Clinical Episode Contracting for Commercial Payers

January 2019

About This Resource

Background

Bundled payments for care delivery have received significant attention within the Medicare payment program through the Bundled Payments for Care Improvement and Oncology Care Model programs, as well as the mandatory Comprehensive Care for Joint Replacement model. There is increasing interest from the private sector in establishing bundled payments for commercial contracts; however, survey research has shown that uptake of commercial models remains limited.[1]

Members of the Health Care Transformation Task Force ("HCTTF" or "Task Force") experienced with episode payment models have identified five keys to bundled payment success: (1) provider (including specialist) engagement; (2) contracts with clear incentives that put providers/specialists in charge of their patients during a care episode; (3) data transparency so providers can see what drives variability and where the money goes; (4) focused quality metrics that are relevant to patients and providers and are easy to collect; and, (5) continuous innovation. With these elements in place, providers are able to identify new ways to improve care and reduce costs within an episode.

In the commercial market, the second key to success – finding and securing contracts that create incentives and alignment for providers, particularly specialists, to become more engaged – is essential yet arguably the most elusive. This is true for several reasons: specialists care for patients when they're sick and have the most needs/utilize the most resources; specialists are trained to understand specific diseases and procedures and are in the best position to find the "path to improvement" in their areas of expertise; and 70 percent or more of healthcare spending is controlled or significantly influenced by specialists. Without these contracts, specialists will continue to be stuck in fee-for-service and we will not see improvement and innovation in one of the most critical segments of the market.

Objective

The HCTTF, under the strategic direction of its Advanced Payer-Provider Partnerships Work Group, has developed this guidance document to help support payers and providers in the establishment of commercial-sector clinical episode payment contracting relationships.

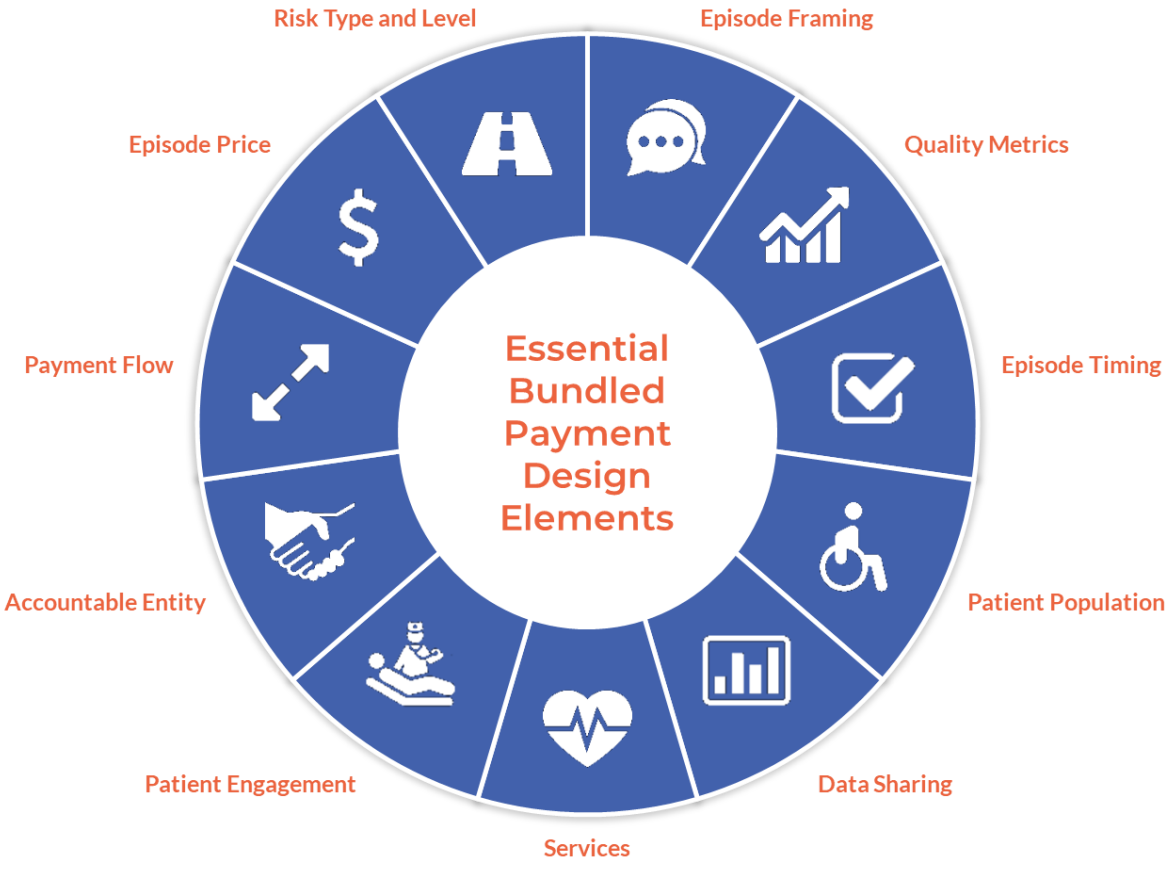
The guidance is generally based on the structure developed by the Health Care Payment Learning and Action Network (LAN) and identifies essential design elements and operational considerations for episode payment models to succeed.[2] While many believe that clinical episode payment programs are complicated, the goal of this document is to create an objective tool for payers and providers to work together to make key program and contract design decisions in a logical, step-wise way. This document also includes links to key resources

