Value-based Care and the CPT® Code Set

PRESENTED BY

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Our Presenters

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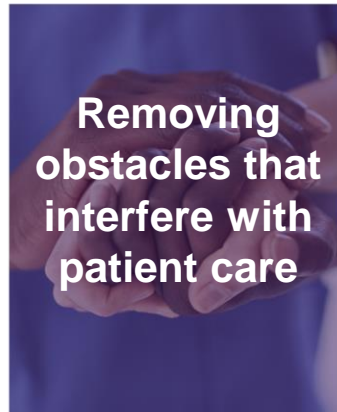
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AMA: The Physicians' Powerful Ally in Patient Care

Representing physicians with a unified voice

Removing obstacles that interfere with patient care

Leading the charge to confront public health crises

Driving the future of medicine

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What We Will Cover Today

Introduction to value-based care

How the CPT® code set enables value-based care

Value-based care programs

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Introduction to Value-based Care

Zach Hochstetler

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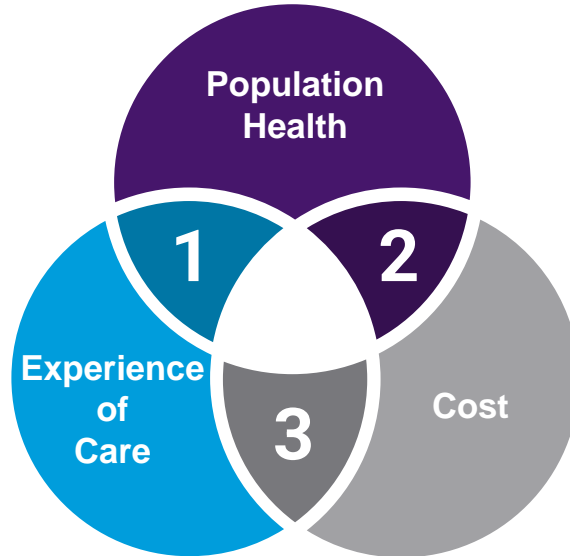
What is value-based care?

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Value-based Care

- ✓ **S**afe
- ✓ **T**imely
- ✓ **E**fficient
- ✓ **E**quitable
- ✓ **E**ffective, and
- ✓ **P**atient-centered

The National Academy of Medicine

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Value-based Care—Triple Aim

Institute for Health Care Improvement (IHI)

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Value-based Care—Quadruple Aim

American Medical Association (AMA)

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Value-based Care—The Value Equation

$$V = \frac{Q \times P}{\$}$$

V (VALUE)

Q (QUALITY)

×

P (PATIENT EXPERIENCE)

$ (COST)

The University of Utah Health

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High-Value Healthcare Framework

