CREATING THE CODING SYSTEMS NEEDED TO IMPLEMENT ALTERNATIVE PAYMENT MODELS

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

www.CHQPR.org
Two Choices for Physicians Under MACRA?

- MACRA
- MERIT-BASED INCENTIVE PAYMENT SYSTEM ("MIPS")
- ALTERNATIVE PAYMENT MODELS
MACRA Actually Enables Three Choices

- Merit-Based Incentive Payment System (“MIPS”)
- CMS-Defined Alternative Payment Models
- Physician-Focused Alternative Payment Models
Why Should *Physicians* Want Alternative Payment Models?
Alternative Payment Models Can Overcome Current FFS Barriers

Barriers in fee-for-service prevent physicians from delivering higher-quality care at lower total cost
Barrier #1 in FFS

BARRIER #1
Payments for new physician services and increases in payments for existing services require reductions in payments for all physician services regardless of value

Barriers in fee-for-service prevent physicians from delivering higher-quality care at lower total cost
If a Specialty Wants Payment for a New Service or Higher Payment

CURRENT FFS

REVISED FFS

Medicare Physician Spending

$ Specialty A CPTs

Specialty A CPTs

Chart Not Drawn to Scale
Federal Budget Neutrality Requires Reductions in All Physician Pmts

CURRENT FFS

REVISED FFS

Budget Neutrality

<table>
<thead>
<tr>
<th>Medicare Physician Spending</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other CPTs</td>
<td></td>
</tr>
<tr>
<td>Specialty A CPTs</td>
<td></td>
</tr>
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<td>Other CPTs</td>
<td></td>
</tr>
<tr>
<td>Specialty A CPTs</td>
<td></td>
</tr>
</tbody>
</table>
Most of the Money in Healthcare Doesn’t Go to *Physicians*

**Medicare Part A, Part B, and Part D Spending in Billions, 2012**

- Prescription Drugs (Part D)
- Other Services
- Home Health Agencies
- Skilled Nursing Facilities
- Hospital Outpatient Services
- Hospital Inpatient Care
- Physicians: 16%
Physicians Order or Influence Most of the Other Spending

Physicians: 16%
Instead of Only Looking Narrowly at Spending on *Physician* Services
Physicians Need to Look at What’s Driving Total Spending

Chart Not Drawn to Scale
Physicians Need to Identify **Avoidable Spending**

**CURRENT FFS**

$\uparrow$

**Total Medicare Spending**

---

**Avoidable Spending**

- Payments for Hospitals, SNFs, Drugs
- Other CPTs
- Specialty A CPTs

---

Chart Not Drawn to Scale
Examples of Avoidable Spending in Every Specialty

**CURRENT FFS**

- **Total Medicare Spending**
  - Avoidable Spending
    - Payments for Hospitals, SNFs, Drugs
    - Other CPTs
    - Specialty A CPTs
  - Medicare Physician Spending

**SURGERY**
- Unnecessary surgery
- Use of unnecessarily-expensive implants
- Infections and complications of surgery
- Overuse of inpatient rehabilitation

**CANCER TREATMENT**
- Use of unnecessarily-expensive drugs
- ER visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life

**CHRONIC DISEASE**
- Failure to address risk factors leading to disease or progression of disease
- ER visits/hospital stays due to exacerbations of condition

**MATERNITY CARE**
- Unnecessary C-Sections
- Early elective deliveries
- Complications of delivery
Many Specialties Have Been Identifying These Opportunities
APMs Can Allow Better Payment for All Specialties…

**CURRENT FFS**

- **Total Medicare Spending**
  - Avoidable Spending
  - Payments for Hospitals, SNFs, Drugs
- Other CPTs
- Specialty A CPTs

**APM**

- Other CPTs
- Specialty A CPTs

*Chart Not Drawn to Scale*
…By Enabling Physicians to Reduce Avoidable Spending
Win-Win-Win Through Alternative Payment Models

CURRENT FFS

$ Total Medicare Spending

Avoidable Spending

Payments for Hospitals, SNFs, Drugs

Other CPTs

Specialty A CPTs

APM

Savings

Avoidable Spending

Payments for Hospitals, SNFs, Drugs

Other CPTs

Specialty A CPTs

WIN: Lower Spending for Payers
WIN: Better Care for Patients
WIN: Better Payment for Physicians

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Barrier #2

Barriers in fee-for-service prevent physicians from delivering higher-quality care at lower total cost.

BARRIER #1
Payments for new physician services and increases in payments for existing services require reductions in payments for all physician services regardless of value.

BARRIER #2
No payment or inadequate payment for many high-value services, e.g.,
- Responding to patient phone calls that can avoid office or ER visits
- Calls among physicians to determine a diagnosis or coordinate care delivery
- Hiring nurses to help chronic disease patients avoid exacerbations
- Providing palliative care to patients with advanced illnesses who are still under treatment
CPT Codes That Medicare Doesn’t Pay For

- Office consultations (99241-5)
- Inpatient consultations (99251-5)
- Standby service (99360)
- Medical team conference (99366-8)
- Preventive medicine counseling (99401-4)
- Telephone evaluation & management (99441-3)
- Education & training for patient self-management (98960-2)
- Telephone assessment by non-physician (98966-8)
- Collection of data from patient (99091)
Many Other High-Value Services That Medicare Doesn’t Pay For

- Office consultations (99241-5)
- Inpatient consultations (99251-5)
- Standby service (99360)
- Medical team conference (99366-8)
- Preventive medicine counseling (99401-4)
- Telephone evaluation & management (99441-3)
- Education & training for patient self-management (98960-2)
- Telephone assessment by non-physician (98966-8)
- Collection of data from patient (99091)

- Palliative care services
- Supervised exercise therapy
- Shared decision-making with patients
Inability to Deliver Unbillable Svcs May Cause Higher Total Spending

Chart Not Drawn to Scale
Alternative Payment Model
Part 1: Pay for High-Value Service

Total Medicare Spending

CURRENT FFS

Avoidable Spending

Payments for Hospitals, SNFs, Drugs

Unbillable Services

Current FFS Payments to Physician

APM

New Billable Services

Current FFS Payments to Physician

Chart Not Drawn to Scale
Alternative Payment Model
Part 2: Accountability for Results

Current FFS Payments to Physician
Unbillable Services
Avoidable Spending
Payments for Hospitals, SNFs, Drugs
Current FFS Payments to Physician

APM Savings
Avoidable Spending
Payments for Hospitals, SNFs, Drugs
New Billable Services

Payment for Additional Services is Adjusted Based on Performance in Reducing Avoidable Spending

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Chart Not Drawn to Scale
The Newly Billable Service is *Only* Billable As Part of an APM

### CURRENT FFS

- **Avoidable Spending**
  - Payments for Hospitals, SNFs, Drugs

- **Current FFS Payments to Physician**

### APM

- **Avoidable Spending**
  - Payments for Hospitals, SNFs, Drugs
  - New Billable Services

- **Savings**

- **Current FFS Payments to Physician**

**Payment for Additional Services is Adjusted Based on Performance in Reducing Avoidable Spending**
Option: Instead of Paying for Each Service, Provide a *Bundled* Pmt

**TOTAL MEDICARE SPENDING**

**CURRENT FFS**

- **Avoidable Spending**
  - Payments for Hospitals, SNFs, Drugs
  - Current FFS Payments to Physician
  - Unbillable Services

**APM**

- **Savings**
  - Avoidable Spending
  - Payments for Hospitals, SNFs, Drugs
  - New Billable Services
  - Current FFS Payments to Physician
  - **New Flexible Bundled Payment for Physician Services**

*Chart Not Drawn to Scale*
Option: Instead of Paying for Each Service, Provide a *Bundled Pmt*

**CURRENT FFS**
- **Avoidable Spending**
  - Payments for Hospitals, SNFs, Drugs
  - Current FFS Payments to Physician
  - Unbillable Services

**APM**
- **Savings**
  - Avoidable Spending
  - Payments for Hospitals, SNFs, Drugs
  - New Billable Services
  - Current FFS Payments to Physician
  - New Flexible Bundled Payment for Physician Services

**ADVANTAGES:**
- Flexibility to customize services to patient needs
- Avoids adjudication battles with payers over individual services & need for non-clinically relevant documentation
Accountability for Results, Not Which Services Were Used

Current FFS Payments to Physician

Avoidable Spending

Payments for Hospitals, SNFs, Drugs

Unbillable Services

New Flexible Bundled Payment for Physician Services

APM Savings

Payments for Hospitals, SNFs, Drugs

New Billable Services

Bundled Payment Amount is Adjusted Based on Performance in Reducing Avoidable Spending

Total Medicare Spending

CURRENT FFS

APM

APM
Supporting the Full Range of Services Physicians Provide

SERVICES DELIVERED DURING THE MONTH TO SUPPORT PATIENT CARE
Some CPT Services Are Currently Paid

SERVICES DELIVERED DURING THE MONTH TO SUPPORT PATIENT CARE

BILLABLE CPT CODES
• E&M 99211-5
Some Desirable CPT Services Are Not Currently Paid

<table>
<thead>
<tr>
<th>SERVICES DELIVERED DURING THE MONTH TO SUPPORT PATIENT CARE</th>
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<tbody>
<tr>
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<tr>
<td>UNBILLABLE CPT CODES</td>
</tr>
<tr>
<td>• Telephone E&amp;M 99441-3</td>
</tr>
<tr>
<td>• Patient educ for self-management 98960-2</td>
</tr>
<tr>
<td>• Telephone assess by non-physician 98966-8</td>
</tr>
<tr>
<td>• Collection of data from patient 99091</td>
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</table>
Some Desirable Services May Not Have CPT Codes

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<tr>
<td><strong>SERVICES WITHOUT CODES</strong></td>
</tr>
<tr>
<td>• Shared decision-making</td>
</tr>
<tr>
<td>• Palliative care team support</td>
</tr>
</tbody>
</table>
Option 1 for APM: Pay for All These Services by Code

SERVICES DELIVERED DURING THE MONTH TO SUPPORT PATIENT CARE

BILLABLE CPT CODES
- E&M 99211-5

UNBILLABLE CPT CODES
- Telephone E&M 99441-3
- Patient educ for self-management 98960-2
- Telephone assess by non-physician 98966-8
- Collection of data from patient 99091

SERVICES WITHOUT CODES
- Shared decision-making
- Palliative care team support

Currently billable services would continue to be paid as today

These services would only be paid if delivered as part of an APM that also requires accountability for the results expected to be achieved from those services
Option 2 for APM: Create a Flexible Monthly Bundle

Services Delivered during the Month to Support Patient Care

<table>
<thead>
<tr>
<th>Billable CPT Codes</th>
<th>Unbillable CPT Codes</th>
<th>Services Without Codes</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Telephone E&amp;M 99441-3</td>
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<td></td>
<td>Telephone assess by non-physician 98966-8</td>
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<td></td>
<td>Collection of data from patient 99091</td>
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</tr>
</tbody>
</table>

Payment for a Month of Patient Care

Monthly Payment for Management of Care

- Face-to-face visits with physician
- Face-to-face visits with other practice staff
- Telephone monitoring and response to problems
- Patient self-management education
- Shared decision-making about treatment options

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Different Patients Need Different Amounts of Services

