth Payor’s operational rules and regulations regarding the implementation and operation of the PROMETHEUS Payment Program by Payor.

L. “PROMETHEUS Payment Program” or the “Program” means the program set forth at www.hci3.org, including the design of and principles associated with the PROMETHEUS Payment model of payment reform, and all documents describing the model as updated and refined on the PPI website from time-to-time.

M. “Provider ECR Budget” means the maximum amount of money for each ECR within the ECR Budget which Provider and Payor have agreed is available to be paid to Provider as set forth in Exhibit A.

N. “PPI” means PROMETHEUS Payment, Inc. and its successors.

O. “Quality Threshold” is that Score as set forth in Exhibit A that Payor and Provider have agreed must be achieved for Provider to be eligible to receive Scored Amounts under paragraph 3.

P. “Reconciliation” means the process described in the Model by which all claims from Provider and all other providers rendering services under an ECR Budget are added up and compared to the pre-calculated ECR Budget in order to determine if there are amounts remaining that will be available to pay Provider under paragraph 3. Reconciliation of ECR Budgets shall occur for an acute ECR no sooner than ninety days from either, for an acute ECR the conclusion of the treatment for the condition for which the patient is receiving services under an ECR Budget, or for chronic care ECRs at the end of the Plan Year (either the “Reconciliation Date”).

Q. “Reconciliation Date” shall mean the date used for Reconciliation hereunder as determined by Payor in accordance with the Policies and the Program. The Payor may, in its reasonable discretion, delay the Reconciliation Date if the Provider has not provided all data required for Reconciliation on a timely basis.

R. “Scorecard/Scores/Scoring” means the process by which a Provider’s quality scores are calculated based upon the data provided by the Provider in accordance with the Policies, the Program and the terms agreed upon in this Amendment.

2. Policies

A. Payor represents and warrants it has provided to Provider all Policies as they were in effect as of the effective date of this Amendment. Payor agrees it will deliver to Provider in writing any updates, changes or additions during the term of the Amendment, no less than thirty (30) days prior to their effective date.

B. The Policies shall contain aspects of the PROMETHEUS Payment Program which are specific to Payor’s implementation and operation of the Model, including such matters as the Quality Threshold Score, the ratio in the Scoring (e.g. 70-30) of Provider’s Scores to those of all other providers treating the patient for the ECR condition, the amounts allocated to the ECR Budget from Potentially Available Complications (PACs) funds as the PROMETHEUS Payment Program defines such terms and the percentile of providers eligible for the ECR Bonus Payment. Such Policies shall be consistent with the Program and if the Program and Policies are inconsistent the Program shall control.

C. Provider shall comply with the applicable Policies and the Program as they are made available hereunder.

3. Provider Claim Submission, Payment and Reporting

A. Provider shall submit claims to Payor as is otherwise set forth in the PPA, and Payor shall pay such claims as set forth therein, except as this Amendment provides for additional payments under paragraph 4 and greater latitude in the delivery and documentation of Covered Services as set forth in paragraphs 5 and 9.

B. Provider shall report data to populate the Scorecard at such times and in such manner as is set forth in the PROMETHEUS Payment Program and PROMETHEUS Payment Policies, with which Provider hereby agrees to comply.

C. Provider shall have the opportunity to review and comment on any data about Provider before the publication in any media of Provider-identified data by either Payor or PPI.; provided, however that the opportunity to review and comment shall not be required to the extent that the data (i) is made public by a third party without breach of this Amendment, (ii) has been independently developed without use of Provider's data, or (iii) publication is required by law without an opportunity for Provider to review and comment.

4. Reconciliation and Payment

A. Within thirty days of the Reconciliation Date for each ECR Budget, as set forth in the PROMETHEUS Payment Policies, Payor shall reconcile the amounts paid pursuant to paragraph 3 during the term of the ECR and the Provider's ECR Budget for such patient's ECR, as modified by Provider's Scores as reported by PPI to Payor (the "Scored Amount") in accordance with the PROMETHEUS Payment Policies. Notwithstanding the foregoing, if Provider has not submitted required data for Scoring on a timely basis, Payor may, in its reasonable discretion extend the period for Reconciliation.

B. To the extent that the amounts paid to Provider under paragraph 3 exceed the total amount available in the Provider's ECR Budget, no additional payment shall be made by Payor to Provider.

C. To the extent that the amounts paid to Provider pursuant to paragraph 3 are less than the Provider's ECR Budget, within ____ days of the completion of Reconciliation, Payor shall pay to Provider the Scored Amount associated with each ECR hereunder.