01

CLEAR VISION

Shared vision with the patient at the center

02

LEADERSHIP

Training emphasizing teamwork

03

IT INFRASTRUCTURE

04

BROAD ACCESS TO CARE

05

PAYMENT MODELS

Remove incentives for volume-based care

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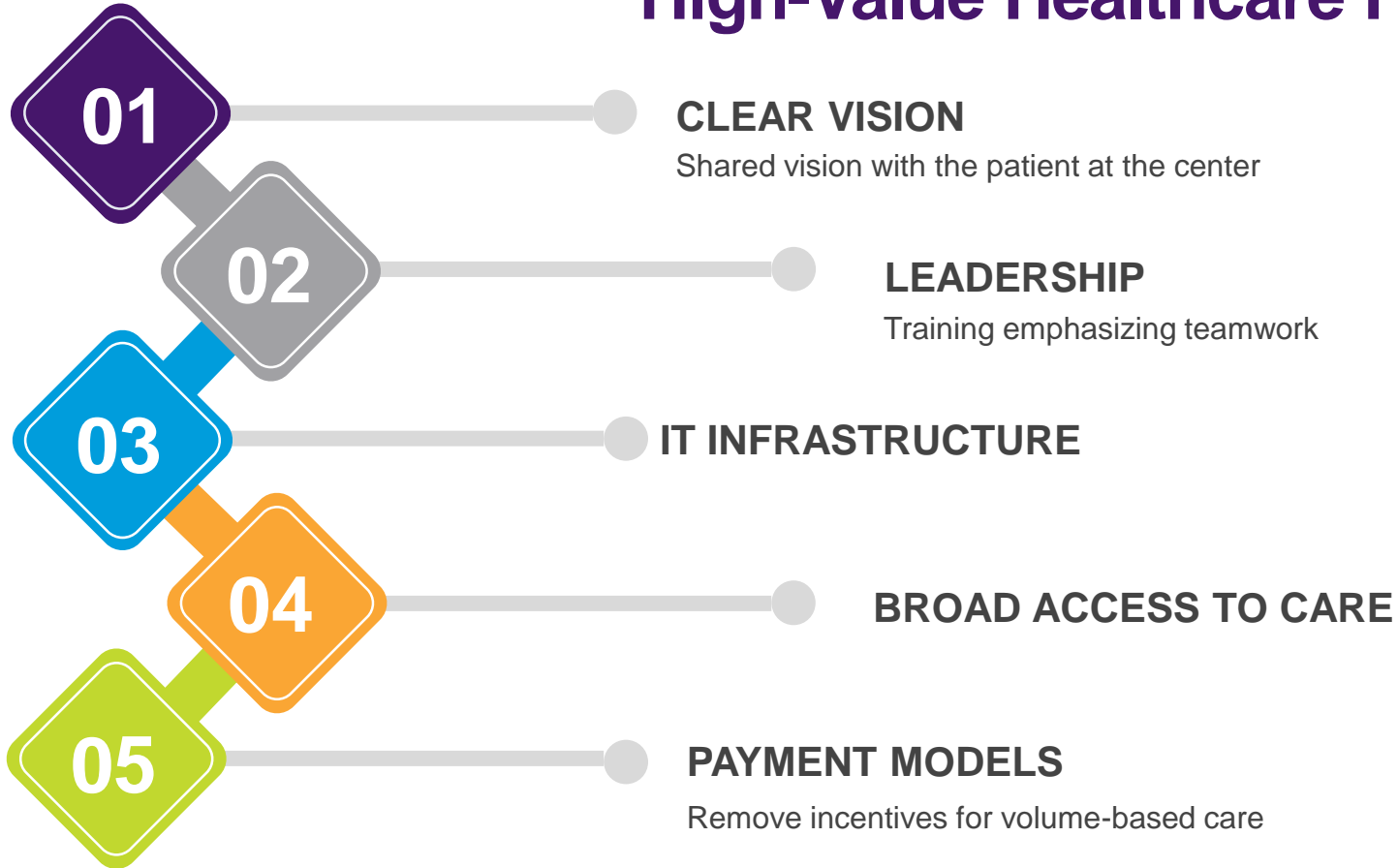
The State of Value-based Care in the U.S.

2021 CMS Innovation Center Strategic Refresh

- -

GOAL

100%

Of Medicare beneficiaries in ACO relationships by:

2030

40%   **FEE FOR SERVICE**
No link to quality & value

20%   **FEE FOR SERVICE**
Link to quality & value

40%   **Advanced Payment Models (APMs)**
Includes both one-sided and two-sided risk models

2022 HCPLAN APM Measurement Report
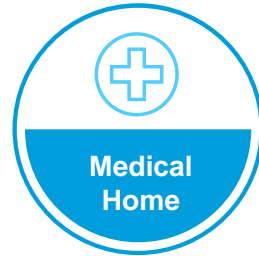*63 Plans, 5 States, Traditional Medicare*

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Value-based Care: Common Pathways

ACO

Bundled Payment

Medical Home

Risk – Upside/ Downside

Capitation

Patient-centered networks with physicians/QHPs working together to lower costs and improve quality and care.

Single payment for services provided for an entire episode of care.

