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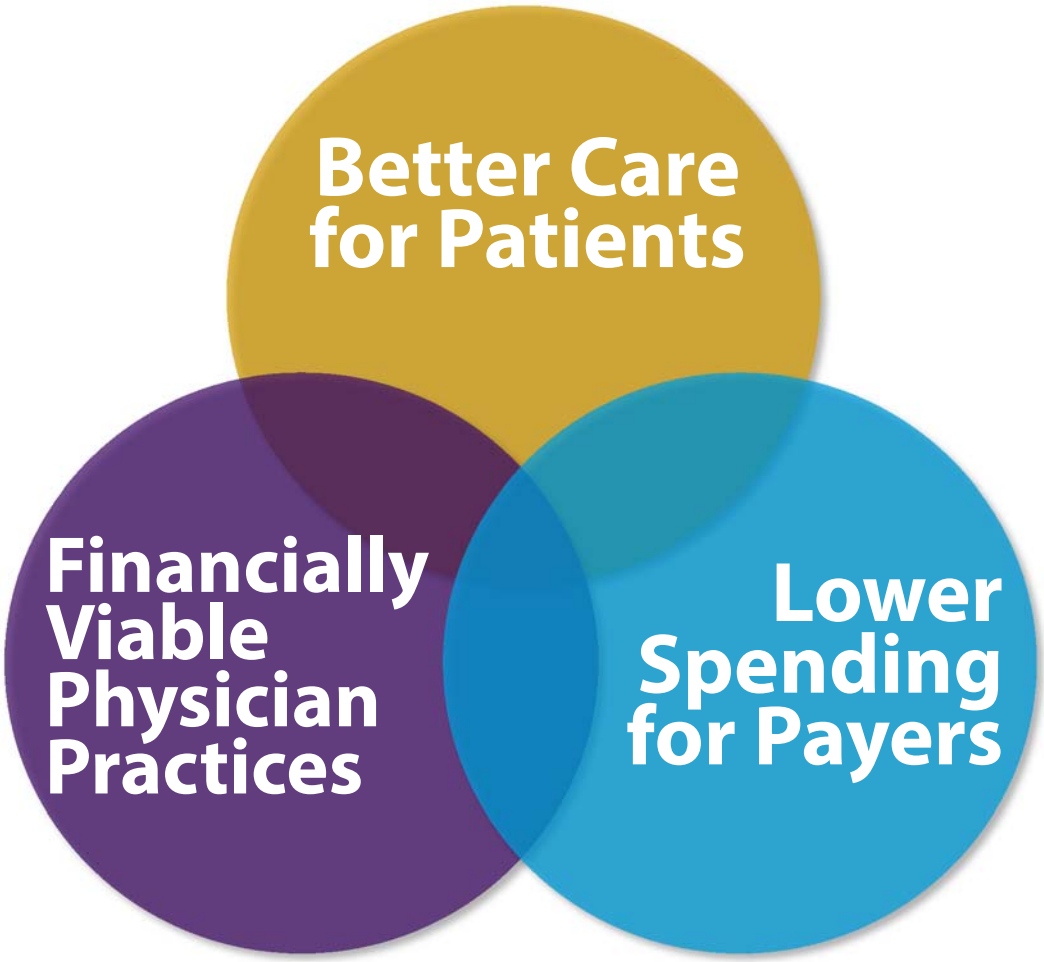
AMERICAN MEDICAL ASSOCIATION

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

A GUIDE TO PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS



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A Guide to Physician-Focused Alternative Payment Models EXECUTIVE SUMMARY

The Barriers in Current Payment Systems to Higher-Value Healthcare

All too often, when physicians try to redesign the ways they deliver services in order to provide higher quality patient care at a lower cost , they find that barriers in current payment systems prevent them from doing so. The two most common barriers are:

- **Lack of payment or inadequate payment for high-value services.** Medicare and most health plans do not pay physicians for many services that would benefit patients and help reduce avoidable spending.
- **Financial penalties for delivering a different mix of services.** Under fee for service (FFS), practices lose revenue if physicians perform fewer or lower-cost services, but their practice costs do not decrease proportionately (if at all), which can cause operating losses.

Alternative Payment Models Can Enable Higher Quality and Lower Costs

Alternative Payment Models (APMs) can provide a way of overcoming the barriers in current payment systems so that physicians can deliver higher-quality care for patients at lower costs for purchasers in ways that are financially feasible for physician practices. To be successful, an APM must have three characteristics:

1. **Flexibility in Care Delivery.** An APM must be designed to give physicians sufficient flexibility to deliver the services patients need in the most efficient and effective way possible.
2. **Adequacy and Predictability of Payment**. An APM must provide adequate and predictable resources to enable physician practices to cover the costs of delivering high-quality care to patients. Payments must be appropriately risk-adjusted based on characteristics of patients that increase their need for services, and limits must be placed on the total amount of financial risk that physicians face.
3. **Accountability for Costs and Quality That Physicians Can Control.** An APM must also be explicitly designed to assure patients and payers that spending will be controlled or reduced and that quality will be maintained or improved. However, individual physicians should only be held accountable for aspects of spending and quality they can control or influence.

The Medicare Access and CHIP Reauthorization Act (MACRA) encourages the creation of APMs and provides incentives for physicians to participate in them. MACRA explicitly encourages the development of "Physician-Focused Payment Models," and the law provides considerable flexibility in defining APMs so that they can support the wide range of health problems physicians treat.

A Menu of Physician-Focused Alternative Payment Models

There is no single approach to APMs that will work for all physicians or their patients. Different medical specialties treat different kinds of health problems, and the opportunities to improve quality and reduce costs differ by the different types of health problems addressed by physicians within each specialty and subspecialty. Moreover, the care delivery changes that are needed to address these opportunities also differ by specialty, as do the barriers in the current payment system that need to be overcome for physicians to redesign care delivery for their patients.

This report describes seven ways of structuring APMs that can be used to address the most common types of opportunities and barriers that physicians face:

APM #1. Payment for a High-Value Service. A physician practice would be paid for delivering one or more desirable services that are not currently billable, and the physician would take accountability for controlling the use of other, avoidable services for their patients.

APM #2. Condition-Based Payment for Physician Services. A physician practice would have the flexibility to use the diagnostic or treatment options that address a patient's condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the physician's practice.

APM #3. Multi-Physician Bundled Payment. Two or more physician practices that are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.

APM #4. Physician-Facility Procedure Bundle. A physician who delivers a procedure at a hospital or other facility would have the flexibility to choose the most appropriate facility for the treatment and to work with the facility to deliver the procedure in the most efficient and high-quality way.