[1]de Brantes F and Delbanco S. The Payment Reform Landscape: Is The Debate Over Retrospective Versus Prospective Bundled Payments a Distraction? Health Affairs Blog. June 23, 2017. https://www.healthaffairs.org/do/10.1377/hblog20170623.060736/full/. Accessed December 5, 2018.
[2]Health Care Payment Learning and Action Network. Accelerating and Aligning Clinical Episode Payment Models. 2016. http://hcp-lan.org/workproducts/cep-whitepaper-final.pdf. Accessed December 5, 2018.

that can assist organizations in pursuing specific design elements. Readers are encouraged to refer to the Task Force's recent report, *Episode Groupers: Key Considerations for Implementing Clinical Episode Models* for information on episode grouper software to support clinical episode program implementation.[3]

Commercial Bundled Payment Template

As discussed above, the following template builds upon the bundled payment framework initially developed by the LAN. The categories on the wheel below are reflected in the template "Design Element" categories.[4]



[3] https://hcttf.org/episode-groupers-key-considerations

[4] It is recommended that users of this tool review the LAN report as well, as other factors such as the regulatory environment and interaction with multiple APMs are not addressed in detail in this resource.

Design Element	Recommendations and Approaches
Episode Framing *Initial episode scoping and defining*	Target patients for initial bundled payment contracts and programs should meet the following criteria: • High prevalence in the population; • Significant variation in cost and quality; • Clear opportunities for providers, both specialty and non-specialty, to find a path to improvement; • Good opportunities to drive savings; and • Good opportunities for patient engagement and shared decision-making. The definition process can start with publicly available and/or proprietary definition sets such as: • CMS • Truven Medical Episode Grouper (MEG) • Optum Episode Treatment Groups (ETG) • Prometheus HCI3 These definition sets can be a good starting point that leads to an in-depth conversation and collaboration with participating clinicians and purchasers to determine the final definitions to use. The goal is to leverage existing research and experience to develop episodes that are well understood by all participants and relatively straightforward to manage and adjudicate. The last component of this process is to finalize the trigger events and detailed list of codes that are associated with the trigger event: ICD diagnosis, ICD procedure, HCPCS/CPT, and DRG classifications. Part of this final process should include identification of service inclusion/exclusion criteria. Exclusion criteria should encompass factors that would constitute early termination of an episode, such as mortality or change of insurance.
Quality Metrics *Selection of relevant, priority quality metrics*	It is critically important to select priority metrics directly related to the episode of care in order to drive improvement. Good quality measures: • Focus on metrics that are meaningful to the patient, provider and the payer; • Limit metrics to a manageable number; and • Minimize onerous requirements to collect data that isn't already available.