- **Low-Need Patients**
  - Current Physician Payments

- **Medium-Need Patients**
  - Current Physician FFS Payments

- **High-Need Patients**
  - Current Physician FFS Payments

Total Medicare Spending $
A Single Bundled Payment Wouldn’t Match Patient Needs

- Low-Need Patients: Current Bundled Physician Payments vs. New Flexible Bundled Physician Payment
- Medium-Need Patients: Current FFS Payments vs. New Flexible Bundled Physician Payment
- High-Need Patients: Current FFS Payments vs. New Flexible Bundled Physician Payment

Chart Not Drawn to Scale
Use a *Stratified* Bundled Payment Based on *Needs*, Not Services

- **Current Physician Payments**
  - Low-Need Patients
  - Medium-Need Patients
  - High-Need Patients

- **Level 1 Bundled Payment**
  - Current Physician FFS Payments

- **Level 2 Bundled Physician Payment**
  - Current Physician FFS Payments

- **Level 3 Bundled Physician Payment**
  - Current Physician FFS Payments

*Chart Not Drawn to Scale*
Because Avoidable Spending is Likely Higher for High-Need Pts…

![Chart showing Avoidable Spending across different payment levels and patient need categories.](image-url)
Stratified Payments Create a Win-Win-Win

Total Medicare Spending

Avoidable Spending
- Payments for Hospitals, SNFs, Drugs
- Current Physician Payments

Low-Need Patients
- Level 1 Bundled Payment
- Savings

Medium-Need Patients
- Level 2 Bundled Physician Payment
- Savings

High-Need Patients
- Level 3 Bundled Physician Payment
- Savings

Avoidable Spending
- Payments for Hospitals, SNFs, Drugs
- Current Physician FFS Payments
- Savings

Chart Not Drawn to Scale

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Codes Needed so Physician Can Indicate Level of Patient Need

MONTHLY PAYMENT FOR MANAGEMENT OF CARE

• Face-to-face visits with physician
• Face-to-face visits with other practice staff
• Telephone monitoring and response to problems
• Patient self-management education
• Shared decision-making about treatment options

• LOW-NEED PATIENT         xxx01
• MEDIUM-NEED PATIENT       xxx02
• HIGH-NEED PATIENT         xxx03
Multiple Specialties Developing Condition-Based Payment APMs

| AAN Headache APM | ACAAI Asthma APM | ACR Rheum. Arth. APM |
## Similarities in Components of the APMs

<table>
<thead>
<tr>
<th>AAN Headache APM</th>
<th>ACAAI Asthma APM</th>
<th>ACR Rheum. Arth. APM</th>
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<tbody>
<tr>
<td><strong>Diagnosis &amp; Initial Treatment</strong>&lt;br&gt;(Monthly up to 3 months)</td>
<td><strong>Diagnosis &amp; Initial Treatment</strong>&lt;br&gt;(Monthly up to 6 months)</td>
<td><strong>Diagnosis &amp; Tx Planning</strong>&lt;br&gt;(One Time)</td>
</tr>
<tr>
<td>Continued Care for Difficult-to-Control Headache&lt;br&gt;(Monthly)</td>
<td>Continued Care for Difficult-to-Control Asthma&lt;br&gt;(Monthly)</td>
<td>Initial Treatment for RA&lt;br&gt;(Monthly up to 6 months)</td>
</tr>
<tr>
<td>Continued Care for Well-Controlled Headache&lt;br&gt;(Additional Service Fees)</td>
<td>Continued Care for Well-Controlled Asthma&lt;br&gt;(Additional service fees)</td>
<td>Continued Care for Difficult-to-Control RA</td>
</tr>
<tr>
<td></td>
<td>Continued Care for Low-Activity RA&lt;br&gt;(Additional service fees)</td>
<td></td>
</tr>
</tbody>
</table>
Each APM Stratified by Patient Needs Relevant to Condition

<table>
<thead>
<tr>
<th>AAN Headache APM</th>
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<th>ACR Rheum. Arth. APM</th>
</tr>
</thead>
</table>
| **Diagnosis & Initial Treatment** *(Monthly up to 3 months)*  
xxx11 1-2 headache day/mo.  
xxx12 3-14 headache/mo or 1+ severe/disabling  
xxx13 Frequent+comorb. or complex disorders  
**Continued Care for Difficult-to-Control Headache** *(Monthly)*  
xxx21 10+ headache/mo  
xxx22 Poor response or comorbidities  
xxx23 Freq. + poor response  
xxx24 Migraine requiring intravenous therapy  
xxx25 Complex migraine  
**Continued Care for Well-Controlled Headache** *(Additional Service Fees)*  
xxx31 Call/email w/patient  
xxx32 Call/email w/physician  | **Diagnosis & Initial Treatment** *(Monthly up to 6 months)*  
xxx11 Mild symp/not asthma  
xxx12 Mod symp/not asthma  
xxx13 Mild symp/asthma  
xxx14 Mod-sev symptoms  
xxx15 Mod-sev+comorbid  
**Continued Care for Difficult-to-Control Asthma** *(Monthly)*  
xxx21 Well-controlled but comorbid/high-risk Rx  
xxx22 Not well-controlled  
xxx23 Very poorly controlled  
xxx24 Very poor + comorbid  
**Continued Care for Well-Controlled Asthma** *(Additional service fees)*  
xxx31 Call/email w/patient  
xxx32 Call/email w/physician  | **Diagnosis & Tx Planning** *(One Time)*  
xxx11 Swelling/pain not RA  
xxx12 Confirmed RA  
xxx20 RA Screening Consult  
**Initial Treatment for RA** *(Monthly up to 6 months)*  
xxx31 Low disease activity  
xxx32 Mod. disease activity  
xxx33 High disease activity  
xxx34 High + comorbid  
**Continued Care for Difficult-to-Control RA**  
xxx41 Low disease activity  
xxx42 Mod. disease activity  
xxx43 High disease activity  
xxx44 High + comorbid  
**Continued Care for Low-Activity RA** *(Additional service fees)*  
xxx51 Call/email w/patient  
xxx52 Call/email w/physician |
Common Approaches Emerging for PCP and Specialist Roles

Symptoms of an Acute or Chronic Condition
Diagnosis and Initial Treatment By Specialist with PCP Input

Symptoms of an Acute or Chronic Condition

Diagnosis and Treatment Planning by Specialist
One-Time Payment

No Condition or Different Condition

PCP Input
Return to PCP Management Whenever Possible

- **Symptoms of an Acute or Chronic Condition**
  - Diagnosis and Treatment Planning by Specialist
    - One-Time Payment
  - No Condition or Different Condition

- **PCP Input**
  - Specialty Consults
    - Payments for Phone/Email Contacts

- **Continued Care By PCP for Patients with Well-Controlled Condition**
  - Monthly PCMH Payment
Provide Specialist Management for Complex Patients

Symptoms of an Acute or Chronic Condition

Diagnosis and Treatment Planning by Specialist

PCP Input

No Condition or Different Condition

Continued Care By PCP for Patients with Well-Controlled Condition
Monthly PCMH Payment

Specialty Consults
Payments for Phone/Email Contacts

Continued Care By Specialist for Patients with Difficult-to-Control Condition
Monthly Payments

One-Time Payment

Payments for Phone/Email Contacts

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Barriers in fee-for-service prevent physicians from delivering higher-quality care at lower total cost.

**Barrier #1**
Payments for new physician services and increases in payments for existing services require reductions in payments for all physician services regardless of value.

**Barrier #2**
No payment or inadequate payment for many high-value services, e.g.,
- Responding to patient phone calls that can avoid office or ER visits
- Calls among physicians to determine a diagnosis or coordinate care delivery
- Hiring nurses to help chronic disease patients avoid exacerbations
- Providing palliative care to patients with advanced illnesses who are still under treatment

**Barrier #3**
Loss of revenue when patients can be treated with lower-cost services or when patients are kept healthy & need fewer services.
Many Opportunities to Reduce Avoidable Procedures...

CURRENT FFS

$ \rightarrow $

Total Medicare Spending

 Avoidable Procedures

Payments for Hospitals, SNFs, Drugs

Payments to Physicians

Chart Not Drawn to Scale
But Physicians Are Paid by the *Procedure* Under FFS

```
<table>
<thead>
<tr>
<th>Current FFS</th>
<th>Current FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Total Medicare Spending</td>
<td></td>
</tr>
<tr>
<td>Avoidable Procedures</td>
<td>Hospital Payment for Avoidable Procedures</td>
</tr>
<tr>
<td>Payments for Hospitals, SNFs, Drugs</td>
<td>Hospital Payments for Necessary Procedures</td>
</tr>
<tr>
<td>Payments to Physicians</td>
<td>Physician $ Avoid. Proc.</td>
</tr>
</tbody>
</table>
```

Chart Not Drawn to Scale
Reducing Avoidable Procedures Reduces Physician Payment, Too

Total Medicare Spending

CURRENT FFS

Avoidable Procedures

Payments for Hospitals, SNFs, Drugs

Payments to Physicians

CURRENT FFS

Hospital Payment for Avoidable Procedures

Hospital Payments for Necessary Procedures

CURRENT FFS

Savings

Payments for Hospitals, SNFs, Drugs

Physician $ Avoid. Proc.


Chart Not Drawn to Scale

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APMs Can Pay Based on Patient Need, Not Just Services Delivered

- **Avoidable Procedures**: Payments for Hospitals, SNFs, Drugs
- **Hospital Payment for Avoidable Procedures**: Physician $ Avoid. Proc.
- **Hospital Payments for Necessary Procedures**: Physician $ Nec. Proc.
- **Payments for Hospitals, SNFs, Drugs**: Physician Payment for Condition Mgt.
- **Savings**: Savings

Chart Not Drawn to Scale
Hypothetical Type of Surgery Billed Under Fee for Service

**SURGERY**

- Surgeon CPT aaaaa
- Anesthesiologist CPT bbbbb
- Pathologist CPT ccccc
- Radiologist CPT ddddd
Assume Surgeries Have to Be Repeated for Some Patients

**INITIAL SURGERY**

- Surgeon: CPT aaaaa
- Anesthesiologist: CPT bbbbb
- Pathologist: CPT cccccc
- Radiologist: CPT ddddd

**REPEAT SURGERY**

- Surgeon: CPT aaaaa
- Anesthesiologist: CPT bbbbb
- Pathologist: CPT cccccc
- Radiologist: CPT ddddd

- Failure to achieve clear margins in lumpectomy
- Inability to complete procedure
- Post-surgical complications
Today: High Repeat Rate Results in Higher Physician Payment

<table>
<thead>
<tr>
<th>INITIAL SURGERY</th>
<th>REPEAT SURGERY (25%)</th>
<th>TOTAL PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon CPT aaaaaa</td>
<td>Surgeon CPT aaaaaa</td>
<td>Surgeon 1.25 aaaaa</td>
</tr>
<tr>
<td>Anesthesiologist CPT bbbbbbb</td>
<td>Anesthesiologist CPT bbbbbbb</td>
<td>Anesthesiologist 1.25 bbbbbbb</td>
</tr>
<tr>
<td>Pathologist CPT cccccc</td>
<td>Pathologist CPT cccccc</td>
<td>Pathologist 1.25 cccccc</td>
</tr>
<tr>
<td>Radiologist CPT ddddddd</td>
<td>Radiologist CPT ddddddd</td>
<td>Radiologist 1.25 ddddddd</td>
</tr>
</tbody>
</table>
Reducing Repeat Rate Is Better for the Patient…