Primary care physician coordinates a centralized care setting for patients.
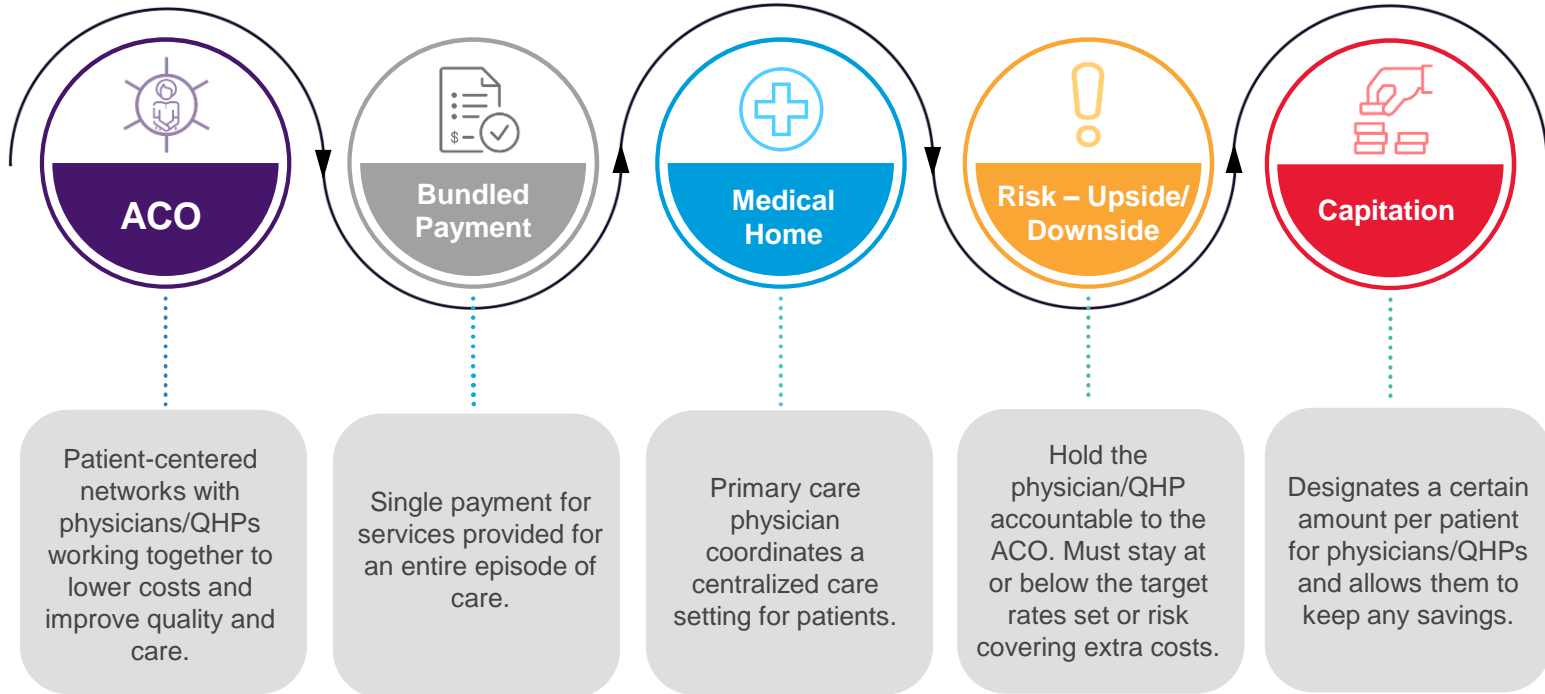
Hold the physician/QHP accountable to the ACO. Must stay at or below the target rates set or risk covering extra costs.

Designates a certain amount per patient for physicians/QHPs and allows them to keep any savings.

