Bundled Payment Initiative

Coronary Artery Bypass Grafting (CABG)
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 of the costs of care in the bundle and the clinical outcomes of the episode.

**Humana’s CABG EBM Program**

- Applies to coronary artery bypass grafting surgery
- Designates the cardiothoracic surgeon as the PAP
- Is specific to Humana Medicare Advantage (MA) HMO- and PPO-covered patients
- Offers PAP gain-share opportunity
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 may:
   - **Share savings** if average costs are below the cost target and quality targets are met.
   - **See no change in pay** if average costs are above the target or quality targets are not met.
**Episode Sequence**

<table>
<thead>
<tr>
<th>Trigger Procedure</th>
<th>Post-trigger Window</th>
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| **Admit to Discharge**  
Bundled Procedure | **CABG: Days 1–30 After Discharge**  
Post-discharge Care |
| • Inpatient/outpatient facility costs  
• Specialist/surgeon professional fees | • Directly related costs:  
  o Readmissions/ED visit  
  o Long-term care/therapy  
  o Medical/surgical procedures  
  o Imaging and testing  
• Specialist visits/exams |
| • 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 |
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

3 of 3 required:

- **30-day readmission rate**: Percent of included episodes with a readmission to an inpatient setting
- **30-day complication rate**: Percent of included episodes with specific complications identified using diagnosis and procedure codes within any claim
- **30-day follow-up care rate**: Percent of included episodes with post-operative follow-up care identified using diagnosis and procedure 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
The program is designed to compare cost of care and clinical outcomes for like episodes of care. To keep 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 which would indicate the patient’s care might not follow a standard path, such as:
- Endocarditis, on admission
- Pneumonia, on admission
- Patient died
- Patient left against medical advice
Enabling PAPs through Reporting

PAP Summary Report (pdf)
- Provided at tax ID level
- Designed to show overall performance in program
- Shows gain-share eligibility

Supplemental Report (pdf)
- Provided at tax ID and physician/provider level
- Designed to show “next level down”
- Focuses on sources of value within program

Patient Level (xlsx)
- Provides tax ID-, 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 on a quarterly basis.
Appendix

- Cost of Care Levels
- Cost Zones
Cost of Care Levels

Current Performance Level
- Current average cost per eligible episode, calculated on an individual group basis (using PAP’s historical performance, expected market trend and expected performance)
- Calculated prior to the beginning of the performance year

Commendable Level (“Target”)
- Target average cost per eligible episode; the “start” of shared savings
- If the average episode is below this target and clinical outcome measures are met, the PAP is eligible to receive a percentage of every $1 below the target in the form of shared savings

Low-cost Level
- Minimum allowable average episode cost to which “gain sharing” is limited; the “end” of shared savings
- If the average episode cost is below this target, the PAP’s shared savings opportunity would be limited to the difference between the commendable threshold and low-cost threshold
Cost Zones

Calculation Thresholds and Methodology

**Risk Payment Zone:**
(Acceptable level — risk-adjusted cost) * # of eligible episodes

**Neutral Zone:**
No harm, no foul

**Gain-share Zone:**
(Commendable level — risk-adjusted cost) * # of eligible episodes

**Low-cost Zone:**
(Commendable level — low-cost threshold) * # of eligible episodes

*Risk Payment Zone only applies to participants choosing to be at upside and downside risk.*

*Thresholds above are examples only. Thresholds will be established prior to program start.*