D. If the Provider qualifies for the ECR Bonus Payment, as determined by the PROMETHEUS Payment Program, Payor shall pay such amounts within ____ days of the conclusion of the annual Reconciliation for all Providers paid on the specific ECR during the year.

E. Payor shall provide to Provider the itemized report from PPI of the calculations supporting all amounts paid hereunder.

F. If two providers seek to be paid amounts remaining in the ECR Budget for the same ECR, Payor shall notify such providers of such dispute, and shall permit them to determine who will be considered the consultant whose payment under paragraph 3 will be the total amount paid to him or it, and who will be eligible to be paid the Scored Amount under 4C hereof. If they cannot resolve the matter between them and each provide written notice of the resolution to Payor within thirty (30) days, the ECR in question shall be considered terminated (i.e. no longer in effect) and the amount already paid under paragraph 3 will be the total amount that either provider will be paid for those Covered Services.

5. Carve-Out Requirements

A. Medical Management Programs. To the extent the PPA requires Provider's care to be subject to medical management programs including but not limited to prior authorization of services, concurrent review, post-payment review, disease management programs, imaging benefit management, utilization and medical necessity review, such requirements shall be waived for services subject to an ECR hereunder.

B. Non-physician Practitioners and Ancillary Personnel. To the extent the PPA specifies which types of clinicians may submit claims for Covered Services, including but not limited to non-physician practitioners and other ancillary personnel, such provisions are waived for services provided pursuant to an ECR hereunder, provided that all personnel comply with state law pertaining to licensure and qualifications in delivering Covered Services.

C. Documentation. To the extent the PPA specifies required documentation of the medical necessity of individual services provided under an ECR, or documentation of specific levels of evaluation and management codes for which claims are submitted under paragraph 2, such requirements shall be waived with respect to services rendered within the Provider's ECR Budget.

D. Care Delivery Flexibility. The parties acknowledge that the purpose of the PROMETHEUS Payment Program is to encourage and facilitate innovative approaches to care delivery to improve quality of care. To the extent Provider uses innovative techniques which are not specifically addressed in the PPA or any other policies of Payor, but which Provider believes will enhance the delivery of care to patients treated under an ECR, the Payor shall be flexible in allowing such innovations in care delivery.

6. Dispute Resolution

A. The following matters are not subject to appeal:

- (1) The choice of a clinical practice guideline as the basis for modeling an ECR
- (2) The scope of or recalibration of an ECR;
- (3) The Provider's ECR Budget, which is set forth in Exhibit A;
- (4) The definitions of severity adjusters, co-morbidities and Potentially Avoidable Complications (PACs) associated with an ECR;
- (5) The rules pertaining to the triggers, termination and conclusion of ECRs;
- (6) The determination to consider an ECR terminated as provided in 4E
- (7) The measures for Scores and the Scorecard.

B. Other issues which are subject to appeal shall be processed as set forth in paragraph 7, and shall be the exclusive processes available to review matters arising in implementation of the PROMETHEUS Payment model.

7. Appeals

A. Appeals to the Payor shall be submitted in accordance with the provisions otherwise applicable in the PPA. *[Note: If no appeal procedures are available under the PPA, Payor must establish an appeals process for appeals assigned to it hereunder.]*

B. Other appeals shall be submitted in accordance with the PROMETHEUS Payment Program.

8. Termination

A. Payor may terminate Provider from participation in the PROMETHEUS Payment model of payment hereunder for breach of an obligation herein, upon notice and thirty (30) days opportunity to cure such breach if such breach is capable of cure or immediately upon written notice if such breach is not capable of cure.

B. Payor may terminate Provider upon thirty (30) days notice from participation in the PROMETHEUS Payment model of payment hereunder because of Provider's inability to exceed the Quality Threshold for payment of the ECR Remainders. No such termination shall be effective until the conclusion of all pending appeals to PPI regarding Scoring.

C. Payor may terminate Provider immediately upon notice in any instance of Payor's good faith belief that Provider has falsified, omitted, or on any other basis submitted inaccurate information upon which any payment could be based hereunder. Provider shall have fifteen (15) days after termination to submit any information to rebut the basis for the termination, which Payor may consider. Such rebuttal is the only appeal of such termination.

D. Provider may terminate its participation in the PROMETHEUS Payment model for any reason upon thirty (30) days notice to Payor.