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Value-based Care: Common Pathways

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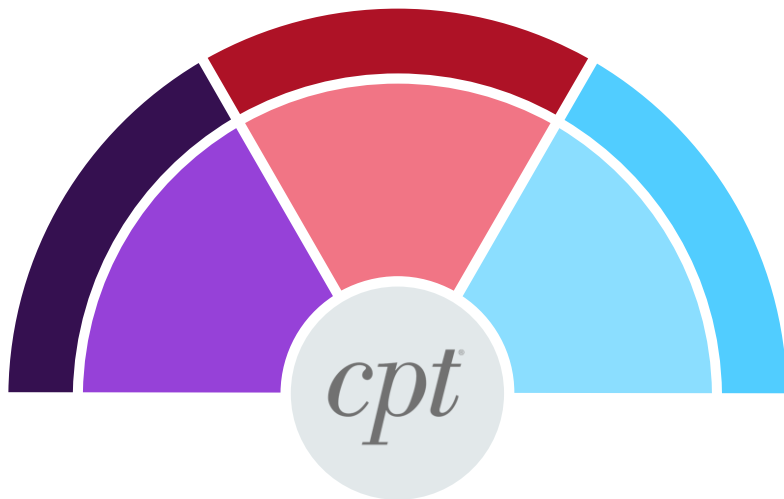
Designates a certain amount per patient for physicians/QHPs and allows them to keep any savings.

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CPT®: Perception vs. Reality

Medical Code Set Terminology Standard

Claims-Based Reporting
The primary terminology for medical services and procedures.

Fee-for-Service Payment
Integral in the predominant fee-for-service payment system.

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CPT®: Perception vs. Reality

Medical Code Set Terminology Standard

Claims-Based Reporting
The primary terminology for medical services and procedures.

Fee-for-Service Payment
Integral in the predominant fee-for-service payment system.

Quality Measures
Determine the scope of medical services included for measurement.

Alternative Payment Models
Determine the scope of medical services included in the model.

Research
Evaluation and assessment of quality, volume, cost.

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CPT® Enables Value-based Care

Ezequiel Silva III, MD

Chair, **AMA/Specialty Society RVS Update Committee**

Past Co-Chair, **AMA Digital Medicine Payment Advisory Group**

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Traditional Fee-for-Service Model

Incentives

Payment made regardless of quality

Doesn't address fragmented care

01 MEDICAL SERVICE

A patient receives a medical procedure or service

02 REPORT CPT®

Report the medical procedure or service level CPT code through the claim

03 PAYMENT per SERVICE

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CPT® Enables Value-based Care: Capitation

01 FINANCIALLY ACCOUNTABLE

Providers/health system agree to be financially accountable for the quality, cost and experience of care.

02 PAYMENT per PATIENT

03 PROVIDE SERVICE/ REPORT CPT

Report medical services through CPT codes.

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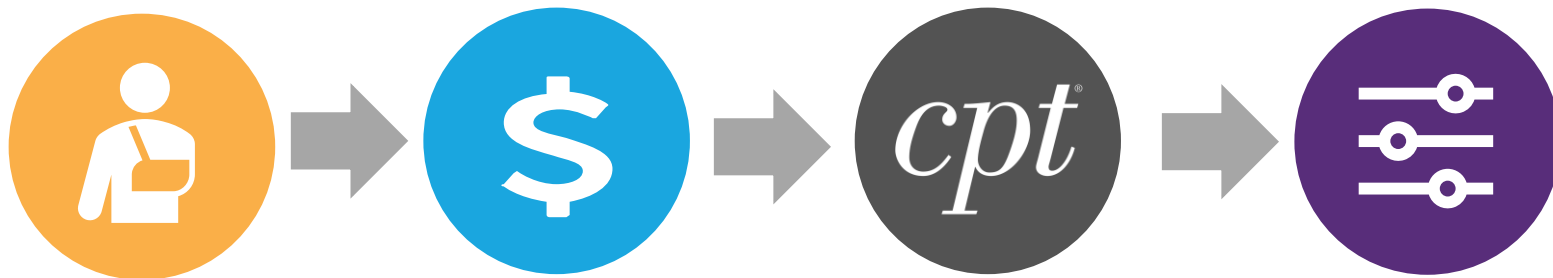# CPT® Enables Value-based Care: Capitation

PENALIZED

If total costs are higher than per person payment, losses are incurred

REWARDED

If total costs are lower than per person payment, savings are kept

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CPT® Enables Value-based Care: Bundled Payment

01 **Episode of Care Identified**

Payer reviews historical prices and combines average costs.