APM #5. Warrantied Payment for Physician Services. A physician would have the flexibility and accountability to deliver care with as few complications as possible.

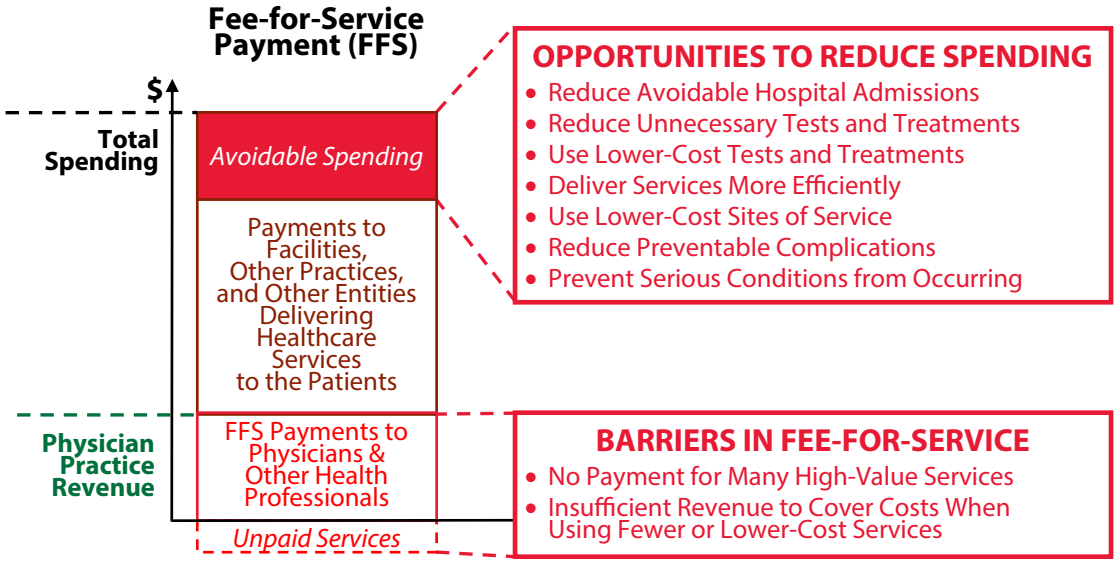
APM #6. Episode Payment for a Procedure. A physician who is delivering a particular procedure could work collaboratively with the other providers delivering services related to the procedure (e.g., the facility where

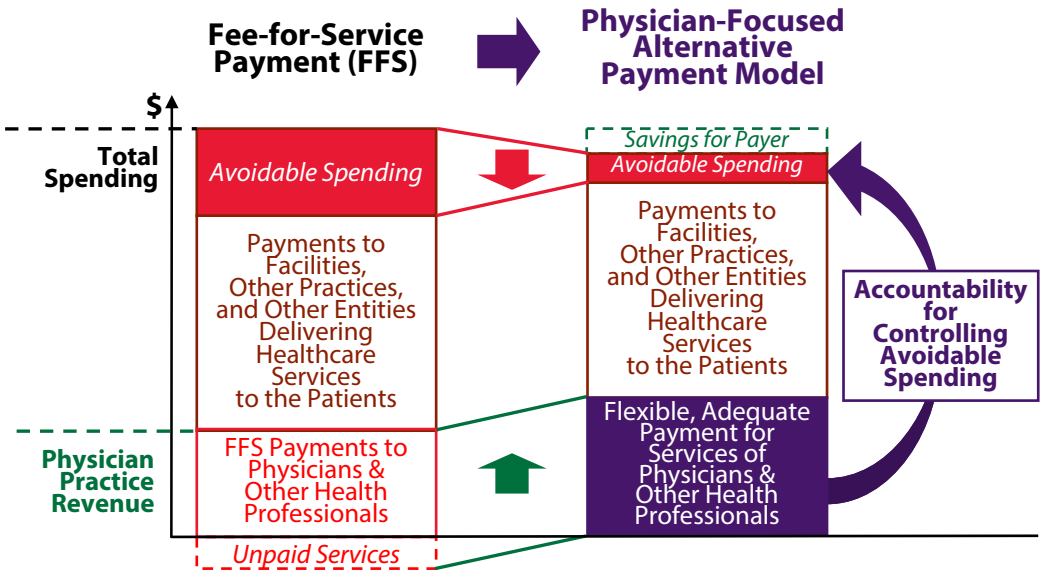
the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications of the procedure, etc.) to improve outcomes and control the total spending associated with the procedure.

APM#7. Condition-Based Payment. A physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers that deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition.

The "right" APM for a particular specialty or a particular physician practice in that specialty will depend on the types of patients and conditions that specialty cares for, the opportunities that exist for improving their care, the barriers the physicians face under the current payment system, and any barriers that exist that are unrelated to payment (e.g., restrictions in laws or regulations). In some cases, two or more APMs could potentially be used to address a particular combination of opportunities and barriers, but one of the models may be more feasible for a particular physician practice given its size or relationships with other providers.

The fastest progress in improving the quality and controlling the cost of healthcare will be achieved if each of the physicians and other providers who deliver care to patients can receive the resources and flexibility they need to improve the aspects of care quality and costs that they can control or influence. Consequently, it is important that Medicare and other payers make all of these APMs available so that every physician practice in every specialty can contribute effectively to the nation's efforts to achieve higher quality, more affordable healthcare.