E. If this Amendment is terminated for any reason, Provider shall not be entitled to any payments under Paragraph 3.

F. This Amendment shall automatically terminate if the PPA is terminated for any reason.

G. Termination of participation in the PROMETHEUS Payment model of payment hereunder shall not terminate the PPA.

9. Cooperation and Collaboration

The parties acknowledge that the implementation of the PROMETHEUS Payment model is a start-up undertaking and will succeed based on the willing cooperation of both parties to refine the program and enhance its features. The parties acknowledge that to maximize the opportunities available to all, that good communication, cooperation and collaboration are critical. Provider agrees to participate, at mutually agreeable times, in discussion opportunities with Payor as well as other providers participating in the program to share experiences. Provider hereby agrees that it will be available, at mutually convenient times, to respond to reasonable inquiries from other providers seeking information about the experience of participation.

10. Intellectual Property and Disclaimers

A. Provider shall at all times own the data reporting Provider's delivery of care to patients for whom Provider is compensated hereunder unless otherwise provided by applicable law.

B. Subject to the limitations on disclosure set forth herein, Provider and Payor each hereby grant PPI a perpetual, royalty free worldwide license to use, make derivative works from, publish and disclose any and all data, reports, metrics or other information reported, available, submitted or developed for or in connection with Scoring or otherwise made available to PPI or its agents or subcontractors hereunder and all derivatives thereof for (1) data analysis; (2) Program improvement, including the further development of existing ECRs or the development of new ECRs; (3) scholarly publication and/or presentation at conferences and (4) other purposes consistent with the further development and adoption of the PROMETHEUS Payment model

C. No license to use the Marks or other IP of PPI is granted under this Agreement; provided, however, that it shall not be deemed a violation of the foregoing if, when engaging in activity permitted hereunder, Payor or Provider correctly refers to the PPI Marks, the Program Materials or any other IP of PPI with the applicable ® symbol or other designation of IP Rights in a manner consistent with the typical usage by PPI.

Provider and Payor each acknowledge that any permitted use of the PPI Marks may not dilute, impair or adversely affect such Marks or the related goodwill. Each of Provider and Payor shall promptly correct its usage of such Marks upon reasonable request.

D. As further provided at <http://www.hci3.org>, Provider acknowledges that it has no ownership or license interest in or to the Program or Materials that existed prior to this Agreement or are created hereafter (including improvements, inventions and derivative works) and that PPI is the sole owner of thereof. If reasonably requested by PPI, Provider shall execute additional documents to confirm such ownership.

E. Nothing contained herein shall modify or otherwise affect any party's ownership of any Intellectual Property that existed prior to this Agreement or any IP Rights related to such Intellectual Property.

I. THE PARTIES RECOGNIZE AND ACKNOWLEDGE THAT THE PROGRAM AND THE MATERIALS ARE NOT INTENDED TO SUBSTITUTE FOR OR TO REPLACE THE SKILL, KNOWLEDGE, AND EXPERIENCE OF LICENSED PHYSICIANS, OTHER CARE PROVIDERS OR ANY HEALTH CARE FACILITY. PPI ASSUMES NO RESPONSIBILITY FOR PATIENT CARE AND EXPRESSLY STATES THAT IT IS NOT PROVIDING THE PROGRAM OR THE MATERIALS AS A SUBSTITUTE OR REPLACEMENT FOR THE MEDICAL JUDGMENT OF PHYSICIANS, OTHER CARE PROVIDERS OR ANY HEALTH CARE FACILITY. THE PROVIDER AND PAYOR AGREE THAT PPI HAS NO RESPONSIBILITY WHATSOEVER FOR THE CONDUCT OF THE BUSINESS OF EITHER OF THEM OR FOR PATIENT CARE. THE PROVIDER AND PAYOR EACH HEREBY RELEASE AND AGREE, JOINTLY AND SEVERALLY, TO DEFEND AND INDEMNIFY PPI AND ITS DIRECTORS, OFFICERS, AGENTS, EMPLOYEES, CONTRACTORS AND SUPPLIERS FROM ANY THIRD PARTY CLAIM RELATED TO MEDICAL CARE.

J. THE PROGRAM AND THE MATERIALS AND ALL SERVICES DELIVERED BY PPI OR ITS AGENTS OR SUBCONTRACTORS ARE PROVIDED "AS IS." ANY AND ALL WARRANTIES, WHETHER EXPRESS OR IMPLIED, OR ARISING BY OPERATION OF LAW, ARE HEREBY DISCLAIMED BY PPI, INCLUDING, BUT NOT LIMITED TO, THE WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, TITLE, DESIGN, ACCURACY AND PERFORMANCE, AND ANY IMPLIED WARRANTY AGAINST INFRINGEMENT OR INTERFERENCE WITH ENJOYMENT.