02 **PAYMENT per BUNDLE**

Payment is made to contracted physicians/QHPs per episode of care.

03 **PROVIDE SERVICE/ REPORT CPT**

Report medical services through CPT codes. Used to track costs compared to bundle payment.

04 **RISK STRATIFICATION**

Ensure care is delivered and costs adjusted for complex patients.

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CPT® Enables Value-based Care: Bundled Payment

PENALIZED

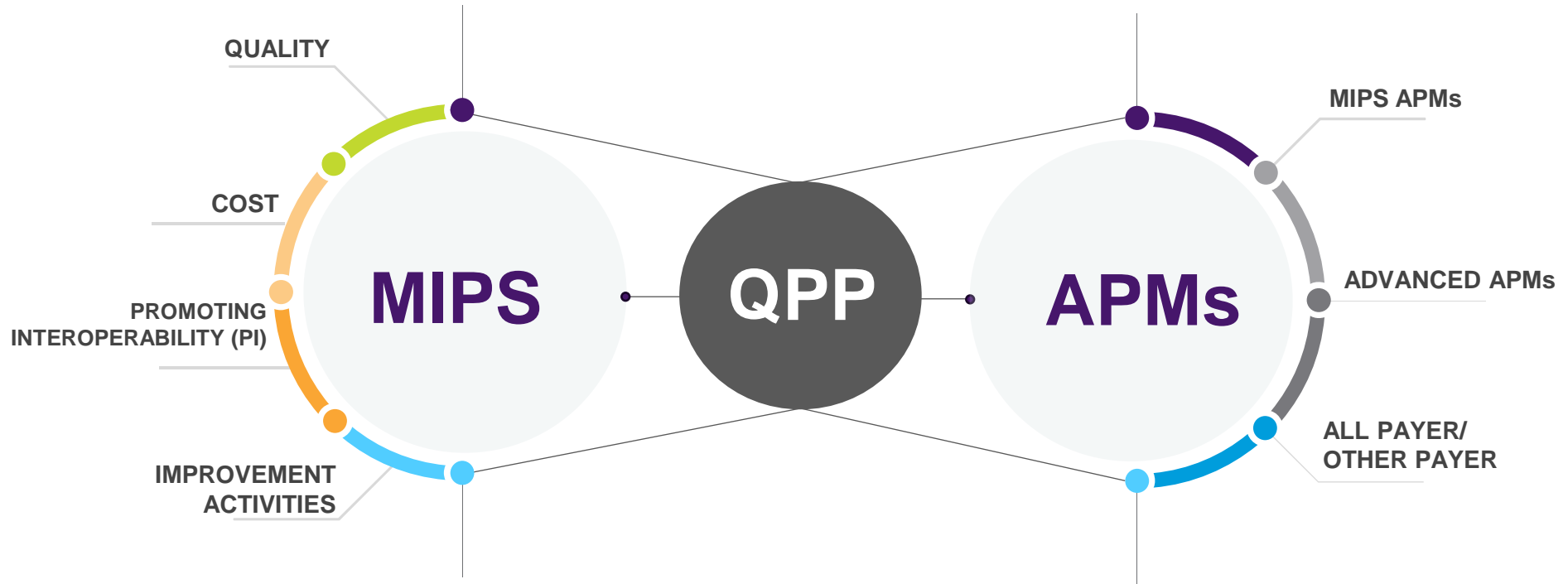If total costs are higher than per **bundle** payment, losses are incurred