I. THE NEED FOR PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS

A. Barriers to Better Care and Lower Costs in Current Payment Systems

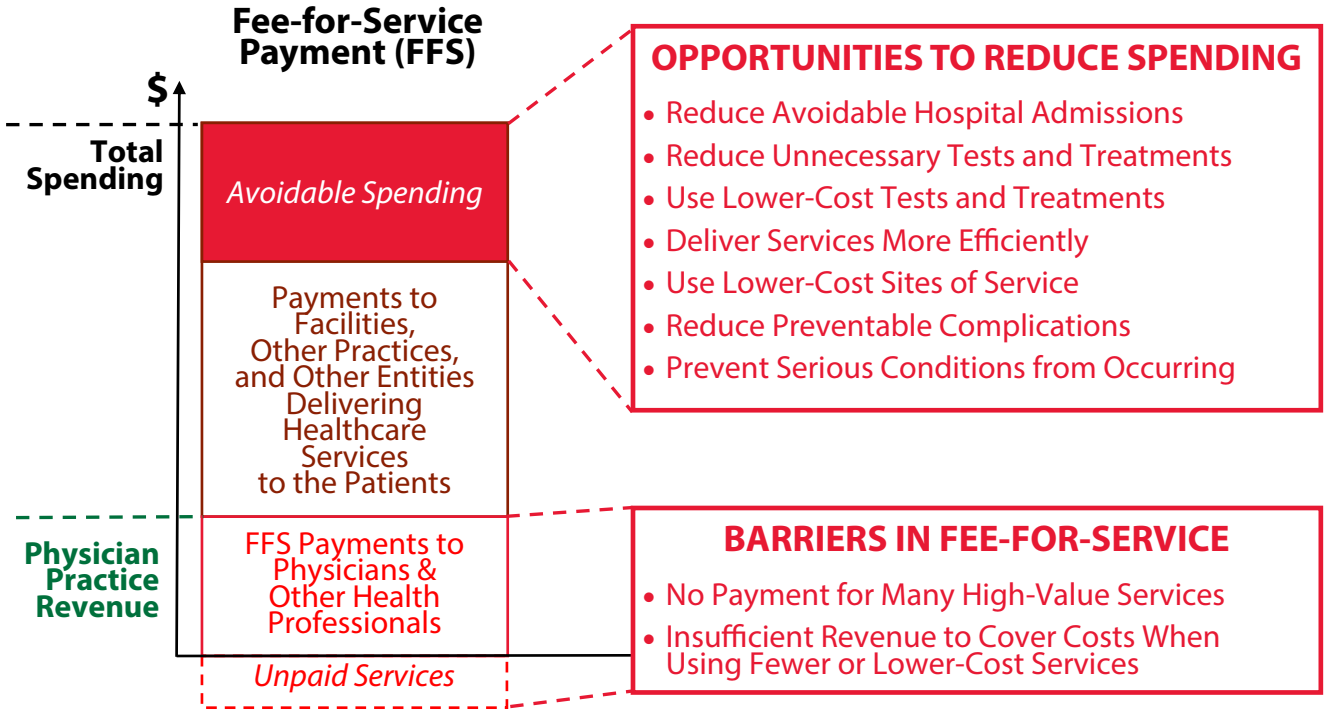
There are many significant opportunities to improve the quality and reduce the costs of healthcare. Many patients develop health problems that could have been prevented, receive tests and procedures that are not needed, are hospitalized because their health problems were not effectively managed, or experience complications and infections that could have been avoided. Other patients could receive different types of treatment than they do today that would be equally effective but cost less. If these unnecessary and avoidable health problems, services, and costs could be eliminated, tens of billions of dollars could be saved and the quality of life for the patients would be improved.[1]

Helping people stay healthy, improving quality, and reducing health care spending will require changes in care delivery. New types of services, innovative ways of delivering existing services, less costly settings for service delivery, and different combinations of services and providers will likely be needed. Only physicians can ensure that these new approaches to delivering services will safely and appropriately address patient needs.

Many physicians are actively working to redesign the ways they deliver and order services in order to provide higher quality care for patients while lowering spending by payers. However, all too often, these desirable changes in care delivery cannot be successfully implemented because of barriers in current payment systems. The two most common barriers are:

1. **Lack of payment or inadequate payment for high-value services.** Medicare and most health plans do not pay physicians for many services that would benefit patients and help reduce avoidable spending. For example, there is generally no payment or inadequate payment for:
   - responding to a patient's phone call about a symptom or problem, which could help the patient avoid the need for far more expensive services, such as an emergency department visit;
   - communications between primary care physicians and specialists to coordinate care, or the time spent by a physician serving as the leader of a multi-physician care team, which can avoid ordering of duplicate tests and prescribing conflicting medications;
   - communications between community physicians and emergency physicians, and short-term treatment and discharge planning in emergency departments, which could enable patients to be safely discharged without admission;
   - providing proactive telephone outreach to high-risk patients to ensure they get preventive care, which could prevent serious health problems or identify them at earlier stages when they can be treated more successfully;
   - spending time in a shared decision-making process with patients and family members when there are multiple treatment options, which has been shown to reduce the frequency of invasive procedures and the use of low-value treatments;
   - hiring nurses and other staff to provide education and self-management support to patients and family members, which could help them manage their health problems more effectively and avoid hospitalizations for exacerbations;
   - providing palliative care for patients in conjunction with treatment, which can improve quality of life for patients and reduce the use of expensive treatments; and
   - providing non-health care services (such as transportation to help patients visit the physician's office) which could avoid the need for more expensive medical services (such as the patient being taken by ambulance to an emergency department).
2. **Financial penalties for delivering a different mix of services.** Under fee for service (FFS) payment, physician practices lose revenue if physicians perform fewer procedures or lower-cost procedures, but the costs of running the practices generally do not decrease proportionately (if at all), which can cause operating losses. For many types of procedures, most of the savings payers experience does not come from the payments that are made to the physician practice, so savings can still be achieved without financially penalizing the physician practice. The most severe impact under FFS is that physician practices do not get paid at all when their patients stay healthy and do not need health care services.

Some physician practices have received special funding from the federal government, private foundations, health plans, and/or provider organizations for demonstration projects to overcome these payment barriers. These projects have enabled physicians to show that with the right financial support, they can deliver better care for patients at lower costs and with greater professional satisfaction than is possible in the typical delivery system today. Unfortunately, despite positive results, many of these demonstration projects have had to be terminated because they cannot be sustained on a long-term basis under the current FFS payment system.



B. Characteristics of Successful Alternative Payment Models

It is unrealistic to expect physicians to improve quality or reduce spending without adequate financial support for their efforts. On the other hand, it is also unrealistic to expect that patients or payers will be willing to pay more or differently without assurances that the quality of care will be improved, spending will be lower, or both. *Alternative Payment Models (APMs)* are needed that support the delivery of higher-quality care for patients at lower costs for purchasers in ways that are financially feasible for physician practices.