K. IN NO EVENT SHALL PPI OR ITS SUBCONTRACTORS OR AGENTS BE LIABLE FOR ANY DIRECT DAMAGES WITH RESPECT TO THIS AGREEMENT BASED ON ANY THEORY OF LIABILITY OR CAUSE OF ACTION. UNDER NO CIRCUMSTANCES SHALL PPI OR ITS SUBCONTRACTORS OR AGENTS BE LIABLE FOR ANY INDIRECT, SPECIAL OR CONSEQUENTIAL DAMAGES, INCLUDING WITHOUT LIMITATION, LOST PROFITS, WHETHER

ARISING IN CONTRACT OR IN TORT, EVEN IF ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

L. PROVIDER HEREBY ACKNOWLEDGES AND AGREES THAT ALTHOUGH CERTAIN PROVISIONS OF THIS AGREEMENT REFER TO PPI AS REQUIRED BY THE TERMS OF PPI'S AGREEMENT WITH PAYOR, PPI IS NOT A PARTY TO THIS AGREEMENT AND PROVIDER HAS NO RIGHTS AGAINST PPI, ITS AGENTS OR SUBCONTRACTORS UNDER THIS AGREEMENT OR OTHERWISE.

11. Miscellaneous

A. To the extent there is any inconsistency between the PPA and this Amendment, this Amendment shall control.

B. All other provisions of the PPA shall remain in full force and effect.

IN WITNESS WHEREOF and intending to be legally bound the parties execute this Amendment.

Provider

Payor

Exhibit A

Payment Amounts

[This Exhibit sets forth the ECRs for which the Provider is participating, the Provider's ECR Budget Amount for each for the Base Payment amount without severity adjusters. This Exhibit should also state under the name of the ECR, the scope of the services the Provider is rendering (e.g. physician services only; physician services and imaging, inpatient and outpatient hospital services, pharmacy services, post-acute rehabilitation services. For an IDS, it would be all services. For the physicians, since they will file claims on 1500s, this could be a CPT code list].

ECR and Scope Base Payment Amount* Quality Threshold Score

* This Exhibit provides only the Base Amount for the Provider's ECR Budget. Severity adjusters will be applied in accordance with the applicable ECR Playbook which can be found at www.prometheuspayout.org/playbook/index.htm

**Integrated Healthcare Association
Bundled Episode Payment Contract
Template**

HEALTH PLAN and HOSPITAL ADDENDUM TO PPO AGREEMENT

THIS BUNDLED PAYMENT ADDENDUM (this “Addendum”) is made and entered into by and between _____, a (“Plan”), and _____, a California _____ (“Provider”), as of _____, 20___. (Plan and Provider are referred to herein individually as a “Party” and collectively as the “Parties”).

This Addendum sets forth the terms and conditions under which Provider will participate in a bundled payment arrangement (“Bundled Payment Program”). Pursuant to the Bundled Payment Program, Provider has contracted with other providers to accept one case rate from Plan for specified services, which include both hospital and post-acute services.

This Addendum effective date (“Bundled Payment Addendum Effective Date”) is listed below and binds this Addendum to the Parties’ [PPO Agreement] dated _____ (the “Agreement”). This Addendum shall have a term coterminous with Agreement.

Bundled Payment Addendum Effective Date: _____.

A. INTRODUCTION

The intent of the Parties is that the negotiated bundled episode payment should include all *Covered Services* provided to a *Covered Person* during the *Episode Period* for:

1. An *Index Procedure* of total knee or total hip replacement for patient with degenerative osteoarthritis;
2. Routine Care appropriate to the Index Procedure; and
3. Patient Complications arising during the stay for *Index Procedure* or during the *Episode Warranty Period* following the surgery, *Included Readmissions* and *Revision Procedures* performed during the Episode Period because of complications associated with the original procedure or for mechanical failure.

Provider and Plan may mutually agree to include an optional rehabilitation package for an additional negotiated fee.

B. DEFINITIONS

1. *Covered Services* The following services are included in the episode definition and negotiated episode payment. They may not be separately billed by Provider when treating a Covered Person during the Episode Period.