Design Element	Recommendations and Approaches

	There are a multitude of sources that can be used to identify appropriate quality metrics for specific conditions and procedures. Specific resources include:
	• CMS models:
	  ○ Bundled Payment for Care Improvement - Advanced Program (BPCI-A) (seven quality metrics, including two all-cause and five bundle-specific)
	  ○ Comprehensive Care for Joint Replacement Model (CJM) (joint replacement measures)
	  ○ Oncology Care Model (OCM) (oncology measures)
	• International Consortium for Health Outcomes Measurement (ICHOM): globally-developed standard sets across 24 common condition categories
	• Agency for Healthcare Research and Quality
	• National Quality Forum (AHRQ)

Episode Timing *Definition of episode length and timing in relation to care*	It is critical to define the start and end of the care episode. The episode period should match with the care process and management needs of the patients who have the specific disease or procedure performed. For example, in the CMS programs there are different episode timeframes: OCM is 6 months and BPCI is 30-90 days. An endoscopy or eye surgery bundle could be very short, a maternity bundle is relatively well-defined, and chronic care bundles could be longer. Episode timing should be long enough and have enough variability to create real opportunities for improvement. Similar to the definitions process, start with the episode timing outlined in pre-determined definition sets such as those identified above (see *Episode Framework*) and work with the clinicians, purchasers and data to determine the final episode length for targeted bundles.
Patient Population *Identification of criteria to support patient inclusion or exclusion in bundles*	Ideally, organizations should develop broad inclusion criteria to create large, statistically significant bundled payment programs and spread risk across an adequately-sized patient pool. Multiple episode types and prices may be developed based on risk and severity adjustments.

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	Some patient types may need to be excluded or specially accounted for in various risk elements such as co-morbidities, specific histories, and recurrent episodes; exclusion criteria and mechanisms should be clearly defined.
Data Sharing *Options for data use when claims data is limited*	Outside of the CMS programs data sharing can be a challenge between commercial payers and providers. Below are a few ways to mitigate this limitation in the absence of full, multi-year claims data sharing: • Work with a third-party intermediary to do the analysis, develop the bundle pricing and opportunity assessment, and agree on what information can and cannot be shared (like specific provider pricing) among the participants. • Utilize publicly available data sources to do the opportunity and pricing analysis. Limit the scope of the bundle definitions to elements where the utilization and pricing is more well known by all parties, e.g., just care that is provided directly by the episode-initiating provider.
Services *Grouping of services into comprehensive bundles or bundles contained to a defined condition/treatment*	**Option 1: Comprehensive Bundles** One option is to include all or most of the services needed by the patient that are related to their treatment for the defined condition. This model would cover almost all complications and follow-up care that arise during the episode. The comprehensive approach also allows episode-initiating providers to "shop around" for services based on provider price variation, which can be significant in many markets and is often not linked to quality outcomes. This is the major source of savings in most commercial bundled payment programs. Comprehensive bundles present providers with both opportunities for saving from a broader spectrum of care, and challenges in elevated care coordination demands. Developing and executing this comprehensive structure requires access to complete historical data sets and relationship development with providers outside the scope of the contracting provider; for example, if Radiation Therapy is

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	part of bundle scope, but the practice doesn't have RT, they will need a partner or subcontract relationship to work within the bundle. **Option 2: Limited Bundles** The limited bundled payment approach focuses on the specific treatment requirements for the defined condition and only includes services directly in the control of accountable physicians/providers (e.g., medical oncologist and infusion technician). Limited bundles restrict risks, as well as opportunities for cost saving, to a level that is easier for providers to control, which requires less demand on care coordination. This approach has relatively fewer data requirements for bundled rate development. For example, if only provider data is available, it will not be sufficient to develop a comprehensive payment model but may be enough to establish limited bundle rates. (See above for more discussion on data requirements.)
Patient Engagement *Recommendations for appropriately engaging patients in bundled payments arrangements*	To maximize opportunities to engage patients and families in advancing high-value care, accountable entities should: • Be transparent in performance and payment structures, using language that is understandable to individuals without a health care background; • Develop shared care planning structures; • Provide direct access to full health records; • Employ easy-to-use patient tracking & engagement tools; • Create flexible care coordination across settings; • Provide direct access to comparative provider quality information; and • Establish systems for PRO collection & monitoring. It is also helpful to develop simple, condition-specific strategies for engaging with patients to help them manage their disease and care over the course of the episode. In some instances, it may be appropriate to utilize high-performance networks and value-based insurance design principles to appropriately guide consumers/patients through