The fact that a payment system is *different* from traditional fee-for-service payment does not automatically mean that it is *better*. In order to be successful in achieving all three of these goals – better care for patients, lower spending for payers, and financial viability for physician practices – an APM must have three characteristics: [2]

1. **Flexibility in Care Delivery.** To be successful, an APM must be designed to give physicians sufficient flexibility to deliver the services patients need in the most efficient and effective way possible. If the current payment system does not pay for specific services that physicians need to deliver in order to improve outcomes or reduce spending on other types of services, the APM must authorize payment for additional services, broaden the definition of the services that can be provided using existing payments, or both.
2. **Adequacy and Predictability of Payment**. To be both successful and sustainable, an APM must provide adequate and predictable resources to enable physician practices to cover the costs of delivering high-quality care to patients. Achieving savings is only a desirable goal if it does not jeopardize access or quality. Moreover, it is impossible for physicians to make investments in facilities and equipment and to recruit, train, and retain high-quality personnel if they cannot predict how much they will be paid for their services or if there are frequent, significant changes in payments. Payments must also be appropriately risk-adjusted based on characteristics of patients that increase their need for services, and limits must be placed on the total amount of financial risk that physicians face.
3. **Accountability for Costs and Quality That Physicians Can Control.** In order to be successful and sustainable, an APM must also be explicitly designed to assure patients and payers that spending will be controlled or reduced and that quality will be maintained or improved. However, individual physicians should only be held accountable for aspects of spending and quality they can control or influence.

The goal of APMs should not be to simply shift financial risk from payers to physician practices, but rather to give physician practices the resources and flexibility they need to take accountability for the aspects of costs and quality they can control or influence. In some cases, a small change in the current payment system, such as payment for a specific type of service in addition to existing FFS payments, may be all that is needed to support better outcomes and lower overall costs. In other cases, a more significant change may be needed, such as restructuring payments for many different services delivered by multiple providers.

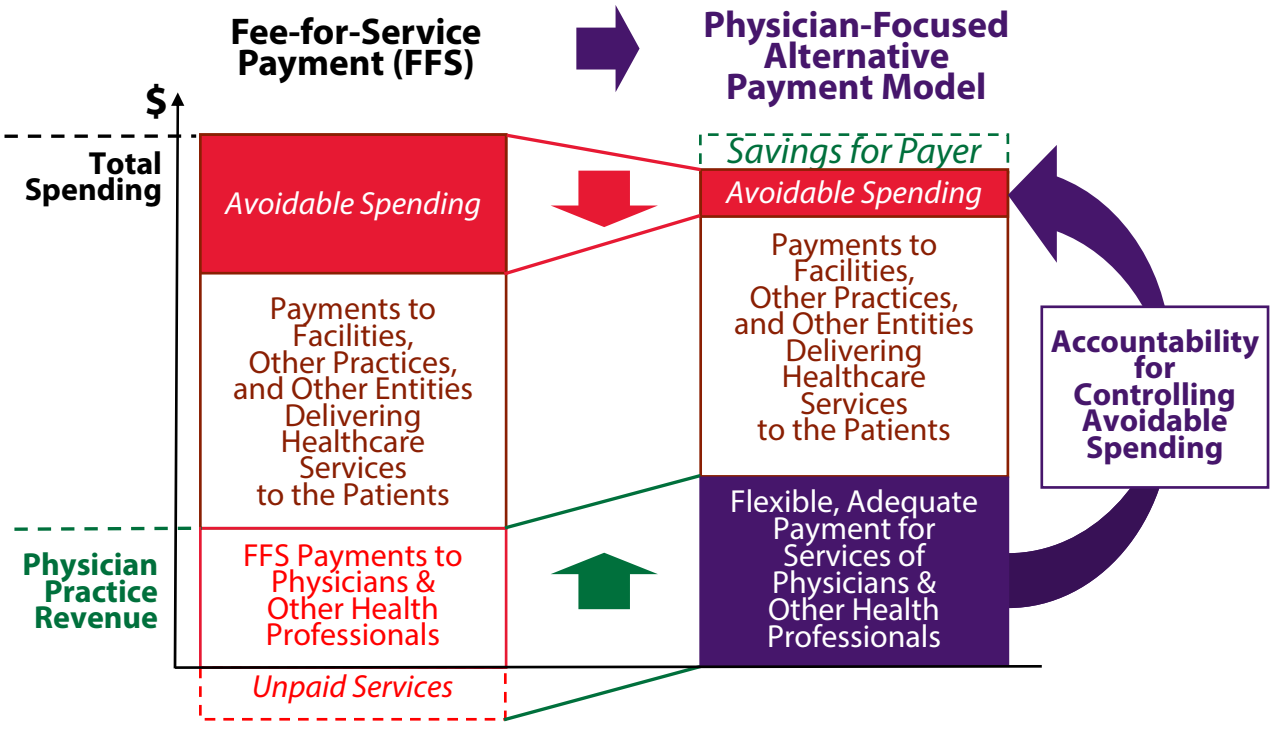
In most cases, traditional pay-for-performance and "value-based purchasing" systems that simply modify current FFS payment rates based on measures of quality or total spending will not be sufficient to serve as a successful APM, since they do not remove the barriers in the current payment system. The problem to be solved is not a lack of "incentives" for physicians to deliver care in a different way, but the failure of the current payment system to adequately support the better and more efficient approaches to care delivery that physicians want to use.[3]

C. Creating Physician-Focused APMs in Medicare

The Medicare Access and CHIP Reauthorization Act (MACRA) that was enacted by Congress in April 2015 encourages the creation of APMs and provides incentives for physicians to participate in them. Physicians who have a minimum percentage of their revenues or patients in APMs will receive supplemental payments beginning in 2019 and they will receive higher updates to their payments under the Physician Fee Schedule (PFS) beginning in 2026, in addition to the benefits of participating in the APMs.

MACRA specifically designates Accountable Care Organizations (ACOs) within the Medicare Shared Savings Program as a qualifying APM. However, many physicians do not view the current design of this program as providing the flexibility in care delivery or the adequacy and predictability in payment that they need to successfully improve patient care while reducing costs. In addition, the program tries to hold the providers in the ACO accountable for the costs of healthcare services that the providers cannot control or influence. These weaknesses have discouraged many physicians from participating and have made it difficult for the ACOs that have been created to be successful.

Fortunately, MACRA explicitly encourages the development of "Physician-Focused Payment Models," and the law provides considerable flexibility in defining APMs so that they can support the wide range of health problems physicians treat. This provides an unprecedented opportunity for physician organizations to work with the Department of Health and Human Services and the Centers for Medicare and Medicaid Services to develop APMs that can support better care for patients, at lower costs for Medicare and other payers, in ways that are financially sustainable for physician practices and other providers.



II. A MENU OF PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS

There is no single Alternative Payment Model that will work for all physicians or their patients. Different medical specialties treat different kinds of health problems, and the opportunities to improve quality and reduce costs will differ for the different types of health problems addressed by physicians within each specialty and subspecialty. Moreover, the care delivery changes that are needed to address these opportunities will also differ by specialty, as will the barriers in the current payment system that need to be overcome if physicians are to redesign care delivery for their patients.