- During the *Episode Period*, and for any included *Readmission*, Covered Services include:
 - All physicians, anesthesiologists, other attending and consulting physicians fees, beginning with the day of surgery;
 - Preoperative visits after the decision is made to operate;

- Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;
- Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- Postsurgical pain management by the surgeon;
- Supplies, except for those identified as exclusions;
- Miscellaneous Services (items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes);
- All other medically necessary services and supplies;
- All inpatient and outpatient professional services;
- All services provided by Provider or its contracting providers under the Bundled Payment Program.
- During the *Episode Warranty Period* (including *Readmission*), Covered Services include:
 - All Covered Services above: outpatient institutional and professional follow-up care, consultations, and related services, including but not limited to medical care, or similar services; and
 - All other related episode covered services will be included unless they are clearly caused by injury or disease other than the underlying disease for which the Index Procedure is being undertaken. For example, injuries due to an automobile accident or disease unrelated to the diagnosis of degenerative osteoarthritis (for example, primary care or specialist visits for a dermatologic condition).
- Covered Services do NOT include the following:
 - The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery;
 - Outpatient prescription drugs;
 - Professional charges for treatment in a skilled nursing facility;

- Outpatient services clearly unrelated to the Index Procedure or underlying condition, for example, pregnancy or, for osteoarthritis treatment, surgical evaluation and planning for a procedure on a different joint than the one on which the Index Procedure was performed (knee replacement on the other leg); and
- Inpatient services not provided during the admission for the Index Procedure or an Included Readmission (for example, admission for an appendectomy).

2. Episode Period

- The Episode Period begins on the date of admission for the Index Procedure and continues to the 90th day following the date of the original admission.
- Readmissions (as defined) that begin within the Episode Period are included in the episode price (may not be separately billed), even if the period of readmission extends beyond 90 days following the date of the original admission. For example, if a patient were readmitted for a surgical site infection on the 89th day of the Episode Period, the Episode Period would be extended until that patient is discharged.
- Covered Persons who elect to have a second Index Procedure (i.e., total knee replacement on the other knee) during the first Episode Period, begin a new 90-day Episode Period on the date of admission for the second surgery.
- For purposes of determining Covered Services, the Episode Period is divided into:
 - The *acute period* begins on the date of admission to Provider or its partner hospital under the Bundled Payment Program for the Index Procedure and continues to the date of discharge from Provider or its partner hospital for the Index Procedure.
 - The *warranty period* begins on the date of discharge from Provider or its partner hospital for the Index Procedure and continues through the 90th day following date of admission for the Index Procedure.
 - The *rehabilitation period* (only for participants contracting for the optional rehabilitation package) begins on the date of discharge for the Index Procedure and continues through the 21st day following discharge for the Index Procedure.

3. Readmissions

For purposes of the Bundled Payment Program, a Readmission is defined to mean any subsequent admission to an acute care facility that occurs within the Episode Period. However, whether a Readmission is included in the contracted episode rate (and thus may not be separately billed) depends on: a) the facility where the patient is readmitted, and b) whether the readmission is considered to have been caused by or related to the Index Procedure (according to rules below).

- Provider agrees that Covered Persons will be readmitted to the applicable hospital (i.e., the hospital participating under the Bundled Payment Program (the “Participating Hospital”)) except when: the Covered Person requires emergency admission to a closer facility, the Covered Person requires care that cannot be provided at the Participating Hospital, or the Covered Person refuses to be readmitted to the Participating Hospital.
- A readmission at to the Participating Hospital is assumed to be related to the Index Procedure and is included in the episode price (may not be separately billed) if the readmission groups to one of the defined set of DRGs below.

Defined DRGs for Index Procedure of Total Knee Replacement

- 175, 176—Pulmonary embolism
- 294, 295—Deep vein thrombophlebitis
- 463, 464, 465—Wnd debrid & skn grft, exc hand, for musculo-conn tiss dis
- 466, 467, 468—Revision of hip or knee replacement
- 485, 486, 487, 488, 489—Knee Procedures with and without pdx of Infection
- 539, 540, 541—Osteomyelitis
- 553, 554—Bone diseases & arthropathies
- 555, 556—Signs & symptoms of musculoskeletal system & conn tissue
- 559, 560, 561—Aftercare, musculoskeletal system & connective tissue
- 564, 565, 566—Other musculoskeletal sys & connective tissues diagnoses
- 602, 603—Cellulitis
- 856, 857, 858, 862, 863—Post-operative or post-traumatic infections
- 870, 871, 872—Septicemia or severe sepsis (note: these DRGs are included only if septicemia is related to a septic joint or central line infection)
- 901, 902, 903—Wound debridements for injuries
- 919, 920, 921—Complications of treatment
- 939, 940, 941—O.R. procedure with diagnosis of other contact w health services