REWARDED

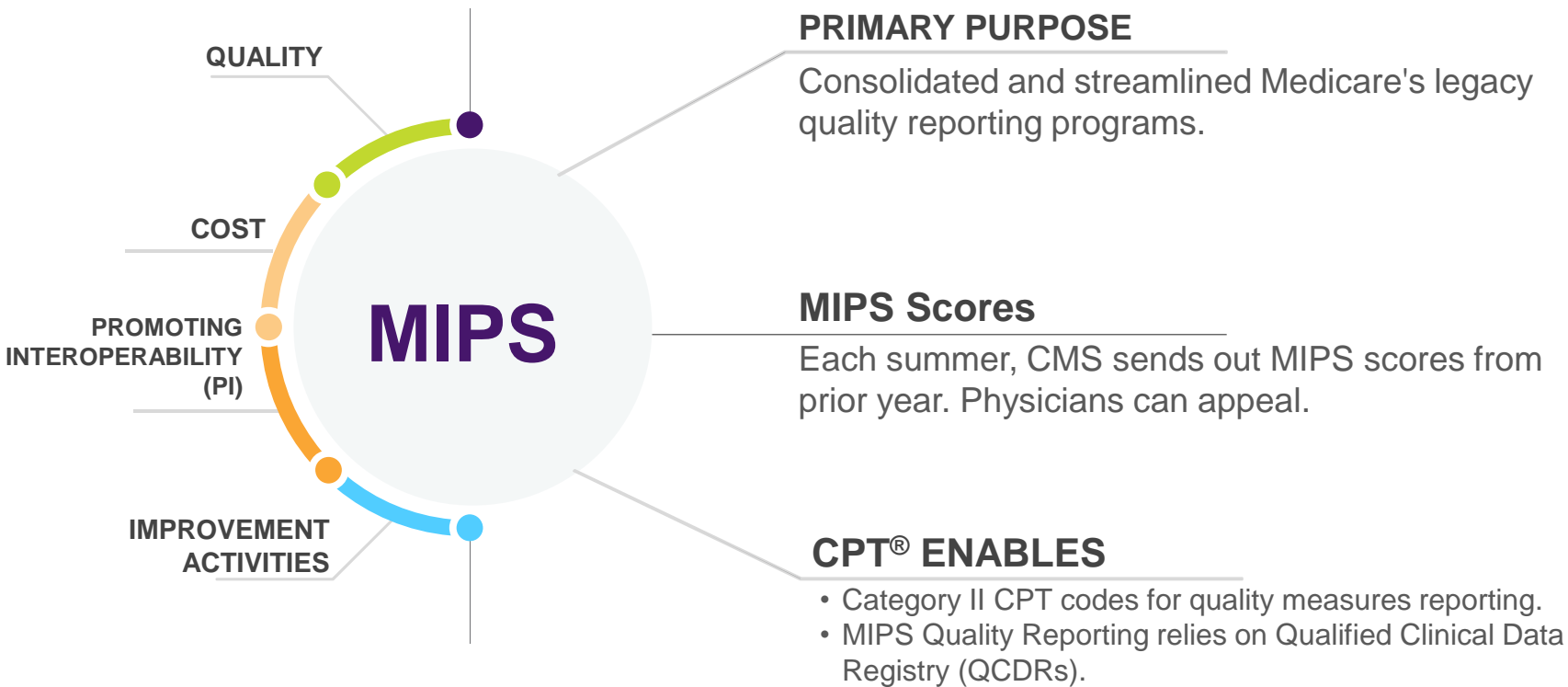If total costs are lower than per **bundle** payment, savings are kept

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Value-based Care Programs

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Medicare: Quality Payment Program (QPP)

MIPS
- QUALITY
- COST
- PROMOTING INTEROPERABILITY (PI)
- IMPROVEMENT ACTIVITIES

QPP

APMs
- MIPS APMs
- ADVANCED APMs
- ALL PAYER/OTHER PAYER

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Medicare:
Merit-based Incentive Payment System (MIPS)

MIPS

QUALITY

COST

PROMOTING INTEROPERABILITY (PI)

IMPROVEMENT ACTIVITIES

PRIMARY PURPOSE

Consolidated and streamlined Medicare's legacy quality reporting programs.