### HIGH REPEAT RATE

#### INITIAL SURGERY
- Surgeon: CPT aaaaaa
- Anesthesiologist: CPT bbbbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT dddddd

#### REPEAT SURGERY (25%)
- Surgeon: CPT aaaaaa
- Anesthesiologist: CPT bbbbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT dddddd

#### TOTAL PAYMENT
- Surgeon: 1.25 aaaaaa
- Anesthesiologist: 1.25 bbbbbbb
- Pathologist: 1.25 ccccc
- Radiologist: 1.25 dddddd

### LOW REPEAT RATE

#### INITIAL SURGERY
- Surgeon: CPT aaaaaa
- Anesthesiologist: CPT bbbbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT dddddd

#### REPEAT SURGERY (10%)
- Surgeon: CPT aaaaaa
- Anesthesiologist: CPT bbbbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT dddddd

#### TOTAL PAYMENT
- Surgeon: 1.25 aaaaaa
- Anesthesiologist: 1.25 bbbbbbb
- Pathologist: 1.25 ccccc
- Radiologist: 1.25 dddddd
Today: Reducing Repeat Rate Reduces Physician Income

### HIGH REPEAT RATE

**INITIAL SURGERY**
- Surgeon: CPT aaaaa
- Anesthesiologist: CPT bbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT dddddd

**REPEAT SURGERY (25%)**
- Surgeon: CPT aaaaa
- Anesthesiologist: CPT bbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT dddddd

**TOTAL PAYMENT**
- Surgeon: 1.25 aaaaa
- Anesthesiologist: 1.25 bbbbb
- Pathologist: 1.25 ccccc
- Radiologist: 1.25 dddddd

### LOW REPEAT RATE

**INITIAL SURGERY**
- Surgeon: CPT aaaaa
- Anesthesiologist: CPT bbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT dddddd

**REPEAT SURGERY (10%)**
- Surgeon: CPT aaaaa
- Anesthesiologist: CPT bbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT dddddd

**TOTAL PAYMENT**
- Surgeon: 1.10 aaaaa
- Anesthesiologist: 1.10 bbbbb
- Pathologist: 1.10 ccccc
- Radiologist: 1.10 dddddd
What If We Create a Payment Based on the Total “Episode”?

<table>
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<tbody>
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<td>• Radiologist</td>
</tr>
</tbody>
</table>

+ REPEAT SURGERY (25%)

<table>
<thead>
<tr>
<th>REPEAT SURGERY (25%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surgeon</td>
</tr>
<tr>
<td>• Anesthesiologist</td>
</tr>
<tr>
<td>• Pathologist</td>
</tr>
<tr>
<td>• Radiologist</td>
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= TOTAL PAYMENT

<table>
<thead>
<tr>
<th>TOTAL PAYMENT</th>
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</thead>
<tbody>
<tr>
<td>• Surgeon</td>
</tr>
<tr>
<td>• Anesthesiologist</td>
</tr>
<tr>
<td>• Pathologist</td>
</tr>
<tr>
<td>• Radiologist</td>
</tr>
</tbody>
</table>

SURGERY EPISODE (BUNDLED/WARRANTIED)

| • Team | CPT EEEEEE |

Priced as 1.20 x (aaaaaa+bbbbbb+cccccc+ddddd)
Step 1: Deliver Better Care and Be Paid for Services Delivered

**BILL AS SERVICES DELIVERED**

<table>
<thead>
<tr>
<th>INITIAL SURGERY</th>
<th>REPEAT SURGERY (15%)</th>
<th>TOTAL PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon CPT aaaaaa</td>
<td>Surgeon CPT aaaaaa</td>
<td>Surgeon 1.15 aaaaaa</td>
</tr>
<tr>
<td>Anesthesiologist CPT bbbbbb</td>
<td>Anesthesiologist CPT bbbbbb</td>
<td>Anesthesiologist 1.15 bbbbbb</td>
</tr>
<tr>
<td>Pathologist CPT cccccc</td>
<td>Pathologist CPT cccccc</td>
<td>Pathologist 1.15 cccccc</td>
</tr>
<tr>
<td>Radiologist CPT dddddd</td>
<td>Radiologist CPT dddddd</td>
<td>Radiologist 1.15 dddddd</td>
</tr>
</tbody>
</table>
Step 2: Reconcile Spending Against the Episode Payment…

BILL AS SERVICES DELIVERED

**INITIAL SURGERY**
- Surgeon: CPT aaaaa
- Anesthesiologist: CPT bbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT ddddd

**REPEAT SURGERY (15%)**
- Surgeon: CPT aaaaa
- Anesthesiologist: CPT bbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT ddddd

**TOTAL PAYMENT**
- Surgeon: 1.15 aaaaa
- Anesthesiologist: 1.15 bbbbb
- Pathologist: 1.15 ccccc
- Radiologist: 1.15 ddddd

RECONCILIATION

**SURGERY EPISODE (BUNDLED/WARRANTIED)**
- Team: CPT EEEEE
  Priced as 1.20 x (aaaaa+bbbb+cccc+dddd)

\[ \text{TOTAL PAYMENT} = \text{BILL AS SERVICES DELIVERED} \times 1.20 \]
…By Subtracting Payments Already Made to Physicians

<table>
<thead>
<tr>
<th>BILL AS SERVICES DELIVERED</th>
<th>RECONCILIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INITIAL SURGERY</strong></td>
<td><strong>SURGERY EPISODE (BUNDLED/WARRANTIED)</strong></td>
</tr>
<tr>
<td>- Surgeon CPT aaaaaa</td>
<td>- Team CPT EEEEE</td>
</tr>
<tr>
<td>- Anesthesiologist CPT bbbbb</td>
<td>Priced as 1.20 x (aaaaaa+bbbbbb+cccccc+dddddd)</td>
</tr>
<tr>
<td>- Pathologist CPT cccccc</td>
<td></td>
</tr>
<tr>
<td>- Radiologist CPT dddddd</td>
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</table>

**REPEAT SURGERY (15%)**

<table>
<thead>
<tr>
<th>+</th>
<th><strong>PAYMENTS MADE</strong></th>
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</thead>
<tbody>
<tr>
<td>- Surgeon CPT aaaaaa</td>
<td>- Surgeon 1.15 aaaaa</td>
</tr>
<tr>
<td>- Anesthesiologist CPT bbbbb</td>
<td>- Anesthesiologist 1.15 bbbbb</td>
</tr>
<tr>
<td>- Pathologist CPT cccccc</td>
<td>- Pathologist 1.15 cccccc</td>
</tr>
<tr>
<td>- Radiologist CPT dddddd</td>
<td>- Radiologist 1.15 dddddd</td>
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**TOTAL PAYMENT**

<table>
<thead>
<tr>
<th>=</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Surgeon 1.15 aaaaaa</td>
</tr>
<tr>
<td>- Anesthesiologist 1.15 bbbbb</td>
</tr>
<tr>
<td>- Pathologist 1.15 cccccc</td>
</tr>
<tr>
<td>- Radiologist 1.15 dddddd</td>
</tr>
</tbody>
</table>
Step 3: Pay Physicians the Balance from the Bundle

Bill as Services Delivered

**Initial Surgery**
- Surgeon: CPT aaaaa
- Anesthesiologist: CPT bbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT ddddd

**Repeat Surgery (15%)**
- Surgeon: CPT aaaaa
- Anesthesiologist: CPT bbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT ddddd

**Total Payment**
- Surgeon: 1.15 aaaaa
- Anesthesiologist: 1.15 bbbbb
- Pathologist: 1.15 ccccc
- Radiologist: 1.15 ddddd

Reconciliation

**Surgery Episode (Bundled/Warrantied)**
- Team: CPT EEEEE
  Priced as 1.20 x (aaaaaa+bbbbbb+cccccc+dddddd)

**Payments Made**
- Surgeon: 1.15 aaaaa
- Anesthesiologist: 1.15 bbbbb
- Pathologist: 1.15 ccccc
- Radiologist: 1.15 ddddd

**Balance**
- .05 x (aaaaaa+bbbbbb+cccccc+dddddd)
  - Surgeon: .05 aaaaa
  - Anesthesiologist: .05 bbbbb
  - Pathologist: .05 ccccc
  - Radiologist: .05 ddddd
# Win-Win-Win: Better Care for Patient w/o Cutting Physician Pay

## BILL AS SERVICES DELIVERED

### INITIAL SURGERY
- Surgeon: CPT aaaaaa
- Anesthesiologist: CPT bbbbb
- Pathologist: CPT ccccc
- Radiologist: CPT ddddd

## RECONCILIATION

### SURGERY EPISODE
(BUNDLED/WARRANTIED)
- Team: CPT EEEEE
  - Priced as 1.20 x (aaaaaa+bbbbbb+cccccc+ddddd)

### MINUS

### PAYMENTS MADE
- Surgeon: 1.15 aaaaa
- Anesthesiologist: 1.15 bbbbb
- Pathologist: 1.15 ccccc
- Radiologist: 1.15 ddddd

## TOTAL PAYMENT
- Surgeon: 1.15 aaaaa
- Anesthesiologist: 1.15 bbbbb
- Pathologist: 1.15 ccccc
- Radiologist: 1.15 ddddd

## BALANCE
- Surgeon: .05 aaaaa
- Anesthesiologist: .05 bbbbb
- Pathologist: .05 ccccc
- Radiologist: .05 ddddd

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Win-Win-Win: Better Care for Patient w/o Cutting Physician Pay

**BILL AS SERVICES DELIVERED**

**INITIAL SURGERY**
- Surgeon CPT aaaaa
- Anesthesiologist CPT bbbbbb
- Pathologist CPT cccccc
- Radiologist CPT dddddd

**SURGERY EPISODE (BUNDLED/WARRANTIED)**
- CPT EEEEE priced as 1.20 x (aaaaa+bbbbb+ccccc+ddddd)

**REPEAT SURGERY**
- Surgeon CPT aaaaa
- Anesthesiologist CPT bbbbbb
- Pathologist CPT cccccc
- Radiologist CPT dddddd

**TOTAL PAYMENT**
- Surgeon 1.15 aaaaa
- Anesthesiologist 1.15 bbbbbb
- Pathologist 1.15 cccccc
- Radiologist 1.15 dddddd

**SAVINGS ARE STILL ACHIEVED BY AVOIDING ALL THE OTHER SPENDING ON THE REPEAT SURGERIES**

**RECONCILIATION**
- SURGERY EPISODE PAYMENTS MADE
  - Surgeon 1.15 aaaaa
  - Anesthesiologist 1.15 bbbbbb
  - Pathologist 1.15 cccccc
  - Radiologist 1.15 dddddd

- MINUS
  - Surgeon .05 aaaaa
  - Anesthesiologist .05 bbbbbb
  - Pathologist .05 cccccc
  - Radiologist .05 dddddd

**SAVINGS ARE STILL ACHIEVED BY AVOIDING ALL THE OTHER SPENDING ON THE REPEAT SURGERIES**
Bundle Doesn’t Constrain Distribution of $ to Match FFS

**BILL AS SERVICES DELIVERED**

**INITIAL SURGERY**
- Surgeon: CPT aaaaa
- Anesthesiologist: CPT bbbbbb
- Pathologist: CPT cccccc
- Radiologist: CPT dddddd

**REPEAT SURGERY (15%)**
- Surgeon: CPT aaaaa
- Anesthesiologist: CPT bbbbbb
- Pathologist: CPT cccccc
- Radiologist: CPT dddddd