This means there will need to be multiple types of APMs in order for physicians in all specialties to participate and in order for all patients to benefit. A good APM will overcome the *specific* payment system barriers a physician practice faces in pursuing the *specific* kinds of improvement opportunities available for the types of patient conditions the physicians in that practice treat.

There is no need for complex and expensive changes in payment structures if simple changes will address the barriers. If paying for a new service code could enable a physician practice to deliver significantly better care at lower overall cost, there is no need to force the practice to find ways to manage a complex bundled payment. On the other hand, if much more extensive changes in care delivery are needed that involve multiple providers, an entirely new type of bundled payment may be needed to provide sufficient flexibility and accountability to support those changes in care, and a physician practice may need to work collaboratively with other physician practices and other types of providers to manage that payment in order to deliver the improved care.

This report describes seven different types of APMs that can be used to address the most common types of opportunities and barriers:

APM #1. Payment for a High-Value Service. A physician practice would be paid for delivering one or more desirable services that are not currently billable, and the practice would take accountability for controlling the use of other, avoidable services for their patients.

APM #2. Condition-Based Payment for Physician Services. A physician practice would have the flexibility to use the diagnostic or treatment options that address a patient's condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the physician practice.

APM #3. Multi-Physician Bundled Payment. Two or more physician practices that are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.

APM #4. Physician-Facility Procedure Bundle. A physician who delivers a procedure at a hospital or other facility would have the flexibility to choose the most appropriate facility for the treatment and to work with the facility to deliver the procedure in the most efficient and high-quality way.

APM #5. Warrantied Payment for Physician Services. A physician would have the flexibility and accountability to deliver care with as few complications as possible.

APM #6. Episode Payment for a Procedure. A physician who is delivering a particular procedure would be able to work collaboratively with the other providers delivering services related to the procedure (e.g., the facility where the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications of the procedure, etc.) in order to improve outcomes and control the total spending associated with the procedure.

APM #7. Condition-Based Payment. A physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers that deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition.

Each of these APMs addresses a different type of opportunity for savings and/or a different barrier in the current payment system. Although each APM design would need to be adapted to the unique services and outcomes associated with a specific health problem or treatment, the basic structure of the APM would be similar across the different specialties and patient conditions to which it is applied. This means that the billing and claims payment system changes made to support one of the APM designs in one specialty could be used for physician practices in other specialties that are using the same basic APM structure.

Some of the APMs could be implemented easily by single specialty physician practices of any size, while other APMs would likely only be feasible for larger physician practices, for multi-specialty practices, or for practices working collaboratively with other physician practices or other providers, such as hospitals. For those APMs that are involve services delivered by multiple specialties or multiple types of providers, an "Alternative Payment Entity" may be needed to accept and distribute payments among the participating providers.[4]

TABLE 1

	CHANGE FROM CURRENT FEE FOR SERVICE SYSTEM				
	Payment Made for Services Not Covered by Current Fee-for-Service Payment	Payment is Based on the Patient's Condition, Not the Treatment Delivered	One Payment is Made for Related Services Delivered by Multiple Physicians	One Payment is Made for Related Services Delivered by Physicians and Facilities	One Payment is Made for Both Planned & Unplanned Services Related to Treatment
APM #1 Payment for a High-Value Service	YES	NO	NO	NO	NO
APM #2 Condition-Based Payment for a Physician's Services	YES	YES	NO	NO	NO
APM #3 Multi-Physician Bundled Payment	YES	YES	YES	NO	NO
APM #4 Physician-Facility Procedure Bundle	YES	NO	NO	YES	NO
APM #5 Warrantied Payment for Physician Services	YES	NO	NO	NO	YES
APM #6 Episode Payment for a Procedure	YES	NO	YES	YES	YES
APM #7 Condition-Based Payment	YES	YES	YES	YES	YES

APM #1: PAYMENT FOR A HIGH-VALUE SERVICE

Goal of the APM:

Pay physicians for delivering desirable services that are not currently billable in order to avoid the need for patients to receive other, more expensive services.

Components of the APM:

1. **Continuation of Existing FFS Payments.** The physician practice can continue to bill and be paid the standard amounts for all CPT® codes that are currently eligible for payment under the Physician Fee Schedule.
2. **Payment for Additional Services.** The practice can also be paid for one or more specific services or combinations of services that are not currently eligible for FFS payment. To receive payment, the practice bills the payer using a code indicating that the service or combination of services was delivered. This may be an existing CPT® code that is not currently billable or a newly-developed code to describe the service or a combination of services. A payment amount is defined for the code based on the cost of delivering the service or combination of services.
3. **Measurement of Avoidable Utilization.** One or more other services are identified that the practice agrees can be avoided or controlled by delivering the newly-payable services. Utilization of these services by the practice's patients is measured to determine the rate of avoidable utilization. A target level of avoidable utilization is defined based on what is known to be achievable by practices that have the resources to deliver appropriate services. The practice's rate of avoidable utilization is compared to the target level to determine whether the physician practice is above or below the target level. The rate is risk-adjusted to reflect patient characteristics that affect utilization but are outside the physician's control.
4. **Measurement of Quality/Outcomes.** If the services to be avoided are undesirable (e.g., treatment of infections or complications following a procedure), the measure of avoidable utilization also represents a measure of quality. However, if the services are sometimes necessary or desirable and sometimes undesirable or unnecessary, then there may also need to be one or more additional measures of quality, outcomes, or appropriateness, in order to ensure that only the undesirable/unnecessary services are being reduced. A target level for the quality/outcome measures or consistency with appropriateness criteria would be defined based on what is known to be achievable by physician practices with similar patients and similar resources.
5. **Adjustment of Payment Amounts Based on Performance.** If the practice's rate of avoidable utilization and quality is within normal statistical variation around the target levels, it receives the standard payment amount for the new code. If the practice's rate of avoidable utilization is significantly higher than the target level or if quality is significantly lower, the payment amount for the new service would be reduced. If utilization is significantly lower or quality is significantly higher, the payment amount would be increased. If the rate of avoidable utilization is much higher than the target level, the physician practice could be ineligible to bill for the new code.
6. **Updating Payments Over Time.** The payment amount for the new service code would be increased each year based on inflation, and the payment amount would be periodically adjusted based on an assessment of the costs of delivering the service in order to ensure that the payment is adequate but no higher than necessary.

Benefits of the APM:

- The patient would benefit by receiving services that cannot currently be provided due to lack of payment.
- The payer would benefit because the expected savings from low levels of avoidable utilization would be greater than the payments made for additional services.
- The physician practice would benefit by receiving the resources needed to deliver desirable services to patients that will avoid complications or the need for the patients to receive less effective services.