MIPS Scores

Each summer, CMS sends out MIPS scores from prior year. Physicians can appeal.

CPT® ENABLES

- Category II CPT codes for quality measures reporting.
- MIPS Quality Reporting relies on Qualified Clinical Data Registry (QCDRs).

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Medicare: Advanced Payment Models (APMs)
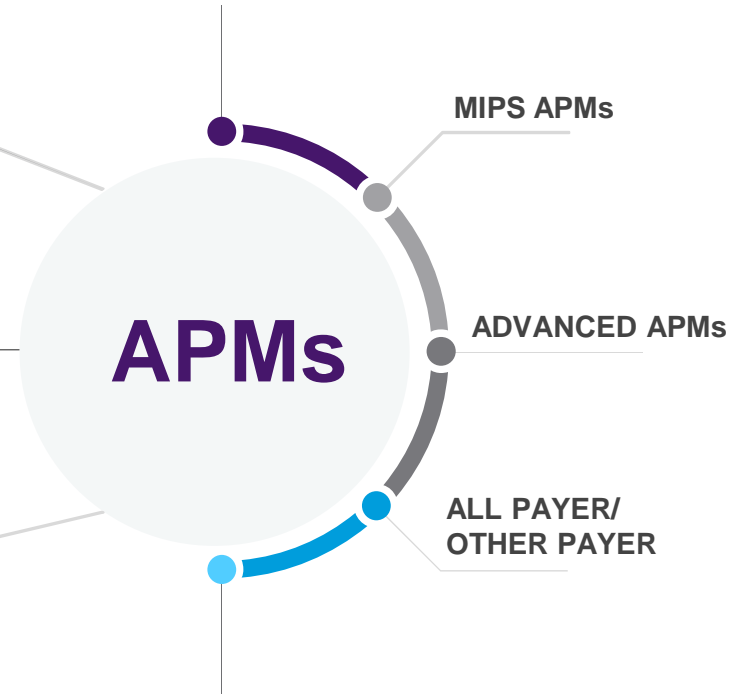
PRIMARY PURPOSE

Designed to further CMS' goal to better align payment for services with cost and quality.

PAYMENT MODEL ALIGNMENT

Organizations choose from available APMs. Realize shared risk or savings based on model.

CPT® ENABLES

CPT codes used to report medical services which account for the overall cost of care delivered.

APMs

MIPS APMs

ADVANCED APMs

ALL PAYER/ OTHER PAYER

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Value-based Care: Advancing Health Equity

1 **HEALTH EQUITY**
Require that all model participants develop and implement a robust health equity plan.

2 **PHYSICIAN LEADERSHIP**
At least **75%** control of each ACO's governing body generally must be held by participating physicians/QHPs.

3 **TRANSPARENCY**
Better visibility into ownership interests and affiliations.

ACO Realizing Equity, Access, and Community Health (ACO REACH) Model

Leadership
2

1
Health Equity

3
Transparency

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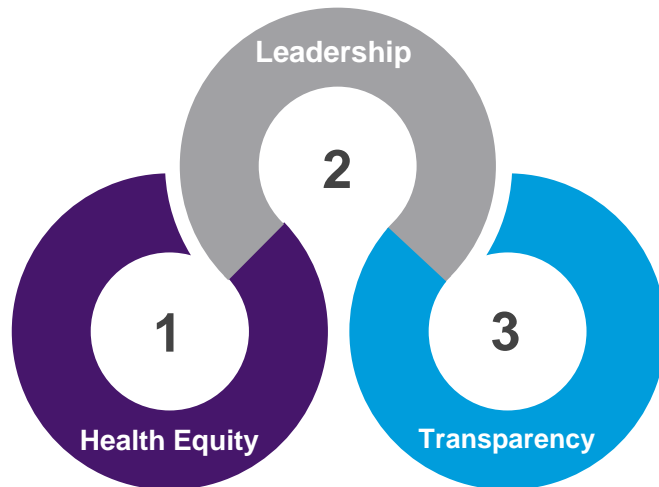
CPT® Editorial Panel Process: Leader in Innovation