Defined DRGs for Index Procedure of Total Hip Replacement

- 175, 176—Pulmonary embolism
- 294, 295—Deep vein thrombophlebitis
- 463, 464, 465—Wnd debrid & skn grft, exc hand, for musculo-conn tiss dis
- 466, 467, 468—Revision of hip or knee replacement
- 480, 481, 482—Hip & Femur procedures except major joint
- 533, 534—Fractures of Femur
- 535, 536—Fractures hip and pelvis
- 537,538—Sprains, strains, dislocation hip , pelvis, thigh
- 539, 540, 541—Osteomyelitis
- 553, 554—Bone diseases & arthropathies
- 555, 556—Signs & symptoms of musculoskeletal system & conn tissue
- 559, 560, 561—Aftercare, musculoskeletal system & connective tissue
- 564, 565, 566—Other musculoskeletal sys & connective tissues diagnoses
- 602, 603—Cellulitis
- 856, 857, 858, 862, 863—Post-operative or post-traumatic infections

- 870, 871, 872—Septicemia or severe sepsis (note: these DRGs are included only if septicemia is related to a septic joint or central line infection)
- 901, 902, 903—Wound debridements for injuries
- 919, 920, 921—Complications of treatment
- 939, 940, 941—O.R. procedure with diagnosis of other contact w health services

4. Index procedures

The tables below outline the primary procedure codes (i.e., are in the primary position on the billing code) that will trigger the provisions of this Addendum. Revision procedures other than those occurring within 90-days of an Index Procedure for a Covered Person participating in this Program are also excluded.

Definition of Total Knee Replacement Index Procedure		
<p>Index Procedure Code: This procedure must exist to trigger the episode.</p> <p>CPT:</p> <ul style="list-style-type: none"> ▪ 27447—Arthroplasty, knee condyle and plateau, medial and lateral compartments <p>ICD-9 Px:</p> <ul style="list-style-type: none"> ▪ 81.54—Total Knee replacement 	<p>DRG: Episode must map to one of these DRGs.</p> <p>MS DRG 470 Major Joint Replacement or Reattachment of Lower Extremity without MCC</p> <p>AND APR DRG SOI of 1 or 2</p>	<p>Diagnosis Exclusions: Diagnosis (any position) must NOT equal one of the following:</p> <p>714.0x—Rheumatoid Arthritis 736.89—Other acquired deformities, lower limb 170.7—Malignant neoplasm of long bones of lower limb 171.3—Malignant neoplasm of soft tissue, lower limb, hip 198.5—Secondary malignant neoplasm of bone, marrow 822, 823, 827, 828. 836, 891—Fractures, dislocations and open wounds 928—Crushing injury</p>
Definition of Total Hip Replacement Index Procedure		
<p>Index Procedure Code: This procedure must exist to trigger the episode.</p> <p>CPT:</p> <ul style="list-style-type: none"> ▪ 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) <p>ICD-9 Px:</p> <ul style="list-style-type: none"> ▪ 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 	<p>DRG: Episode must map to one of these DRGs.</p> <p>MS DRG 470 Major Joint Replacement or Reattachment of Lower Extremity without MCC</p> <p>AND APR DRG SOI of 1 or 2</p>	<p>Diagnosis Exclusions: Diagnosis (any position) must NOT equal one of the following:</p> <p>714.0x—Rheumatoid Arthritis 736.89—Other acquired deformities, lower limb 170.7—Malignant neoplasm of long bones of lower limb 171.3—Malignant neoplasm of soft tissue, lower limb, hip 198.5—Secondary malignant neoplasm of bone, marrow 822, 823, 827, 828. 836, 891—Fractures, dislocations and open wounds 928—Crushing injury</p>

5. Optional rehabilitation package

If the Parties agree, the episode may include an optional package of rehabilitation services that will be provided during the *rehabilitation period* (defined above under *Episode Period*). This package will include:

- Initial evaluation by a physical therapist, including development of a recommended physical therapy plan;
- All physical therapy visits provided during the *rehabilitation period*;
- Evaluation by a home health aide or occupational therapist of the Covered Person's physical environment and need for durable medical equipment; and
- All home health visits and/or blood draws to calculate the international normalized ratio (INR) for Covered Persons receiving anti-coagulant therapy provided during the *rehabilitation period*.