**TOTAL PAYMENT**
- Surgeon: 1.15 aaaaa
- Anesthesiologist: 1.15 bbbbbb
- Pathologist: 1.15 cccccc
- Radiologist: 1.15 dddddd

**RECONCILIATION**

**SURGERY EPISODE (BUNDLED/WARRANTIED)**
- Team: CPT EEEEE
  Priced as $1.20 x (aaaaa+bbbbb+ccccc+ddddd)

**PAYMENTS MADE**
- Surgeon: 1.15 aaaaa
- Anesthesiologist: 1.15 bbbbbb
- Pathologist: 1.15 cccccc
- Radiologist: 1.15 dddddd

**TOTAL:**
- Surgeon: $1.15 aaaaa
- Anesthesiologist: $1.15 bbbbbb
- Pathologist: $1.15 cccccc
- Radiologist: $1.15 dddddd

**BALANCE**
- .05x(aaaaa+bbbbb+ccccc+ddddd)
  - Surgeon: .05 aaaaa
  - Anesthesiologist: .05 bbbbbb
  - Pathologist: .05 cccccc
  - Radiologist: .05 dddddd
Physicians Control How They’re Compensated Based on Results

<table>
<thead>
<tr>
<th>BILL AS SERVICES DELIVERED</th>
<th>RECONCILIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INITIAL SURGERY</strong></td>
<td><strong>SURGERY EPISODE</strong></td>
</tr>
<tr>
<td>• Surgeon CPT <code>aaaaaa</code></td>
<td>(BUNDLED/WARRANTIED)</td>
</tr>
<tr>
<td>• Anesthesiologist CPT <code>bbbbbb</code></td>
<td></td>
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<tr>
<td>• Pathologist CPT <code>cccccc</code></td>
<td></td>
</tr>
<tr>
<td>• Radiologist CPT <code>ddddd</code></td>
<td><strong>Priced as 1.20 x</strong></td>
</tr>
<tr>
<td></td>
<td>(aaaaaa+bbbbbb+cccccc+ddddd)</td>
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</table>

<table>
<thead>
<tr>
<th>REPEAT SURGERY (15%)</th>
<th><strong>PAYMENTS MADE</strong></th>
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</thead>
<tbody>
<tr>
<td>• Surgeon CPT <code>aaaaaa</code></td>
<td>• Surgeon 1.15 <code>aaaaaa</code></td>
</tr>
<tr>
<td>• Anesthesiologist CPT <code>bbbbbb</code></td>
<td></td>
</tr>
<tr>
<td>• Pathologist CPT <code>cccccc</code></td>
<td></td>
</tr>
<tr>
<td>• Radiologist CPT <code>ddddd</code></td>
<td>• Anesthesiologist 1.15 <code>bbbbbb</code></td>
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</table>

<table>
<thead>
<tr>
<th><strong>TOTAL PAYMENT</strong></th>
<th><strong>BALANCE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surgeon 1.15 <code>aaaaaa</code></td>
<td>• Surgeon .02 <code>aaaaaa</code></td>
</tr>
<tr>
<td>• Anesthesiologist 1.15 <code>bbbbbb</code></td>
<td></td>
</tr>
<tr>
<td>• Pathologist 1.15 <code>cccccc</code></td>
<td>• Anesthesiologist .05 <code>bbbbbb</code></td>
</tr>
<tr>
<td>• Radiologist 1.15 <code>ddddd</code></td>
<td>• Pathologist .10 <code>cccccc</code></td>
</tr>
<tr>
<td></td>
<td>• Radiologist .03 <code>ddddd</code></td>
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</tbody>
</table>
Physicians Must Also Be Accountable for Poor Results

**BILL AS SERVICES DELIVERED**

<table>
<thead>
<tr>
<th>INITIAL SURGERY</th>
<th>REPEAT SURGERY (25%)</th>
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</thead>
<tbody>
<tr>
<td>Surgeon CPT aaaaa</td>
<td>Surgeon CPT aaaaa</td>
</tr>
<tr>
<td>Anesthesiologist CPT bbbbb</td>
<td>Anesthesiologist CPT bbbbb</td>
</tr>
<tr>
<td>Pathologist CPT cccccc</td>
<td>Pathologist CPT cccccc</td>
</tr>
<tr>
<td>Radiologist CPT ddddd</td>
<td>Radiologist CPT ddddd</td>
</tr>
</tbody>
</table>

**RECONCILIATION**

<table>
<thead>
<tr>
<th>SURGERY EPISODE</th>
<th>MINUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(BUNDLED/WARRANTIED)</td>
<td>PAYMENTS MADE</td>
</tr>
<tr>
<td>Team CPT EEEEE</td>
<td>Surgeon 1.25 aaaaa</td>
</tr>
<tr>
<td>Priced as 1.20 x (aaaaaa+bbbbb+ccccc+ddddd)</td>
<td>Anesthesiologist 1.25 bbbbbb</td>
</tr>
<tr>
<td></td>
<td>Pathologist 1.25 cccccc</td>
</tr>
<tr>
<td></td>
<td>Radiologist 1.25 dddddd</td>
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**TOTAL PAYMENT**

<table>
<thead>
<tr>
<th></th>
<th>BALANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon 1.25 aaaaa</td>
<td>Surgeon -.05 aaaaa</td>
</tr>
<tr>
<td>Anesthesiologist 1.25 bbbbbb</td>
<td>Anesthesiologist -.05 bbbbbb</td>
</tr>
<tr>
<td>Pathologist 1.25 cccccc</td>
<td>Pathologist -.05 cccccc</td>
</tr>
<tr>
<td>Radiologist 1.25 dddddd</td>
<td>Radiologist -.05 dddddd</td>
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</table>
Today, Physicians Lose By Delivering Innovative Services

CURRENT FFS

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<thead>
<tr>
<th>INITIAL SURGERY</th>
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<tbody>
<tr>
<td>Surgeon</td>
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</tr>
<tr>
<td>Anesthesiologist</td>
<td>CPT bbbbb</td>
</tr>
<tr>
<td>Pathologist</td>
<td>CPT ccccc</td>
</tr>
<tr>
<td>Radiologist</td>
<td></td>
</tr>
<tr>
<td>New Service</td>
<td>$000.00</td>
</tr>
</tbody>
</table>

- New service not described in CPT
- CPT service not paid by payer
- Longer time by physician to ensure accuracy or reduce complications
Today, Physicians Lose By Delivering Innovative Services

<table>
<thead>
<tr>
<th>CURRENT FFS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INITIAL SURGERY</strong></td>
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</tr>
<tr>
<td>• Surgeon CPT aaaaa</td>
<td></td>
</tr>
<tr>
<td>• Anesthesiologist CPT bbbbbb</td>
<td></td>
</tr>
<tr>
<td>• Pathologist CPT cccccc</td>
<td></td>
</tr>
<tr>
<td>• Radiologist</td>
<td></td>
</tr>
<tr>
<td>• New Service $000.00</td>
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</tbody>
</table>

+  

<table>
<thead>
<tr>
<th>REPEAT SURGERY (10%)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>• Surgeon CPT aaaaa</td>
<td></td>
</tr>
<tr>
<td>• Anesthesiologist CPT bbbbbb</td>
<td></td>
</tr>
<tr>
<td>• Pathologist CPT cccccc</td>
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<tr>
<td>• Radiologist</td>
<td></td>
</tr>
<tr>
<td>• New Service $000.00</td>
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<table>
<thead>
<tr>
<th>TOTAL PAYMENT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surgeon 1.10 aaaaa</td>
<td></td>
</tr>
<tr>
<td>• Anesthesiologist 1.10 bbbbbb</td>
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</tr>
<tr>
<td>• Pathologist 1.10 cccccc</td>
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<table>
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<tr>
<th>UNCOMPENSATED SERVICE</th>
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<tr>
<td>• New Service $0</td>
<td></td>
</tr>
</tbody>
</table>
## Under Bundled Payment, More $ Are Available After Reconciliation

### BILL AS SERVICES DELIVERED

**INITIAL SURGERY**
- Surgeon: CPT `aaaaa`
- Anesthesiologist: CPT `bbbbb`
- Pathologist: CPT `ccccc`
- Radiologist: \[aaaaa + bbbbb + ccccc + ddddd\] $000.00

**REPEAT SURGERY (10%)**
- Surgeon: CPT `aaaaa`
- Anesthesiologist: CPT `bbbbb`
- Pathologist: CPT `ccccc`
- Radiologist: \[aaaaa + bbbbb + ccccc + ddddd\] $000.00

### RECONCILIATION

**SURGERY EPISODE (BUNDLED/WARRANTIED)**
- Team: CPT `EEEEE`
  - Priced as 1.20 x \(aaaaa + bbbbb + ccccc + ddddd\)

**MINUS**

**PAYMENTS MADE**
- Surgeon: 1.10 `aaaaa`
- Anesthesiologist: 1.10 `bbbbb`
- Pathologist: 1.10 `ccccc`

### TOTAL PAYMENT
- Surgeon: 1.10 `aaaaa`
- Anesthesiologist: 1.10 `bbbbb`
- Pathologist: 1.10 `ccccc`
Bundled Payment Allows Fair Compensation for New Approaches

<table>
<thead>
<tr>
<th>BILL AS SERVICES DELIVERED</th>
<th>RECONCILIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INITIAL SURGERY</strong></td>
<td><strong>SURGERY EPISODE (BUNDLED/WARRANTIED)</strong></td>
</tr>
<tr>
<td>• Surgeon CPT aaaaa</td>
<td>• Team CPT EEEEEE</td>
</tr>
<tr>
<td>• Anesthesiologist CPT bbbbb</td>
<td>Priced as 1.20 x (aaaaaa+bbbbbb+cccccc+ddddd)</td>
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<tr>
<td>• Pathologist CPT cccccc</td>
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<td>• Radiologist</td>
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<td>• New Service $000.00</td>
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<table>
<thead>
<tr>
<th>REPEAT SURGERY (10%)</th>
<th>PAYMENTS MADE</th>
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</thead>
<tbody>
<tr>
<td>• Surgeon CPT aaaaa</td>
<td>• Surgeon 1.10 aaaaa</td>
</tr>
<tr>
<td>• Anesthesiologist CPT bbbbb</td>
<td>• Anesthesiologist 1.10 bbbbb</td>
</tr>
<tr>
<td>• Pathologist CPT cccccc</td>
<td>• Pathologist 1.10 cccccc</td>
</tr>
<tr>
<td>• Radiologist</td>
<td>• Radiologist 1.0 ddddd</td>
</tr>
<tr>
<td>• New Service $000.00</td>
<td>• New Service .2 ddddd</td>
</tr>
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</table>

= 

<table>
<thead>
<tr>
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<th>BALANCE</th>
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<tr>
<td>• Surgeon 1.10 aaaaa</td>
<td>• Surgeon .10 aaaaa</td>
</tr>
<tr>
<td>• Anesthesiologist 1.10 bbbbb</td>
<td>• Anesthesiologist .10 bbbbb</td>
</tr>
<tr>
<td>• Pathologist 1.10 cccccc</td>
<td>• Pathologist .10 cccccc</td>
</tr>
<tr>
<td></td>
<td>• Radiologist 1.0 ddddd</td>
</tr>
<tr>
<td></td>
<td>• New Service .2 ddddd</td>
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</tbody>
</table>
Two Different Ways to Pay Physicians Under Bundled Payment
“Retrospective Reconciliation”: CPT Still Used for Payment