Examples:

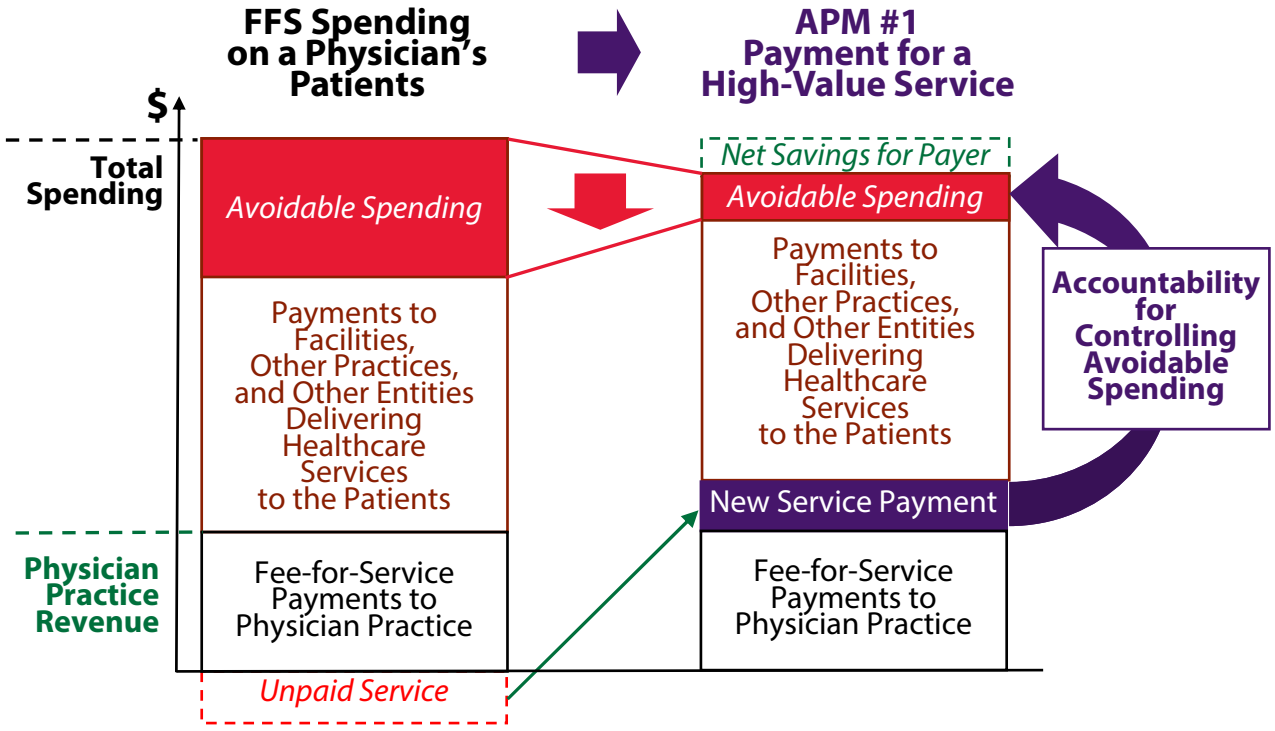
- **Payment for Services to Reduce Avoidable Emergency Room Visits and Hospitalizations of Cancer Patients.** Under this APM, in addition to current E&M services payments, an oncology practice would be able to bill and be paid for delivering care management services to patient undergoing chemotherapy treatment. A bill would be submitted to the payer for each month of services using a newly-defined service code to indicate that care management services were delivered in that month. The practice would have the flexibility to use the payment for whatever combination of specific care management services it deemed appropriate. The rate at which the oncology practice's patients visited an emergency department or were admitted to the hospital for conditions related to cancer treatment (such as dehydration or fever) would be measured and compared to a target level, and the practice's monthly payment for care management would be adjusted up or down based on that performance measure. The practice's visit/admission rate would be risk-adjusted based on the types of cancers treated and the toxicity levels of the treatments used. (This is one of the elements of the American Society of Clinical Oncology's proposal for Patient-Centered Oncology Payment.[5])
- **Payment for Services to Support Safely Discharging Emergency Room Patients without Hospital Admission.** Under this APM, in addition to current E&M services payments, emergency physicians could bill and be paid for discharge planning and coordination services for patients seen in the emergency department. The emergency physician would have the flexibility to use this additional payment to support additional physician time or additional staff to help appropriate patients

return home (or return to the facility where they resided) rather than being admitted to the hospital. The rate at which the patients of the emergency medicine practice or emergency department are admitted to the hospital would be measured and compared to a target level, and a quality indicator, such as the rate of returns to the ED, would also be measured, with both rates risk-adjusted based on clinical and other characteristics of the patients. The amounts paid to the emergency physicians for discharge planning and coordination would be adjusted up or down based on performance on these measures.

- **Payment to Support Implementation of Appropriate Use Criteria for Diagnostic Testing.** Under this APM, in addition to current CPT codes for E&M visits, a physician practice would bill and be paid for the time and resources needed to apply appropriate use criteria and engage in an education/shared decision-making process with patients in order to determine the most appropriate diagnostic tests to use when the patient has symptoms (e.g., chest pain) or is at high risk of developing a disease or a recurrence (e.g., cancer). The proportion of tests ordered that were consistent with the appropriate use criteria would be measured and compared to expected rates based on registry data, and the amounts paid to the physician practice for the application of the criteria would be adjusted up or down based on performance. Since performance would be based on appropriate use, not absolute rates of utilization, no separate measures of quality would be needed. (This is also an element of the American Society of Clinical Oncology's proposal for Patient-Centered Oncology Payment.)

Difference from Other Payment Models:

- In contrast to typical pay-for-performance programs, the physician practice would be paid for the additional services it needs to deliver in order to improve quality or reduce total costs.
- In contrast to a typical shared savings program, an individual physician practice's payments would not be explicitly tied to how much money that practice saved the payer. Instead, the physician practice would be paid adequately to deliver appropriate services, and the payer would save money by spending less on avoidable services (for the patients in all participating practices) than the additional payments made to all practices participating in the APM. A physician practice that already had achieved low rates of avoidable utilization by delivering services without adequate payment would be able to receive additional payment in order to sustain that performance without having to further reduce avoidable utilization, and a physician practice that had an unusually high rate of avoidable utilization would need to make significant reductions in order to receive the additional payment.