6. Covered Person

For inclusion in the Bundled Payment Program, a patient must be:

- Undergoing surgery provided by an orthopedic surgeon contracting directly or indirectly with Plan to provide services under the Bundled Payment Program;
- Admitted to the Participating Hospital under the Bundled Payment Program to provide specified services under the Participating Hospital's applicable payor agreement;
- Presenting for the Index Procedure with an American Society of Anesthesiologists (ASA) rating of <3 (and post-discharge assignment to APR-DRG SOI level of 1 or 2);
- Presenting for the Index Procedure without:
 - Clinical history that demonstrates a clinical condition of active cancer, HIV/AIDS, or End Stage Renal Disease
 - Body Mass Index (BMI) of 40 or greater;
- Over age 18 and under age 65 on the date of surgery; and
- Covered (as primary plan) by a participating employer and health plan on date of surgery.

7. Patient complications

All Covered Services provided to treat patient complications that arise during the Episode Period are included in the negotiated episode rate, and may not be separately billed through the end of Episode Period. Examples of complications include patients with infections, wound issues or cellulitis. Service examples include: joint injection, pain management, X-Ray or MRI, dislocation, incision and drainage of hip joint, removal of hip prosthesis. (All outpatient services after the end of the Episode

Period will be excluded from Covered Services; e.g. treatment for infections that continues for 12 months. However, all costs of an included readmission that begins within the Episode Period even if the readmission extends beyond the 90-day window will be included as a Covered Service).

8. Revision Procedures

Revision procedures are included in the episode payment only if performed within the 90-day Episode Period as a result of patient complications or device failure.

Revision Procedures for Knee Replacement		
<p>Procedure Code These procedure codes constitute a covered revision if performed within 90-days of Index Procedure</p> <p>CPT:</p> <ul style="list-style-type: none"> • 27486—Revision joint total knee arthroplasty with or without allograft 1 component • 27487—Revision joint total knee arthroplasty fem and entire tibl component <p>ICD-9 Px:</p> <ul style="list-style-type: none"> ▪ 00.80—Revision of knee repl, total (all components) ▪ 00.81—Revision of knee repl, tibial component ▪ 00.82—Revision of knee repl, femoral component 00.83—Revision of knee replacement, patellar component ▪ 00.84—Revision of knee replacement, tibial insert (linear) ▪ 81.55—Revision of knee replacement, NOS 	<p>DRG: Admission must map to one of these DRGs.</p> <p>MS DRGs 466—Revision of hip or knee replacement with MCC 467—Revision of hip or knee replacement with CC 468—Revision of hip or knee replacement without CC/MCC</p> <p>APR SOI limitation does not apply if patient was included in the bundle for the Index Procedure.</p>	<p>Included Diagnoses:</p> <ul style="list-style-type: none"> ▪ All
Revision Procedures for Hip Replacement		
<p>Procedure Code These procedure codes constitute a covered revision if performed within 90-days of Index Procedure</p> <p>CPT:</p> <ul style="list-style-type: none"> • 27134—Revision of total hip arthroplasty; both components, with or without autgraft or allograft • 27137—Revision total hip arthroplasty, acetabular component only, with or without autgraft of allograft • 27138—Revision total hip arthroplasty, femoral component only, with or without autgraft or allograft <p>ICD-9 Px:</p> <ul style="list-style-type: none"> ▪ 00.70—Revision of hip repl, both acetabular and femoral components) ▪ 00.71—Revision of hip repl, acetabular component 	<p>DRG: Admission must map to one of these DRGs.</p> <p>MS DRGs 466—Revision of hip or knee replacement with MCC 467—Revision of hip or knee replacement with CC 468—Revision of hip or knee replacement without CC/MCC</p> <p>APR SOI limitation does not apply if patient was included in the bundle for the Index Procedure.</p>	<p>Included Diagnoses:</p> <ul style="list-style-type: none"> ▪ All

<ul style="list-style-type: none"> ▪ 00.72—Revision of hip repl, femoral component 00.73—Revision of hip replacement, acetabular liner and/or femoral head only ▪ 00.87—Resurfacing hip, partial, acetabulum 		
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9. Routine care appropriate to the Index Procedure

This includes:

- Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- Postoperative Visits - Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- Postsurgical Pain Management - By the surgeon;
- Supplies (except for those identified as exclusions and Miscellaneous Services) - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes; and
- Diagnostic tests and procedures, including diagnostic radiological procedures.

C. REFERRALS AND PROVIDER QUALIFICATION CRITERIA

1. Patient Referral

Once a patient is identified as a qualified candidate for the Bundled Payment Program, Provider will follow the authorization requirements as described in the Agreement.