BILL AS SERVICES DELIVERED

<table>
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<tbody>
<tr>
<td>Surgeon</td>
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<tr>
<td>Anesthesiologist</td>
</tr>
<tr>
<td>Pathologist</td>
</tr>
<tr>
<td>Radiologist</td>
</tr>
</tbody>
</table>

+ REPEAT SURGERY (15%)

| Surgeon         | CPT aaaaaa |
| Anesthesiologist| CPT bbbbbbb |
| Pathologist     | CPT ccccccc |
| Radiologist     | CPT dddddd |

TOTAL PAYMENT

| Surgeon         | 1.15 aaaaaa |
| Anesthesiologist| 1.15 bbbbbbb |
| Pathologist     | 1.15 ccccccc |
| Radiologist     | 1.15 dddddd |
### “Retrospective Reconciliation”: CPT Still Used for Payment

#### Bill as Services Delivered

<table>
<thead>
<tr>
<th>Initial Surgery</th>
<th>Surcharge</th>
<th>Anesthesiologist</th>
<th>Pathologist</th>
<th>Radiologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon CPT aaaaaa</td>
<td></td>
<td>CPT bbbbb</td>
<td>CPT cccccc</td>
<td>CPT ddddd</td>
</tr>
<tr>
<td>Anesthesiologist CPT bbbbb</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathologist CPT cccccc</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Radiologist CPT ddddd</td>
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#### Repeat Surgery (15%)

<table>
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<th></th>
<th>Anesthesiologist</th>
<th>Pathologist</th>
<th>Radiologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiologist CPT bbbbb</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Pathologist CPT cccccc</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiologist CPT ddddd</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Total Payment

| Surgeon 1.15 aaaaaa | Anesthesiologist 1.15 bbbbb | Pathologist 1.15 cccccc | Radiologist 1.15 ddddd |

#### Reconciliation

| Surgery Episode (Bundled/Warrantied) | Team CPT EEEEE | Priced as 1.20 x (aaaaaa+bbbbbb+cccccc+ddddd) |

<table>
<thead>
<tr>
<th>Initial Surgery Payments Made</th>
<th></th>
<th>Anesthesiologist 1.15 bbbbb</th>
<th>Pathologist 1.15 cccccc</th>
<th>Radiologist 1.15 ddddd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon 1.15 aaaaaa</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesiologist 1.15 bbbbb</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pathologist 1.15 cccccc</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiologist 1.15 ddddd</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Balance

| Surgeon .05 aaaaaa | Anesthesiologist .05 bbbbb | Pathologist .05 cccccc | Radiologist .05 ddddd |

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Option 2: “Prospective” Payment

BILL THE BUNDLE

SURGERY EPISODE (BUNDLED/WARRANTIED)
• Team CPT EEEEEE
  Priced as 1.20 x
  (aaaaa+bbbbbb+cccccc+dddddd)
Option 2: “Prospective” Payment

**BILL THE BUNDLE**

**SURGERY EPISODE (BUNDLED/WARRANTIED)**
- Team CPT EEEEE
  - Priced as $1.20 \times (aaaaa+bbbb+cccc+dddd)$

**ALLOCATION BY PHYSICIANS**

**COMPENSATION**
- Surgeon 1.2 aaaaa
- Anesthesiologist 1.2 bbbbb
- Pathologist 1.2 ccccc
- Radiologist 1.2 ddddd

**OR**

**COMPENSATION**
- Surgeon 1.1 aaaaa
- Anesthesiologist 1.1 bbbbb
- Pathologist 1.5 ccccc
- Radiologist 1.5 ddddd
Even Under Prospective Payment, You Need to Know What Was Done

**BILL THE BUNDLE**

**SURGERY EPISODE (BUNDLED/WARRANTIED)**
- Team CPT EEEEE
- Priced as 1.20 x
  (aaaaa+bbbb+cccc+ddddd)

**ALLOCATION BY PHYSICIANS**

**COMPENSATION**
- Surgeon 1.2 aaaaa
- Anesthesiologist 1.2 bbbbbb
- Pathologist 1.2 cccccc
- Radiologist 1.2 dddddd

OR

**COMPENSATION**
- Surgeon 1.1 aaaaa
- Anesthesiologist 1.1 bbbbbb
- Pathologist 1.5 cccccc
- Radiologist 1.5 dddddd
Codes for Discrete Services and Bundled Payments Will Co-Exist

<table>
<thead>
<tr>
<th>RETROSPECTIVE BUNDLED PAYMENT</th>
<th>PAYMENTS MADE AS DISCRETE SERVICES ARE DELIVERED</th>
<th>BUNDLE OR EPISODE PRICE IS A BUDGET FOR TOTAL SPENDING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Existing CPT Codes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>New CPT Codes for APM Services</strong></td>
<td></td>
<td></td>
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<td><strong>New APM Codes for Bundled Payment</strong></td>
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<td>New APM Codes for Bundled Payment</td>
</tr>
<tr>
<td>New CPT Codes for APM Services</td>
<td>New APM Codes for Bundled Payment</td>
</tr>
</tbody>
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## Codes for Discrete Services and Bundled Payments Will Co-Exist

<table>
<thead>
<tr>
<th>RETROSPECTIVE BUNDLED PAYMENT</th>
<th>PROSPECTIVE BUNDLED PAYMENT</th>
<th>FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments Made as Discrete Services Are Delivered</td>
<td>Bundle or Episode Price is a Budget for Total Spending</td>
<td>Bundle or Episode Price is What is Paid</td>
</tr>
<tr>
<td>Existing CPT Codes</td>
<td>New APM Codes for Bundled Payment</td>
<td>Existing CPT Codes</td>
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<td>New CPT Codes for APM Services</td>
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</tbody>
</table>

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Modifiers Needed to Indicate Relationship of Services & Bundles
Modifiers Needed to Indicate Relationship of Services & Bundles

• If an individual service will *rarely* be performed for circumstances other than those to which the bundle applies
  – Modifier to indicate when that service is *outside* the bundle
  – Example: Bundle for a particular type of surgery
    • Surgery CPT code aaaaa
    • Bundled code EEEEEE
    • If patient does not qualify for bundle, report aaaaa-XX (XX=outside bundle)
Modifiers Needed to Indicate Relationship of Services & Bundles

• If an individual service will **rarely** be performed for circumstances other than those to which the bundle applies
  – Modifier to indicate when that service is **outside** the bundle
  – Example: Bundle for a particular type of surgery
    • Surgery CPT code aaaaa
    • Bundled code EEEEEE
    • If patient does not qualify for bundle, report aaaaa-XX (XX=outside bundle)

• If an individual service will **frequently** be performed for circumstances other than those to which the bundle applies
  – Modifier to indicate when that service is part of the bundle *if the physician performing the service wishes to be paid differently*
  – Example: Bundle for a particular type of surgery
    • Pathology CPT code ccccc
    • Bundled code EEEEEE
    • CPT ccccc assumed to be part of bundle if present
    • If pathologist wishes adjusted payment, report ccccc-EE (EE=inside bundle)
    • Otherwise, pathologist continues to be paid standard amount for ccccc
No Single Approach to APMs

APM #1: Payment for a High-Value Service
APM #2: Condition-Based Payment for a Physician’s Services
APM #3: Multi-Physician Bundled Payment
APM #4: Physician-Facility Procedure Bundle
APM #5: Warrantied Payment for Physician Services
APM #6: Episode Payment for a Procedure
APM #7: Condition-Based Payment
Proceduralists Can Reduce Complications & Improve Efficiency

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending

Proceduralist
Hospital
Procedural Episode Payments Support Higher Quality/Lower Cost

- High Spending on Complications & Post-Acute Care
- Low Complication & PAC Spending
What if You Can Avoid the Procedure Altogether?

- Medical Management

- Proceduralist
  - Hospital
  - Procedural Episode Payment

- High Spending on Complications & Post-Acute Care
- Low Complication & PAC Spending
Specialists Managing a *Condition* Can Avoid Unnecessary *Procedures*
Condition-Based Payment Supports Use of Highest-Value Treatment

Condition-Based Payment

Procedural Episode Payment

- Proceduralist
- Hospital

Condition Specialist

Medical Management

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending
Are We Making the Payment for the Correct Condition??

Condition-Based Payment

Wrong Condition

Correct Condition

Procedural Episode Payment

Proceduralist

Hospital

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending

Medical Management

Correct Treatment

Proceduralist

$
Diagnostic Error is a Fundamental Quality Issue Underlying All Others
The Diagnostician Ensures the *Right Condition* is Being Treated

- **Condition-Based Payment**
  - Diagnostician
  - Condition Specialist
  - Correct Condition
  - Correct Treatment

- **Procedural Episode Payment**
  - Proceduralist
  - Hospital
  - Medical Management
  - High Spending on Complications & Post-Acute Care
  - Low Complication & PAC Spending

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“Condition-Based” Payment Also Needed to Support Good Diagnosis

Condition-Based Payment (Symptoms)

Condition-Based Payment (Diagnosis)

Procedural Episode Payment

Proceduralist

Hospital

High Spending on Complications & Post-Acute Care

Medical Management

Low Complication & PAC Spending

Correct Condition

Correct Treatment
### Five Elements Needed to Specify an Alternative Payment Model

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<td>Physician Who Is Accountable for Cost &amp; Quality?</td>
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All of These Elements Exist Today in CPT-Based FFS

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<th>Elements of an APM</th>
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<td>More billable services delivered to higher-need pts</td>
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<td>Physician who bills using the CPT code</td>
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Physician-Focused APMs Need Physician-Defined Coding

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<td>Multiple levels defined based on patient characteristics</td>
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<td>Physician who bills using the CPT code</td>
<td>Physician who bills as the manager of the bundle of services</td>
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## Undesirable Workarounds Being Used Today Due to Lack of Codes

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<th>Payer-Administered APMs</th>
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<tr>
<td>Trigger for Payment?</td>
<td>Submission of claim with CPT and ICD codes</td>
<td>Submission of claim with bundled service or condition mgt code</td>
<td>Trigger based on current CPT, ICD, or DRG codes</td>
</tr>
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<td>Services Included In a Single Payment?</td>
<td>CPT code defines services included; coding rules avoid double billing</td>
<td>Bundled service code defines services included and excluded &amp; time period involved</td>
<td>Claims retrospectively “grouped” into bundle using formula based on CPT and ICD codes</td>
</tr>
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<td>Amount of Payment for Service?</td>
<td>Defined in advance by standard RVU weight and annual conversion factor</td>
<td>Defined in advance based on expected cost of delivering services in bundle</td>
<td>“Shared savings” payments determined after care is delivered</td>
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<td>Adjustment for Differences in Patient Needs?</td>
<td>More billable services delivered to higher-need pts</td>
<td>Multiple levels defined based on patient characteristics</td>
<td>Adjusted using risk score based on (some) prior ICD codes</td>
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<td>Physician Who Is Accountable for Cost &amp; Quality?</td>
<td>Physician who bills using the CPT code</td>
<td>Physician who bills as the manager of the bundle of services</td>
<td>Physician is “attributed” responsibility after care is delivered</td>
</tr>
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</table>
Example: Physician Who Cares For Patients At Risk of Admission

YEAR 0

$ Total Spending Relevant to the Physician’s Services

FFS Payment to Hospital for Admissions

E&M to Physician

Physician Practice Revenue

Chart Not Drawn to Scale
Assume Many Admissions Are Potentially Avoidable

YEAR 0

$ Total Spending Relevant to the Physician’s Services

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

Physician Practice Revenue

Chart Not Drawn to Scale
In Current APMs, Target Spending Is Set Below Current Spending

YEAR 0

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

Current Spend

Target Spending

Chart Not Drawn to Scale
If Physician Delivers Services That Aren’t Currently Billable...