APM #2: CONDITION-BASED PAYMENT FOR A PHYSICIAN'S SERVICES

Goal of the APM:

Give a physician the flexibility to use the most appropriate diagnostic or treatment option for a patient's condition without reducing the operating margins of the physician's practice, including diagnosis or treatment options not supported through the current payment system.[6]

Components of the APM:

1. **Payment Based on the Patient's Health Condition Rather Than Services Delivered.** The physician practice can bill and be paid for treating or managing the care of patients with a specific health condition (or combination of conditions), rather than having payment tied to the delivery of specific services or treatments. The physician practice has the flexibility to use the payment to support both services that are currently billable as well as new services that are not currently billable. The bundle could be defined to include services delivered on a single day or over a longer period of time, such as a month.
2. **Condition-Based Payment Replaces Some Current Fee-for-Service Payments to the Physician Practice.** For patients who have the relevant health condition(s) and are eligible for services through the Condition-Based Payment, the physician practice no longer bills for individual CPT® codes for services that are included in the Condition-Based Payment.[7] The practice continues to bill and be paid for individual services to the patients that are *not* related to the condition (such as treatment for an unrelated acute episode or accident) using the appropriate CPT® codes. If the practice unintentionally submitted a separate bill for one of the services included in the Condition-Based Payment, the payer would simply not pay the bill for that individual service.[8] Payments to other providers that deliver services for the condition (e.g., payment to a hospital for services the physician performs at the hospital, or payments to a laboratory for tests the physician orders) would still be made separately by the payer to those providers. (See APM #3 - Multi-Physician Bundled Payment and APM #4 - Physician-Facility Procedure Bundle for discussions of bundled payments that involve services delivered by multiple providers, rather than just by one physician practice.)
3. **Payment Amounts Stratified Based on Patient Needs.** The physician practice would bill for an eligible patient by choosing a code from a new family of bundled service codes (these would be "condition-based" codes rather than procedure codes). Each of these condition-based codes would be defined based on patient characteristics that are expected to result in a mix of services from the physician practice with similar costs, similar to the way hospital Diagnosis Related Groups define a range of patients who are expected to require similar amounts of hospital resources during an inpatient stay. Different codes would be assigned different amounts of payment based on differences in the expected costs of services for the patients.
4. **Measurement of Appropriateness/Outcomes.** In order to ensure that patients continue to receive the most appropriate services through the Condition-Based Payment, the physician practice would either agree to document the application of appropriate use criteria (if such criteria exist) or to measure quality or outcomes for treatment of the patient's condition and compare the quality/outcome measures to benchmarks.
5. **Adjustment of Payment Amounts Based on Performance.** The payment amounts for the condition-based codes would be reduced if the physicians in the practice failed to apply appropriate use criteria or if the quality/outcome measures were significantly below benchmark levels.
6. **Updating Payments Over Time.** The Condition-Based Payment amounts would be increased each year based on inflation, and the payment amounts would be periodically adjusted based on an assessment of the costs of delivering care to the patients who have the condition in order to ensure that the payments are adequate but no higher than necessary.

Benefits of the APM:

- The patient would benefit because the flexibility under the Condition-Based Payment would allow the physician practice to deliver different types or combinations of services to patients that cannot currently be provided due to lack of payment, and to deliver care for the patient's condition more effectively at a lower total cost.
- The payer would benefit because either (1) the new combination of services enables the physician to order fewer or lower-cost services from other providers or results in fewer health problems or complications for the patient, so the payer would spend less overall, or (2) the practice can accept a lower payment for the Condition-Based Payment than the payer would have expected to pay for the individual services that would have been provided under the current payment system.
- The physician practice would benefit by having the flexibility to deliver the most appropriate services to patients without concern about which service will generate more revenue for the practice.

Examples:

- **Monthly Payments for Chronic Disease Management.** Under this APM, a primary care practice or specialty practice that is helping a patient manage a chronic disease such as asthma, COPD, diabetes, heart failure, or inflammatory bowel disease (or a combination of such conditions) would bill for a single payment amount each month. The practice would no longer bill for Evaluation & Management payments for these patients. (The practice *could* continue to bill for E&M services for patients without chronic diseases and it could continue to bill for any individual procedures performed on all patients, including chronic disease patients.[9]) The

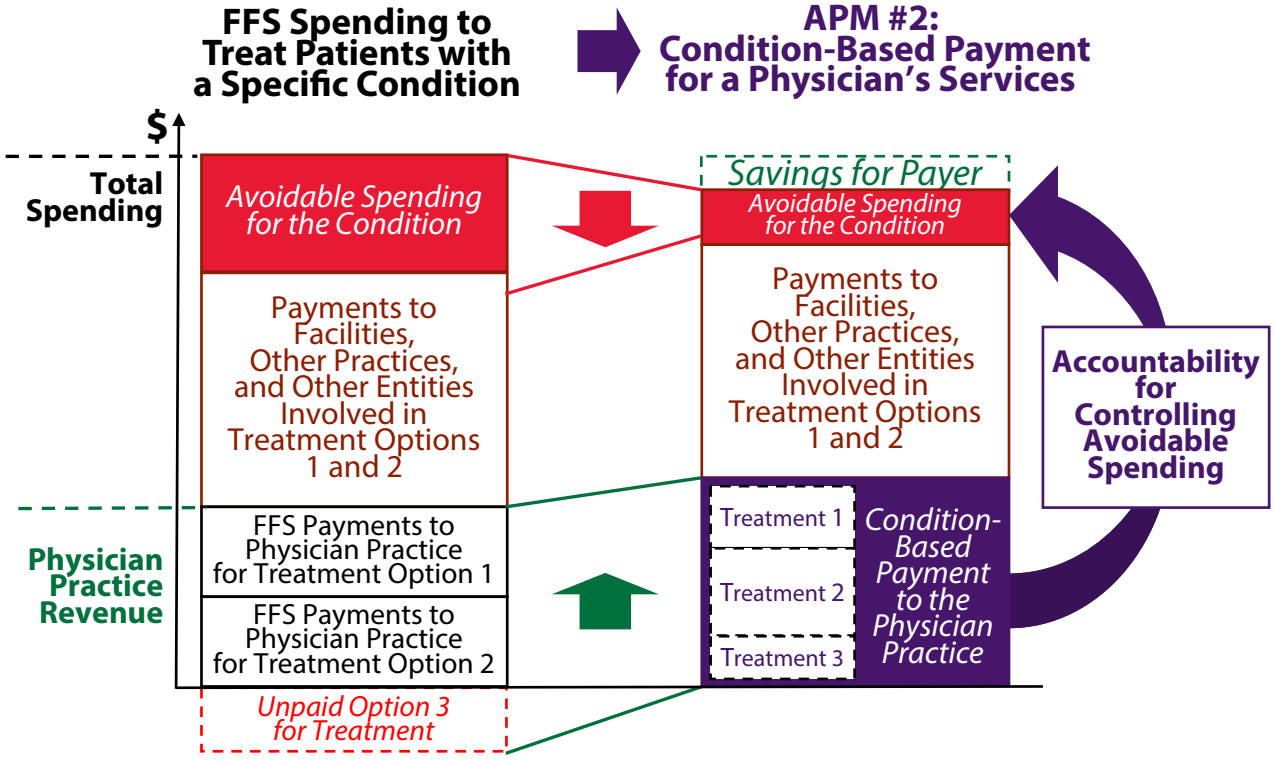
practice would have the flexibility to use the payments for whatever combination of services were most effective – office visits, phone calls, emails, support from non-physician staff, etc. Monthly payments would be higher for patients with multiple chronic diseases or more severe chronic diseases, since the patients would be expected to need more contacts with physicians or practice staff. Quality measures and rates of hospitalization would be calculated and compared to benchmarks to ensure patients were receiving necessary care. [10]