1 **CATEGORY III CODES**

Emerging Technology

2 **DIGITAL MEDICINE**

New Resources and Precedent Setting Category I Codes

3 **PLA CODES**

Laboratory Innovation

4 **ADVOCACY**

Public Policy to Support Innovation in Value-based Care

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CPT® Enables Value-based Care: Category III

01 **Access and Equity**

Increase access for more equitable care

02 **Quality and Experience**

Expand options for patients

03 **Physician Reach**

Allow innovative technology to be available to physician practices

Cat III: More than enabling payment

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CPT® Enables Value-based Care: Category II

MEASURE

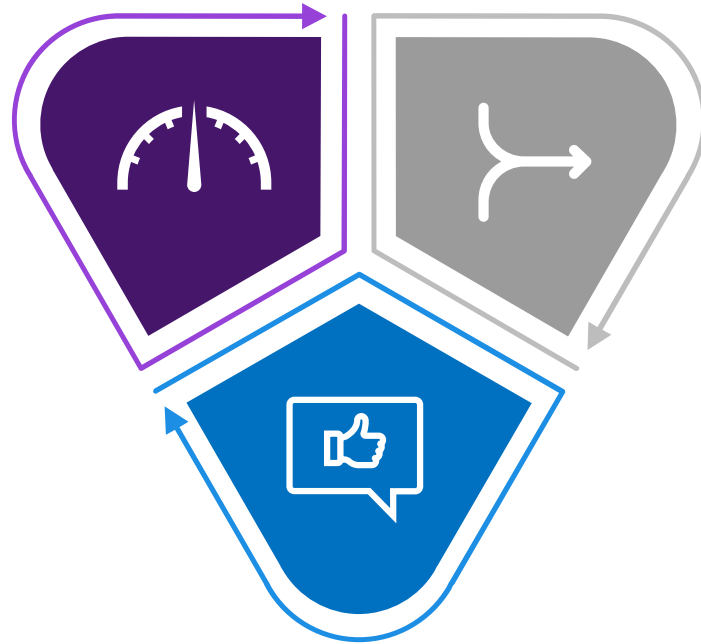Specific measures tied to unique CPT codes.

SIMPLIFY

Simplify reporting across programs to decrease administrative burden.

DATA COLLECTION

Agreement on the factors that contribute to quality patient care.

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Together we discussed:

✓ **What value-based care is**

✓ **How the CPT® code set enables value-based care**

✓ **Value-based care programs**

Questions?

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cpt Standard

Introducing the CPT® 2024 Standard Data File

Featuring:

✓ Added valuable content, including CPT Consumer-Friendly Descriptors in Spanish

✓ Usability improvements

LEARN MORE
platform.ama-assn.org

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CPT® & RBRVS
2024 ANNUAL SYMPOSIUM
Virtual • Nov. 15–17, 2023

Prepare for 2024 with the authority on the CPT® code set

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ama-assn.org/cpt-symposium

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Stay Informed With Additional AMA Resources

The AMA's **Medicare Basics series** provides an in-depth look at important aspects of the Medicare physician payment system. Through straightforward explanations, policymakers and physician advocates can learn about key elements of the payment system and why they are in need of reform.

ama-assn.org/medicare-basics-series

Intended for both current and future participants in value-based care (VBC) arrangements, **The Future of Sustainable Value-Based Care and Payment: Voluntary Best Practices to Advance Data Sharing** offers voluntary best practices for overcoming key challenges associated with data-sharing for VBC arrangements that persist today.

ama-assn.org/vbc-data-sharing

The **AMA Digital Medicine Payment Advisory Group** identifies barriers to digital medicine adoption and proposes comprehensive solutions on coding, payment, coverage and more.

ama-assn.org/dmpag

Through research, the **AMA Future of Health** blueprint has been developed to address the digital health disconnect and achieve optimized digitally enabled care.

ama-assn.org/driving-future-health

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