YEAR 0

$ Total
Spending
Relevant
to the
Physician’s
Services

Avoidable
Admissions

FFS
Payment
to
Hospital
for
Admissions

E&M to
Physician

YEAR 1

Current Spend
Target Spending

Non-Billable
Service

Chart Not
Drawn
to
Scale

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...And Thereby Reduces the Number of Admissions...

YEAR 0

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

YEAR 1

FFS Payment to Hospital for Admissions

E&M to Physician

Current Spend
Target Spending

Chart Not Drawn to Scale
Savings Generated for Payer, But Physician Loses Money in Year 1

Year 0
- Avoidable Admissions
- E&M to Physician

Year 1
- Savings for Payer
- FFS Payment to Hospital for Admissions

Non-Billable Service
- Loss for Physician

Total Spending Relevant to the Physician’s Services

Current Spend Target Spending

Chart Not Drawn to Scale

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Loss is Greater if New Services Substitute for Current Services

YEAR 0

- **Avoidable Admissions**
  - FFS Payment to Hospital for Admissions
  - E&M to Physician

YEAR 1

- **Savings**
  - FFS Payment to Hospital for Admissions
  - E&M to Physician

**Current Spend Target Spending**

- **Loss of Fees Non-Billable Service**
- **Loss for Physician**
- **Savings for Payer**

**Total Spending Relevant to the Physician’s Services**

**Chart Not Drawn to Scale**
Physician Receives a Share of Savings a Year After Expenses

YEAR 0

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

YEAR 1

Payer Share of Savings

FFS Payment to Hospital for Admissions

E&M to Physician

Provider Share of Savings

YEAR 2

Payment to Hospital for Admissions

Lower E&M

Loss of Fees Non-Billable Service

Loss of Fees Non-Billable Service

Current Spend
Target Spending

Chart Not Drawn to Scale
Shared Savings Payment May Not Cover Costs & Losses

YEAR 0

- **Avoidable Admissions**
  - FFS Payment to Hospital for Admissions
  - E&M to Physician

YEAR 1

- **Payer Share of Savings**
  - FFS Payment to Hospital for Admissions
  - E&M to Physician

YEAR 2

- **Payment to Hospital for Admissions**
  - Lower E&M

- **Current Spend**
  - Target Spending

- **Chart Not Drawn to Scale**

**Shared Savings $ May Not Cover Year 1**

- **Loss of Fees**
  - Non-Billable Service

- **Shared Savings $ May Not Cover Year 2**

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Shared Savings Payment May Not Cover Costs & Losses

NO ONE KNOWS HOW BIG THE LOSS IS BECAUSE THERE IS NO RECORD OF UNBILLABLE SERVICES
Physician Spending Includes Both Billable and Non-Billable Services

- **Avoidable Admissions**
- **FFS Payment to Hospital for Admissions**
- **E&M to Physician**
- **FFS Payment to Hospital for Admissions**
- **Lower E&M**
- **Loss of Fees**
- **Non-Billable Service**

**Total Spending Relevant to the Physician’s Services**

**Current Spend**

**Target Spending**

**Physician Practice Revenue**

Chart Not Drawn to Scale
Payer Only Sees the Services That Are Billable Under FFS...

YEAR 0

Total Spending Relevant to the Physician’s Services

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

FFS Payment to Hospital for Admissions

Lower E&M

FFS Payment to Hospital for Admissions

Lower E&M

Current Spend

Target Spending

Payer Spending

“Visible” Spending Under FFS

Loss of Fees Non-Billable Service

Invisible to Payer

Chart Not Drawn to Scale
…Payer Revises Target Spending Based Only on Spending It Sees…

YEAR 0

- Avoidable Admissions
- FFS Payment to Hospital for Admissions
- E&M to Physician

YEAR 4+

- Current Spend
- Target Spending
- New Target

- FFS Payment to Hospital for Admissions
- Lower E&M

Chart Not Drawn to Scale
…Leaving No Revenue for the Services That Created Savings

YEAR 0

Total Spending Relevant to the Physician's Services

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

YEAR 4+

Current Spend

Target Spending

New Target

FFS Payment to Hospital for Admissions

Lower E&M

Loss of Fees Non-Billable Service

Chart Not Drawn to Scale

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Payer Wins, Physician Loses

YEAR 0 → YEAR 1 → YEAR 2-3 → YEAR 4+

**Avoidable Admissions**
- FFS Payment to Hospital for Admissions

**Physician Practice Revenue**
- E&M to Physician

**Loss of Fees Non-Billable Service**
- Smaller Losses

**Total Spending Relevant to the Physician’s Services**
- Year 0
- Year 1
- Year 2-3
- Year 4+

**Payer Savings**
- FFS Payment to Hospital for Admissions
- Provider Share of Savings
- Lower E&M

**Physician Loss**
- FFS Payment to Hospital for Admissions

Chart Not Drawn to Scale

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Prospective Bundled Amounts (Can) Avoid This Problem

YEAR 0  TRUE APM

$ Total Actual Spending

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

Payer Savings

Payment to Hospital for Admissions

Office Visits & Other Billable & Non-Billable Services

Physician Margin

Bundled Payment or Budget for Physician Services

Physician Practice Revenue

Current Spend

Total Actual Spending

Bundle Price

Actual Physician Spending

Chart Not Drawn to Scale

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Problems With “Attributing” Patients & Services to Physicians & Episodes

• Attribution Systems
  – Since physicians currently have no way to indicate what aspects of a patient’s health care they are managing, “attribution” software is used to assign patients using statistical calculations based on CPT codes
  – Example:
    • PMPM payments made to PCPs to support non-visit based care
    • PMPM payments are paid only for attributed patients
    • Attribution systems are based on E&M visits
    • Result: Reduction in E&M visits can result in loss of PMPM payment
  – Solution: Codes to allow physicians to specify relationship to patient
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• Episode Groupers
  – Since physicians currently have no way to indicate that a particular service is related to a specific episode of care, “episode grouper” software is used to guess at which services are related to a particular procedure or condition based on current CPT codes and ICD codes
  – Example:
    • CMS Joint Replacement Bundled Payments are based on DRGs
    • Complications may cause patient assignment to non-joint replacement DRG
  – Solution: Codes to allow physicians to associate services with episodes
Problems With Current Risk Adjustment Systems

Risk Adjustment: CMS uses the Hierarchical Condition Category (HCC) system to risk adjust payments to physicians under various APMs

- HCCs were designed to predict total spending by Medicare Advantage plans (and do not do that very well), they were not designed to predict patient needs for services related to specific procedures or health problems
- HCCs are based on ICD codes, and even ICD-10 codes do not capture many important aspects of disease severity or other patient characteristics that can significantly affect service needs and outcomes, e.g.,
  - Stage of cancer
  - Severity of heart failure, COPD, rheumatoid arthritis
  - Failure of first-line treatment
  - Patient functional status
- HCCs weight diagnoses codes the same way for all patients, even though different comorbidities have different impacts on the types of care delivered by different physicians for different primary conditions
- Solution: Coding by physicians to indicate relevant patient needs
# Physician-Focused APMs Need Physician-Defined Coding

<table>
<thead>
<tr>
<th>Elements of an APM</th>
<th>Current CPT &amp; Physician Fees</th>
<th>Physician-Defined APMs</th>
<th>Payer-Administered APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trigger for Payment?</strong></td>
<td>Submission of claim with CPT and ICD codes</td>
<td>Submission of claim with bundled service or condition mgt code</td>
<td>Trigger based on current CPT, ICD, or DRG codes</td>
</tr>
<tr>
<td><strong>Services Included In a Single Payment?</strong></td>
<td>CPT code defines services included; coding rules avoid double billing</td>
<td>Bundled service code defines services included and excluded &amp; time period involved</td>
<td>Claims retrospectively “grouped” into bundle using formula based on CPT and ICD codes</td>
</tr>
<tr>
<td><strong>Amount of Payment for Service?</strong></td>
<td>Defined in advance by standard RVU weight and annual conversion factor</td>
<td>Defined in advance based on expected cost of delivering services in bundle</td>
<td>“Shared savings” payments determined after care is delivered</td>
</tr>
<tr>
<td><strong>Adjustment for Differences in Patient Needs?</strong></td>
<td>More billable services delivered to higher-need pts</td>
<td>Multiple levels defined based on patient characteristics</td>
<td>Adjusted using risk score based on (some) prior ICD codes</td>
</tr>
<tr>
<td><strong>Physician Who Is Accountable for Cost &amp; Quality?</strong></td>
<td>Physician who bills using the CPT code</td>
<td>Physician who bills as the manager of the bundle of services</td>
<td>Physician is “attributed” responsibility after care is delivered</td>
</tr>
</tbody>
</table>
MACRA Requires Development of New Codes for These Reasons

- **Care Episode Groups** (and associated codes)
  - take into account the patient’s clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and other factors determined appropriate by the Secretary

- **Patient Condition Groups** (and associated codes)
  - take into account the patient’s clinical history at the time of a medical visit, such as the patient’s combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and other factors determined appropriate by the Secretary

- **Patient Relationship Categories** (and associated codes)
  - define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service
Congress Set Tight Deadlines for Development & Implementation

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**IMPLEMENTATION ON CLAIMS FORMS IN 2018**
Best Choice for Physicians: Physician-Designed APMs

MACRA

MERIT-BASED INCENTIVE PAYMENT SYSTEM ("MIPS")

CMS-DEFINED ALTERNATIVE PAYMENT MODELS

PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS
Voluntary Choice to Participate, Not Mandatory APMs

Merit-Based Incentive Payment System ("MIPS")

Physician Choice

CMS-Defined Alternative Payment Models

Physician-Focused Alternative Payment Models
Many APMs Already Being Created That Need Coding Support

- **APMs paying for additional services beyond current CPT**
  - ASCO Patient-Centered Oncology Payment (PCOP)
  - ACEP Acute Care Transition APM
- **APMs using procedural bundles/episodes**
  - Private payer hip & knee surgery bundled/episode payments
  - Digestive Health Network Colonoscopy Bundled Payment
  - ACRO/ASTRO bundled payment for radiation oncology
- **APMs using bundled payments for condition management**
  - ACC SMARTCare payment for diagnosis of stable angina
  - AAHPM, AAN, ACAAI, ACC, ACR APMs for advanced illness, epilepsy, headache, asthma, heart failure, and rheumatoid arthritis
Suggestions for AMA & CPT Panel Action
Suggestions for AMA & CPT Panel Action