2. Qualification Criteria

Provider must at all times meet Plan’s qualification criteria for Bundled Payment Program participation.

D. PAYMENT TERMS

1. General Payment Terms

For the provision of Covered Services to a patient, Plan will pay Provider under the terms of this Addendum, subject to any benefit plan limitations as described in the Parties' Agreement. The obligation for payment under this Addendum is solely that of Plan. Provider will accept as payment in full for Covered Services rendered the total of amounts payable by Plan pursuant to this Agreement, plus allowed patient charges pursuant to the terms of the Agreement, as may be amended.

2. The Case Rate Payment

Claims for Covered Services included in the case rate for the Episode Period will be paid to Provider at _____ and will be paid pursuant to Section D.3 below. 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. This Addendum shall not apply to any services, including, without limitation, Covered Services that are the financial responsibility of a third party that is not a Plan under this Agreement.

- a) Price: Knee (with or without optional rehab package)
- b) Price: Hip (with or without optional rehab package)
- c) Stop loss or catastrophic claim provisions if any

3. Payment Schedule

For cases paid pursuant to the Bundled Payment Program, Provider will bill the Plan for the full bundled amount no more than sixty (60) days from the date that the applicable Covered Person was discharged from the Participating Hospital for the Index Procedure. Plan will pay Provider within 30 days after receipt of the claim. Notwithstanding the foregoing, in addition to the claim above, Provider shall submit to the Plan a Final Claim at the end of the Episode Period for purposes of data reporting only. For purposes of this Section D.3., a "Final Claim" means an invoice, reasonably detailed, that illustrates all health care services provided to the Covered Person pursuant to the Bundled Payment Program during the Episode Period.

4. 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.

5. Late Payment Penalty

If payment is not received by Provider within 30 days from the date Plan receives a claim from Provider, Plan shall pay Provider interest at a rate of one and one-half percent (1.5%) on any unpaid balance each month the balance is overdue. Provider will make best efforts to notify Plan in writing of its intent to assess this late payment penalty.

6. Referrals to Non-Participating Providers

In the event that a Participating Hospital or other provider under the Bundled Payment Program refers a Covered Person to another facility or provider not participating in the Bundled Payment

Program (collectively, “Non-Participating Providers”) during the Episode Period, and the Participating Hospital or other provider intends to continue treating such Covered 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 Episode Period 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.

7. Premature Closure of Case

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

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

Note that readmission to a hospital other than the Participating Hospital during the Episode Period 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 Addendum. 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 Person leaves the Participating Hospital or otherwise discontinues treatment during the Episode Period “against medical advice.”

E. MISCELLANEOUS PROVISIONS

1. Quality Improvement

Provider agrees to participate and cooperate with Plan and others as desirable or appropriate for purposes of furthering quality improvement and reporting processes as developed for the Bundled Payment Program (e.g., quality measure development and reporting, patient education and/or shared-decision making processes). These processes will not include public reporting of quality information unless such reporting is mutually agreed upon in advance by Provider.

2. Grievance Procedure

The grievance procedure outlined in the Agreement will apply to the processing of any patient complaint regarding Covered Services furnished by Provider.

3. Coordination of Benefits

Provider agrees to coordinate with Plan for proper determination of the coordination of benefits and to bill and collect from other payors such charges for which the other payor is responsible. Such coordination is intended to preclude Provider from receiving or a Covered Person from paying an aggregate of more than one hundred percent (100%) of the rates set forth in this Addendum for Covered Services.

4. Continuation of Services

Upon any termination of this Addendum and Provider’s participation in the Bundled Payment Program, Provider, at Plan’s request, shall remain obligated to furnish those Covered Services that Provider is qualified to provide to any Covered Person under Provider’s care at the time of termination; however, compensation for such services provided after the termination of this Addendum shall be pursuant to the Agreement, and not this Addendum.

5. Effect of Addendum

This Addendum and associated Agreement supersede any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter. As to any particular patient who has accessed Provider for Covered Services under the terms of a prior agreement, the terms of that prior agreement will continue to apply to that patient’s care through the duration of treatment for which terms are included under the prior agreement.

IN WITNESS WHEREOF, the Parties have executed this ADDENDUM on the dates set forth below opposite their respective names.

“PLAN”

“PROVIDER”

By _____
(Signature)

By _____
(Signature)

(Printed Name)

(Printed Name)

Title _____ Date _____

Title _____ Date _____

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