Bundled Payment Initiative

Total Joint Replacement (TJR)

Humana®

Bundled Payment Overview

Humana offers a retrospective, episode-based model (EBM) bundled payment initiative. In the initiative, one physician/healthcare provider is designated as the principal accountable provider (PAP) for the patient's care throughout the episode of care. The PAP is responsible for all costs of care in the bundle and the clinical outcomes of the episode.

Humana's TJR EBM Program

- Applies to elective total joint replacement (hip or knee)
- Is specific to Humana Medicare Advantage (MA) HMO- and PPO-covered patients
- Designates the orthopedic surgeon as the PAP
- Offers PAP gain-share opportunity

Retrospective Episode

Patients and physicians continue to receive and deliver care as they do today.

1) Patients seek care and select physicians/healthcare providers as they do today.

2) Claims are submitted the same way they are today.

3) Humana reimburses for all services as it does today.

Incentives are paid based on cost and clinical outcomes after close of the performance period.

4) Humana reviews claims from the performance period to identify a PAP for each episode.

5) Humana calculates the average cost per episode for each PAP and then compares risk-adjusted average costs to predetermined thresholds.

6) PAPs who meet quality metrics will receive:

- **Shared savings** if average costs are below the cost target.

OR

- An **individual episode payment (IEP) bonus** for episodes that have a cost below the locality threshold.

Episode Sequence

	Pre-trigger Window	Trigger Procedure	Post-trigger Window
	TJR: Days 1-45 before Surgery Assessment and Pre-admission	**Admit to Discharge** Bundled Procedure	**TJR: Days 1-90 after Discharge** Post-discharge Care

Episode Services Included	• Specialist visits/exams
	• Lab tests
	• Imaging
		• Inpatient/outpatient facility costs
		• Specialist/surgeon professional fees
			• Directly related costs:
			  ○ Readmissions/ED visit
			  ○ Long-term care/therapy
			  ○ Medical/surgical procedures
			  ○ Imaging and testing
			• Specialist visits/exams

Sources of Value	• Ensure appropriate and effective mix of care • Reduce unnecessary or duplicate services	• Use optimal care setting and most cost-efficient facility • Optimize length of stay • Reduce readmissions	• Ensure optimal care setting and care for post-procedure recovery • Reduce complications • Reduce readmissions

Performance Measurement

A PAP's overall performance within the bundled payment initiative is measured using quantitative indicators that are focused on clinical outcomes and cost of care.

CLINICAL OUTCOMES should be met or surpassed to be eligible for a gain-share payment

4 of 4 required:

30-day readmission rate: Percent of included episodes with a readmission to an inpatient setting

30-day DVT/PE rate: Percent of included episodes with deep vein thrombosis (DVT)/ pulmonary embolism (PE) identified using diagnosis codes within any claim

90-day infection rate: Percent of included episodes with postoperative infection identified using diagnosis codes within any claim

90-day dislocation/fracture: Percent of included episodes with a hip or knee dislocation or fracture identified using diagnosis codes within any claim

COST OF CARE target should be met or surpassed to be eligible for a gain-share payment

1 of 1 required:

Average risk-adjusted episode cost: Average risk-adjusted allowed claims cost for included services on all eligible episodes

Inclusion/Exclusion Criteria

The program is designed to compare cost of care and clinical outcomes for like episodes of care. Tokeep the comparison as close as possible, every episode is examined using the exclusion criteria below. Episodes that meet the exclusion criteria are likely to be outside the normal experience and are therefore excluded from program performance measurements/results.

Business Exclusions

- PFFS line of business
- Inconsistent enrollment
- Dual enrollment
- Third-party liability
- Incomplete episode
- High-cost outlier

Clinical Exclusions – "Different Care Pathway"

Claims-based evidence for various clinical conditions that would indicate the patient's care might not follow a standard path, such as:

- Active cancer management
- HIV
- Patient left against medical advice
- Patient died

Enabling PAPs through Reporting

PAP Summary Report (PDF)

- Provided at Tax ID Number (TIN) level
- Designed to show overall performance in program
- Shows gain-share eligibility

Supplemental Report (PDF)

- Provided at TIN and physician/provider level
- Designed to show “next level down”
- Focuses on sources of value within program

Patient Level (xlsx)

- Provides TIN-, physician/provider- and patient-level summaries of included episode cost/quality in one file
- Highlights outliers
- Provides excluded episode reasons

Reporting package is provided to participants quarterly.