• **Move quickly to solicit and approve new codes for APMs**
  – Lack of codes will impede implementation of physician-focused APMs
  – Without codes, APMs will use groupers/attribution, not physician decisions
  – Burden for physicians if each payer develops its own codes (G codes, S codes)
  – Without a multi-specialty process, APMs will have conflicting structures
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• **Create a new CPT category IV dedicated to APM codes**
  – Codes for discrete services delivered as part of APMs
  – Codes for bundles of services for diagnosis or treatment
  – Codes stratified by patient characteristics
  – Modifiers to show relationship of services and bundles
  – Codes and/or modifiers to indicate physician role in patient care or bundle
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  – Lots of work needed quickly on top of current CPT work
  – Opportunity to involve physicians who have participated in APMs
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- **Work with specialties to ensure consistency of APMs where possible**
  - Phases of care (diagnosis, initial treatment, continued treatment, etc.)
  - Multiple levels of services/bundles based on patient characteristics
  - Methods of classifying severity or stage of disease
  - Methods of classifying patient functional status
Additional Resources

www.PaymentReform.org
For More Information:

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

Miller.Harold@CHQPR.org
(412) 803-3650

www.CHQPR.org
www.PaymentReform.org
APPENDIX:
Similarities and Differences from Current CPT
## Similar Concepts Already Exist in CPT for Most Items

<table>
<thead>
<tr>
<th>CODING SOLUTIONS</th>
<th>EXISTING ANALOGIES IN CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Codes to describe discrete services that will be delivered (only) inside of APMs (where there will be accountability for spending &amp; quality)</td>
<td>• CPT II codes to describe discrete services that are delivered as part of a regular CPT service</td>
</tr>
</tbody>
</table>
| • Codes to be used (only) for APMs that describe a “bundle” of services that achieve a particular diagnostic or therapeutic goal, but with the flexibility to determine exactly which combination of services will be delivered  | • CPT codes for obstetrics  
  ➢ Overall Delivery Bundle  
  ➢ Delivery only  
  ➢ Antepartum care only  
  ➢ Postpartum care only |
|  ➢ Procedural services & bundles  
  ➢ Condition management services & bundles  
  ➢ Diagnostic services & bundles     | • CPT “capitation” codes for ESRD  
  ➢ Month of service  
  ➢ Range of number of visits       |
| • Modifiers to indicate whether a particular service is being delivered in an APM or not | • 54/55/56 modifiers for portions of global surgery bundle                           |
| • Code Levels (for both discrete services and bundles) to distinguish combinations of patient characteristics that affect physician resources needed for care and/or cost/quality outcomes | • 59 modifier for distinct service                                                |
| • Codes to indicate that a physician is managing or coordinating care for a patient (even if no discrete services are being delivered) | • Multiple CPT “capitation” codes for ESRD based on patient age                       |
|                                                                                 | • Anesthesia Physical Status Modifiers                                               |
|                                                                                 | • CPT Transitional Care Mgt code                                                    |
Challenges in Using Current CPT Categories for APM Codes

• Coding Needs
  – Discrete Services: Codes for CPT-like services only delivered as part of APMs; may or may not be paid separately, depending on APM cash flow methodology
  – Bundles/Episodes: Codes for delivery of flexible combinations of services for diagnosis or treatment
  – Modifiers: Methods of indicating which individual services are associated with bundles/episodes and what role the physician is playing

• CPT Category I
  – Evidence typically requested to create CPT (Category I) codes may not exist for new APM services if it hasn’t been possible to implement them without payment
  – Payments for codes would trigger budget-neutral reduction of conversion factor

• CPT Category III
  – Category III does not require the same level of evidence as Category I, but APM bundled payments and additional services that are created from or similar to existing CPT-I codes would be fundamentally different than typical “emerging technology, services, and procedures”
  – APM codes would need to be used indefinitely, not retired after 5 years

• CPT Category II
  – Codes used only for tracking services and not for payment would create a disincentive to use new services in retrospective reconciliation versions of bundled payment models because cash flow would be immediate for (billable) CPT-I codes but delayed for (non-billable) CPT-II codes
ASCO

Patient-Centered Oncology Payment (PCOP)
PCOP Basic Model
4 New Codes + P4P

50+ Current Billing Codes

99211 Established Patient Office Visit – Level 1
99212 Established Patient Office Visit – Level 2
99213 Established Patient Office Visit – Level 3
99214 Established Patient Office Visit – Level 4
99215 Established Patient Office Visit – Level 5
99231 Subsequent Hospital Care – Level 1
99232 Subsequent Hospital Care – Level 2
99233 Subsequent Hospital Care – Level 3
96401 Subcutaneous chemotherapy administration
96402 Subcutaneous chemotherapy administration
96405 Intralesional chemotherapy administration
96406 Intralesional chemotherapy administration
96409 Push chemotherapy administration
96411 Push chemotherapy administration
96413 Injection chemotherapy administration
96415 Injection chemotherapy administration
96416 Injection chemotherapy administration
96417 Injection chemotherapy administration
96420 Intra-arterial push chemotherapy
96422 Intra-arterial infusion chemotherapy
96423 Intra-arterial infusion chemotherapy
96425 Intra-arterial infusion chemotherapy
96440 Pleural cavity chemotherapy
96446 Peritoneal cavity chemotherapy
96450 CNS chemotherapy
96521 Refilling and maintenance of portable pump
96522 Refilling and maintenance of implantable pump
96523 Irrigation of implanted venous access device
96542 Chemotherapy injection via subcutaneous reservoir
96549 Unlisted chemotherapy procedure
79005 Oral radiopharmaceutical therapy
79101 Radiopharmaceutical infusion
79200 Radiopharmaceutical intracavitary administration
79300 Radiopharmaceutical therapy
79403 Radiopharmaceutical therapy infusion
96356 Intravenous infusion, non-chemotherapy
96357 Intravenous infusion, non-chemotherapy
96358 Intravenous infusion, non-chemotherapy
96359 Subcutaneous infusion, non-chemotherapy
96360 Subcutaneous infusion, non-chemotherapy
96361 Intravenous infusion, hydration
96362 Intravenous infusion, hydration
96363 Intravenous infusion, hydration
96364 Intravenous infusion, hydration
96365 Intravenous infusion, non-chemotherapy
96366 Intravenous infusion, non-chemotherapy
96367 Intravenous infusion, non-chemotherapy
96368 Intravenous infusion, non-chemotherapy
96369 Subcutaneous infusion, non-chemotherapy
96370 Subcutaneous infusion, non-chemotherapy
96371 Subcutaneous infusion, non-chemotherapy
96372 Injection, non-chemotherapy
96373 Intra-arterial injection, non-chemotherapy
96374 Intravenous push, non-chemotherapy
96375 Intravenous push, non-chemotherapy
96376 Intravenous push, non-chemotherapy
96377 Intravenous push, non-chemotherapy
96378 Unlisted injection or infusion, non-chemotherapy
96379 Unlisted injection or infusion, non-chemotherapy
96380 Intravenous infusion, hydration
96381 Intravenous infusion, hydration
96382 Intravenous infusion, hydration
96383 Intravenous infusion, hydration

+ 4 New Service/Billing Codes

1. New Patient Treatment Planning (One-time)
2. Care Management During Treatment (Monthly)
3. Care Management During Active Monitoring (Monthly, Limited Time)
4. Participation in Clinical Trials (Monthly)
PCOP Option A: Create Bundled Codes

### 50+ Current Billing Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
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</tr>
<tr>
<td>99214</td>
<td>Established Patient Office Visit – Level 4</td>
</tr>
<tr>
<td>99215</td>
<td>Established Patient Office Visit – Level 5</td>
</tr>
<tr>
<td>99231</td>
<td>Subsequent Hospital Care – Level 1</td>
</tr>
<tr>
<td>99232</td>
<td>Subsequent Hospital Care – Level 2</td>
</tr>
<tr>
<td>99233</td>
<td>Subsequent Hospital Care – Level 3</td>
</tr>
<tr>
<td>96401</td>
<td>Subcutaneous chemotherapy administration</td>
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<td>96402</td>
<td>Subcutaneous chemotherapy administration</td>
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<tr>
<td>96405</td>
<td>Intrallesional chemotherapy administration</td>
</tr>
<tr>
<td>96406</td>
<td>Intrallesional chemotherapy administration</td>
</tr>
<tr>
<td>96409</td>
<td>Push chemotherapy administration</td>
</tr>
<tr>
<td>96411</td>
<td>Push chemotherapy administration</td>
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<tr>
<td>96413</td>
<td>Infusion chemotherapy administration</td>
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<td>96415</td>
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<td>79005</td>
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<td>96368</td>
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<td>96369</td>
<td>Subcutaneous infusion, non-chemotherapy</td>
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<td>96371</td>
<td>Subcutaneous infusion, non-chemotherapy</td>
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<tr>
<td>96372</td>
<td>Injection, non-chemotherapy</td>
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<td>96373</td>
<td>Intra-arterial injection, non-chemotherapy</td>
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<td>96374</td>
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<tr>
<td>96375</td>
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</tr>
<tr>
<td>96376</td>
<td>Intravenous push, non-chemotherapy</td>
</tr>
<tr>
<td>96379</td>
<td>Unlisted injection or infusion, non-chemotherapy</td>
</tr>
<tr>
<td>96380</td>
<td>Intravenous infusion, hydration</td>
</tr>
<tr>
<td>96381</td>
<td>Intravenous infusion, hydration</td>
</tr>
</tbody>
</table>

### ~ 10 New Bundled Codes
- New Patient Payment
- Treatment Month (4-6 Levels) Stratified by:
  - Comorbidities
  - Performance (Functional) Status
  - Drug Toxicity
  - Regimen Complexity
- Active Monitoring Month (2 Levels)

### + 4 New Service/Billing Codes

1. New Patient Treatment Planning
2. Care Management During Treatment
3. Care Management During Active Monitoring
4. Participation in Clinical Trials

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Digestive Health Network

Bundled Payment for Colorectal Cancer Screening Colonoscopy
Bundled Payment Encompassing Multiple Existing CPT Codes

xxxxT: Comprehensive Bundled Payment for Colorectal Cancer Screening Colonoscopy

- Colonoscopy (44388, 44389, 44391, etc.)
- Anesthesia (00810, 008X1, 008X2)
- Moderate Sedation (99151, 99152, 99153, etc.)
- Pathology (88305, 88313, 88342, 88341)
- Radiology (74261, 74262, 74280)
- Evaluation & Management (99201-99205, etc.)
American College of Allergy, Asthma, & Immunology

Patient-Centered Asthma Care Payment (DRAFT)
### Three Phases of Payment Stratified by Patient Risk/Symptoms

<table>
<thead>
<tr>
<th>Payment Categories</th>
<th>Stratified Bundled Service Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diagnosis and Initial Treatment for Poorly-Controlled Asthma-Like Symptoms</td>
<td>xxx11: Mild symptoms not due to asthma</td>
</tr>
<tr>
<td></td>
<td>xxx12: Mod-severe symptoms not asthma</td>
</tr>
<tr>
<td></td>
<td>xxx13: Mild symptoms due to asthma</td>
</tr>
<tr>
<td></td>
<td>xxx14: Mod-severe symptoms of asthma</td>
</tr>
<tr>
<td></td>
<td>xxx15: Mod-severe asthma + comorbidity</td>
</tr>
<tr>
<td></td>
<td><strong>Monthly payments up to 6 months</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Replaces E&amp;M payments</strong></td>
</tr>
<tr>
<td>2. Continued Care for Difficult-to Control Asthma</td>
<td>xxx21: Well-controlled asthma with comorbidities or high-risk meds</td>
</tr>
<tr>
<td></td>
<td>xxx22: Not well controlled asthma</td>
</tr>
<tr>
<td></td>
<td>xxx23: Very poorly controlled asthma OR not well controlled + comorb.</td>
</tr>
<tr>
<td></td>
<td>xxx24: Very poorly controlled + comorb.</td>
</tr>
<tr>
<td></td>
<td><strong>Monthly payment as long as eligible</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Replaces E&amp;M payments</strong></td>
</tr>
<tr>
<td>3. Continued Care for Well-Controlled Asthma</td>
<td>xxx31: Telephone call or email with patients regarding symptoms or</td>
</tr>
<tr>
<td></td>
<td>medication side effects</td>
</tr>
<tr>
<td></td>
<td>xxx32: Telephone call or email between PCP &amp; specialist to address</td>
</tr>
<tr>
<td></td>
<td>issues</td>
</tr>
<tr>
<td></td>
<td><strong>Additional payments to support continued management by PCP</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Replaces E&amp;M payments</strong></td>
</tr>
</tbody>
</table>
American College of Rheumatology