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	an episode of care. However, this should be done very thoughtfully to ensure patient health/wellbeing is not adversely impacted; this is especially important in limited bundles, where the full financial effects of adverse health consequences may not be felt by the initiating provider.
Accountable Entity *Characteristics of successful provider accountability*	The accountable provider entity should be chosen based on their ability to manage and improve the care process; knowledge of the clinical condition; level of direct contact and influence they have with patients; commitment and readiness to re-engineer and improve the way that care is delivered; and ability to take and manage a portion of the risk. Provider gainsharing and development of high-performance networks are powerful tools that can significantly influence the outcome of episode payment models. Gainsharing models and contracts have become more prevalent and simpler as the Medicare bundled payment programs have proliferated. These can generally be straightforward arrangements that spell out specific performance expectations and activities that gainsharing partners need to perform, and the amount of gains they are eligible to receive if gains are earned. It is important to have an experienced attorney help develop and evaluate these agreements.
Payment Flow *Recommendations for payment structure (retrospective versus prospective)*	In general, is recommended that payment programs be initially structured using the Retrospective Reconciliation model that CMS used in the BPCI, CJR, and OCM programs. It is easier to start and learn faster in this model. As the program progresses and grows, payers and providers can move to a prospective model if that is the long-term preference. Once the program is in place and providers gain an understanding of the specific claims payment processes of the participants, it is recommended to move toward a prospective model. In either a retrospective or prospective model, it is recommended to initially use a purchaser's prevailing

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	provider rate schedule. Episode-initiating providers can re-negotiate rates with other bundle participants over the course of the program if they choose.
Episode Price *Goals for episode pricing structures*	The price should be set such that it accomplishes the following goals: • Saves money for the purchaser compared to their average historical costs; • Creates potential savings for the patient through lower deductibles and co-pays; and • Enables the episode-initiating provider to make more money than traditional fee-for-service through more efficient utilization of services, value-based site of service choices, and innovative clinical process design. This needs to be balanced through quality metrics and checks on stinting of services, selection bias, and other factors that could negatively impact consumers. It is also important that the episode-initiating providers have visibility into historical claims data and a clearly defined perspective on where and how to improve the process and reduce costs. It is recommended that the target episode price include a combination of regional average and provider's historical cost performance. An estimate of cost savings opportunities and achievable quality improvements, such as lower hospitalization rates or ER rates, can be included. Another factor to consider in target price setting is precise case-mix adjustment. Case-mix adjustment allows for better alignment of program design and payer/provider incentives. Case-mix adjustment is already being used to set target pricing in CMS's BPCI-A bundles (See "Patient Population" section above for more on the topic). The episode price can be revised over time to ensure continual improvement by both more- and less-efficient providers. In this way, the episode price automatically integrates savings and simultaneously incentivizes a compression of variation in cost and quality across all providers.

Design Element	Recommendations and Approaches
	Finally, the episode pricing model should take into account services that are historically under reimbursed, and thus, underused, but are of high value to the patient. Care coordination, patient engagement, shared decision-making, and assessment of patient-reported pain and function are examples of services that could fall under this category. The Monthly Enhanced Oncology Services payments within the OCM program are an example of this structure.
Risk Type and Level *Considerations for risk sharing model design*	The risk sharing model should accomplish enough downside and upside to motivate real engagement in the process, innovation, and change on the part of the specialists and care management team. History seems to show this could range from almost full up and downside risk (like BPCI) to upside only models with moderate hurdle rates (like OCM). Strategies are needed for the protection against "catastrophic" downside risk. This threshold is generally low for specialty physicians and only slightly higher for hospitals.

Additional Resources

Masucci et al. Legal Issues in Designing Bundled Payments and Shared Savings Arrangements in the Commercial Payor Context. Nixon-Peabody, 2013. https://www.nixonpeabody.com/en/ideas/articles/2013/09/26/legal-issues-in-designing-bundled-payments-and-shared-savings-arrangements-in-the-comme. Accessed December 5, 2018.

Robert Wood Johnson Foundation. Bundled Payment: The Quest for Simplicity in Pricing and Tying Payment to Quality. June 2013. http://forces4quality.org/af4q/download-document/6534/Resource-rwjf406415.pdf. Accessed December 5, 2018.

About Us

The Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. The Task Force is committed to rapid, measurable change, both for itself and the country. It aspires to have 75 percent of its members' business operating under value-based payment arrangements by 2020.

This work was led by the Task Force's Advanced Payer-Provider Partnerships Work Group, chaired by Emily Brower (Trinity Health), Mai Pham (Anthem, Inc.), and David Terry (Archway Health). Special thanks to David Terry for his leadership in developing this template.