APM for Diagnosis & Treatment of Rheumatoid Arthritis (DRAFT)
## Four Phases of Payment Stratified by Patient Risk/Symptoms

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<tbody>
<tr>
<td><strong>1. Diagnosis and Treatment Planning for Potential Rheumatoid Arthritis</strong></td>
<td>xxx11: Swelling/pain present but no RA</td>
</tr>
<tr>
<td>• One-time payment replaces E&amp;M</td>
<td>xxx12: Definite diagnosis of RA</td>
</tr>
<tr>
<td>• Payment for phone call or email w/ PCP to assess need for referral</td>
<td>xxx20: Patient with joint pain/swelling</td>
</tr>
<tr>
<td><strong>2. Initial Treatment for RA</strong></td>
<td>xxx31: Low disease activity and no major comorbidities</td>
</tr>
<tr>
<td>• Monthly payment for up to 6 months</td>
<td>xxx32: Moderate disease activity OR Low activity + Comorbidities</td>
</tr>
<tr>
<td>• Replaces E&amp;M payments</td>
<td>xxx33: High disease activity OR Moderate activity + Comorb.</td>
</tr>
<tr>
<td></td>
<td>xxx34: High disease activity + Comorb. OR Failure of drug (1 month)</td>
</tr>
<tr>
<td><strong>3. Continued Care for Patients with Difficult-to Control RA</strong></td>
<td>xxx41: Low activity + high-risk medication</td>
</tr>
<tr>
<td>• Monthly payment as long as eligible</td>
<td>xxx42: Moderate disease activity</td>
</tr>
<tr>
<td>• Replaces E&amp;M payments</td>
<td>xxx43: High activity or increase</td>
</tr>
<tr>
<td></td>
<td>xxx44: High activity + comorbidities</td>
</tr>
<tr>
<td><strong>4. Continued Care for Low-Activity RA</strong></td>
<td>xxx50: Patient is being managed</td>
</tr>
<tr>
<td>• Additional payments for phone/email w/ rheumatologist &amp; patient or PCP</td>
<td>xxx51: Phone call/email with patient</td>
</tr>
<tr>
<td></td>
<td>xxx52: Phone/email among physicians</td>
</tr>
</tbody>
</table>
American College of Cardiology

SMARTCare APM
(DRAFT)
Example: Wide Range of Tests Used to Diagnose Chest Pain

<table>
<thead>
<tr>
<th>Test</th>
<th>Physician Payment</th>
<th>Hospital Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive Angiogram</td>
<td>$498</td>
<td>$2,605</td>
</tr>
<tr>
<td>Stress PET</td>
<td>$357</td>
<td>$1,341</td>
</tr>
<tr>
<td>Nuclear Stress</td>
<td>$292</td>
<td>$1,164</td>
</tr>
<tr>
<td>Stress MRA</td>
<td>$412</td>
<td>$497</td>
</tr>
<tr>
<td>Stress Echo</td>
<td>$319</td>
<td>$473</td>
</tr>
<tr>
<td>CT Angiogram</td>
<td>$295</td>
<td>$293</td>
</tr>
<tr>
<td>Treadmill Test</td>
<td>$212</td>
<td>$276</td>
</tr>
<tr>
<td>Office Visit+ECG</td>
<td>$175</td>
<td></td>
</tr>
</tbody>
</table>
Many Tests are Overused and Leads to Unnecessary Intervention

Cost of Alternative Cardiac Tests

<table>
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<tr>
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<th>Physician Payment</th>
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<td>Office Visit+ECG</td>
<td>$175</td>
<td></td>
</tr>
</tbody>
</table>

Unnecessary PCIs/Stents
Avoiding Unnecessary Tests Could Save a Lot of Money

Savings from Using Lower-Cost Cardiac Testing

- Invasive Angiogram: $1,405
- Stress PET: $1,647
- Nuclear Stress: $2,194
- Stress MRA: $2,312
- Stress Echo: $2,515
- CT Angiogram: $2,615
- Treadmill Test: $2,872
- Office Visit+ECG: $3,000

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But Physician (& Hospital) Payment is Linked to # and Type of Tests

Savings from Using Lower-Cost Cardiac Testing

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Physician Payment</th>
<th>Savings on Physician Payment</th>
<th>Hospital Payment</th>
<th>Savings on Hospital Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive Angiogram</td>
<td>$500</td>
<td>$1,264</td>
<td></td>
<td>$2,764</td>
</tr>
<tr>
<td>Stress PET</td>
<td>$141</td>
<td>$1,264</td>
<td></td>
<td>$2,405</td>
</tr>
<tr>
<td>Nuclear Stress</td>
<td>$206</td>
<td>$1,441</td>
<td></td>
<td>$2,647</td>
</tr>
<tr>
<td>Stress MRA</td>
<td>$86</td>
<td>$2,108</td>
<td></td>
<td>$2,994</td>
</tr>
<tr>
<td>Stress Echo</td>
<td>$179</td>
<td>$2,132</td>
<td></td>
<td>$2,311</td>
</tr>
<tr>
<td>CT Angiogram</td>
<td>$203</td>
<td>$2,312</td>
<td></td>
<td>$2,515</td>
</tr>
<tr>
<td>Treadmill Test</td>
<td>$286</td>
<td>$2,329</td>
<td></td>
<td>$2,585</td>
</tr>
<tr>
<td>Office Visit+ECG</td>
<td>$323</td>
<td>$2,549</td>
<td></td>
<td>$2,772</td>
</tr>
</tbody>
</table>
Financial Penalties for Physicians From Appropriate Use of Testing

Savings from Using Lower-Cost Cardiac Testing

- Invasive Angiogram
- Stress PET: $141
- Nuclear Stress: $206
- Stress MRA: $86
- Stress Echo: $179
- CT Angiogram: $203
- Treadmill Test: $286
- Office Visit+ECG: $323

17-65% Reductions in Fees

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Example: Instead of Paying for Individual Types of Cardiac Tests...
...Pay Physicians For Diagnosis, Not Based on # or Type of Tests
Higher-Risk Patients Will Need More/More Expensive Testing

More Expensive Tests Needed for Higher-Risk Patients

- Invasive Angiogram
- Stress PET
- Office Visit+ECG
- Nuclear Stress
- Stress Echo
- Office Visit+ECG

Low-Risk Patients

Medium-Risk Patients

High-Risk Patients

- Treadmill Test
- Office Visit+ECG

$0 $500 $1,000 $1,500 $2,000 $2,500 $3,000 $3,500

- Physician Payment
- Hospital Payment
Diagnosis Payment Based on Patient Risk, Not #/Type of Tests

Risk-Stratified Diagnosis Payment

- High-Risk Patients
  - Invasive Angiogram: $500
  - Stress PET: $500
  - Office Visit+ECG: $500

- Medium-Risk Patients
  - Nuclear Stress: $350
  - Stress Echo: $350
  - Office Visit+ECG: $350

- Low-Risk Patients
  - Stress Echo: $200
  - Treadmill Test: $200
  - Office Visit+ECG: $200

Savings

- Physicians Payment
- Hospital Payment
- Savings
Alternative Payment Model Based on Diagnostic Goal, Not Services

<table>
<thead>
<tr>
<th>SMARTCare APM</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of Stable Ischemic Heart Disease</td>
<td></td>
</tr>
<tr>
<td>• One-Time Payment</td>
<td></td>
</tr>
<tr>
<td>• Replaces E&amp;M and payments for stress tests and angiograms for a six month period</td>
<td></td>
</tr>
</tbody>
</table>
## Payment Amounts Stratified by Patient Risk/Symptoms

<table>
<thead>
<tr>
<th>SMARTCare APM</th>
<th>Stratified Bundled Service Codes</th>
</tr>
</thead>
</table>
| **Evaluation of Stable Ischemic Heart Disease** | xxx01: Low pre-test probability of CAD & good score on Seattle Angina Q.  
xxx02: Intermediate pre-test probability and good score on SAQ  
OR Low pre-test prob. + fair SAQ  
OR Intermediate risk **result on test**  
xxx03: Intermediate pre-test probability and poor score on SAQ  
OR High-risk result on stress test  
xxx04: High pre-test probability  
OR Blockage on angiogram  
xxx00: ACS, AMI, Ineligible for APM |
| • One-Time Payment  
• Replaces E&M and payments for stress tests and angiograms for a six month period |
Physician Needs a Way to Indicate if Services Are In or Out of APM

<table>
<thead>
<tr>
<th>PATIENT ELIGIBLE FOR APM</th>
<th>NOT ELIGIBLE FOR APM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>APM BUNDLED PAYMENT</strong></td>
<td><strong>REPORTED AND INCLUDED IN BUNDLE</strong></td>
</tr>
<tr>
<td>• xxx01 (Level 1)</td>
<td>• 75571 (CT Calcium Score)</td>
</tr>
<tr>
<td>• xxx02 (Level 2)</td>
<td>• 75574 (CT Angiogram)</td>
</tr>
<tr>
<td>• xxx03 (Level 3)</td>
<td>• 75559 (Cardiac MRI)</td>
</tr>
<tr>
<td>• xxx04 (Level 4)</td>
<td>• 78452 (SPECT MPI)</td>
</tr>
<tr>
<td></td>
<td>• 78491-78492 (PET)</td>
</tr>
<tr>
<td></td>
<td>• 92978-92979 (IVUS)</td>
</tr>
<tr>
<td></td>
<td>• 93015-93018 (Stress Test)</td>
</tr>
<tr>
<td></td>
<td>• 93350-93352 (Stress Echo)</td>
</tr>
<tr>
<td></td>
<td>• 93452-93460 (Angiogram)</td>
</tr>
<tr>
<td></td>
<td>• 93571-93572 (FFR)</td>
</tr>
</tbody>
</table>
Option: Creating a “Total Bundle” Not Just for Physician Services

### CURRENT FFS

- **Avoidable Spending**
  - Payments for Hospitals, SNFs, Drugs
  - Current FFS Payments to Physician

- **Unbillable Services**

### APM

- **Savings**
  - Avoidable Spending
  - Payments for Hospitals, SNFs, Drugs
  - New Billable Services

### APM

- **Savings**
  - Avoidable Spending
  - Payments for Hospitals, SNFs, Drugs
  - New Flexible Bundled Payment for Physician Services

### APM

- **Savings**
  - Avoidable Spending
  - Payments for Hospitals, SNFs, Drugs
  - Payment for Physician Services

**TOTAL BUNDLE**