- **Case Rates for Radiation Therapy for Cancer.** Under this APM, a radiation oncology practice would bill for a single payment amount for an entire course of radiation therapy for a patient. The amount of payment would not be based on the specific type of treatment used, but it would be based on the type of cancer and on patient-specific factors affecting the appropriate radiation therapy. The amount of payment for a particular category of patients would be based on the average spending on the different treatment modalities used for similar patients in the past. The radiation oncologist would have the flexibility to use whichever type of treatment was most appropriate for the patient. (The American Society of Radiation Oncology is developing this type of payment model for breast cancer treatment and palliative care of bone metastases; some radiation oncology practices have implemented this approach with commercial health plans.[11])

- **Monthly Payments for Chemotherapy Treatment.** Under this APM, a medical oncology practice would bill for a single payment amount for each month that a patient is undergoing chemotherapy. The monthly payment would replace E&M services payments and payments for about 50 different CPT codes describing different types of infusions and injections (drugs and diagnostic tests would still be billed for and paid separately). The oncology practice would have the flexibility to use the monthly payment to provide the combination of services that best met the patient's needs without concern for which services generated more revenue. The amount of payment would differ depending on patient characteristics such as comorbidities and the toxicity and complexity of the treatment regimen, instead of being based on the number of office visits or on whether infused or oral therapy was used. (This is similar to the proposal for Consolidated Payments for Oncology Care developed by the American Society of Clinical Oncology.[12])

Difference from Other Payment Models:

In contrast to typical pay-for-performance programs and shared savings programs, the physician practice would have the flexibility to deliver new types of services and different combinations of services rather than being limited to what can be billed under the current fee-for-service payment system.



APM #3: MULTI-PHYSICIAN BUNDLED PAYMENT

Goal of the APM:

Give multiple physicians who are providing services to the same patient the flexibility and resources needed to redesign their services in coordinated ways that will improve quality and reduce the costs of diagnosis or treatment.

Components of the APM:

1. **Single Bundled Payment for Services Delivered by Two or More Physicians.** A single payment is made that covers the services delivered by two or more physicians in order to diagnose a patient's condition or to deliver a specific treatment for a diagnosed health problem. The physicians would have the flexibility to use the bundled payment for services that are not currently eligible for payment as well as for services for which they can currently bill the payer, and they would also have the flexibility to divide the payment differently than what they would receive under the current payment system.
2. **Bundled Payment May Supplement and/or Replace Current Fee-for Service Payments to the Physicians.** The bundled payment could be designed to increase revenue to the physician practices in order to support delivery of one or more specific services or combinations of services that are not currently eligible for payment under the Physician Fee Schedule or that do not currently receive adequate payment. The bundled payment could also be designed to replace payment for some existing services, i.e., the physicians delivering those services would no longer bill for individual CPT® codes for the services but would instead use the bundled payment to cover the costs of those services. The exact structure of the bundle will depend on the nature of the barriers in the current payment system.
3. **Patient Agreement to Use the Multi-Physician Team for the Services.** In order to receive the benefits of the more coordinated and flexible care, the patient would need to agree to use only the physicians on the team for all services covered by the Bundled Payment.
4. **Bundled Payment Paid to an Alternative Payment Entity Designated by the Participating Physicians.** The participating physician practices would designate an organizational entity to receive the bundled payment. This "Alternative Payment Entity" could either be one of the physician practices (which would agree to pay the other physician practices their shares of the bundled payment for the components of services they provide) or it could be a new organization (e.g., a limited liability corporation that is jointly owned by the participating practices) that would receive the payment and allocate it among the participating practices based on rules the practices adopt.
5. **Payment Amounts Stratified Based on Patient Needs.** The designated Alternative Payment Entity bills the payer for services to an eligible patient using a new service code. If some patients need significantly more services than others, a family of new bundled service codes would be used, with each code defined based on patient characteristics that are expected to need combinations of services from the participating practices with similar total costs.
6. **Measurement of Avoidable Utilization of Other Services**. If the bundled payment is designed to increase total payments to the physician practices, one or more other services are identified that the physician practices agree can be reduced or controlled by delivering the newly-payable services using the bundled payment. The utilization of these services for the physician practices' patients is measured to determine the rate of avoidable utilization, and a target level of avoidable utilization is defined based on what is known to be achievable by physician practices that have the resources to deliver appropriate services. The rate of avoidable utilization for the practices' patients is compared to the target level to determine whether the practices are above or below the target level. The rate is risk-adjusted to reflect patient characteristics that affect utilization but are outside the physician practices' control.
7. **Measurement of Appropriateness/Quality/ Outcomes.** If the bundled payment replaces payments for two or more existing services, then in order to ensure that patients continue to receive appropriate and high quality services under the bundled payment arrangement, the participating physicians would either agree to document the application of appropriate use criteria (if such criteria exist) or to measure quality and/ or outcomes for the patients and compare the measures to benchmarks.
8. **Adjustment of Payment Amounts Based on Performance.** The amounts paid for the bundled service codes would be reduced if the avoidable utilization was not reduced, if physicians failed to apply appropriate use criteria, or if quality or outcome measures were significantly below benchmark levels.
9. **Updating Payments Over Time.** The bundled payment amounts would be increased each year based on inflation, and the payment amounts would be periodically adjusted based on an assessment of the costs of delivering the services to patients to ensure that the payments are adequate but no higher than necessary.

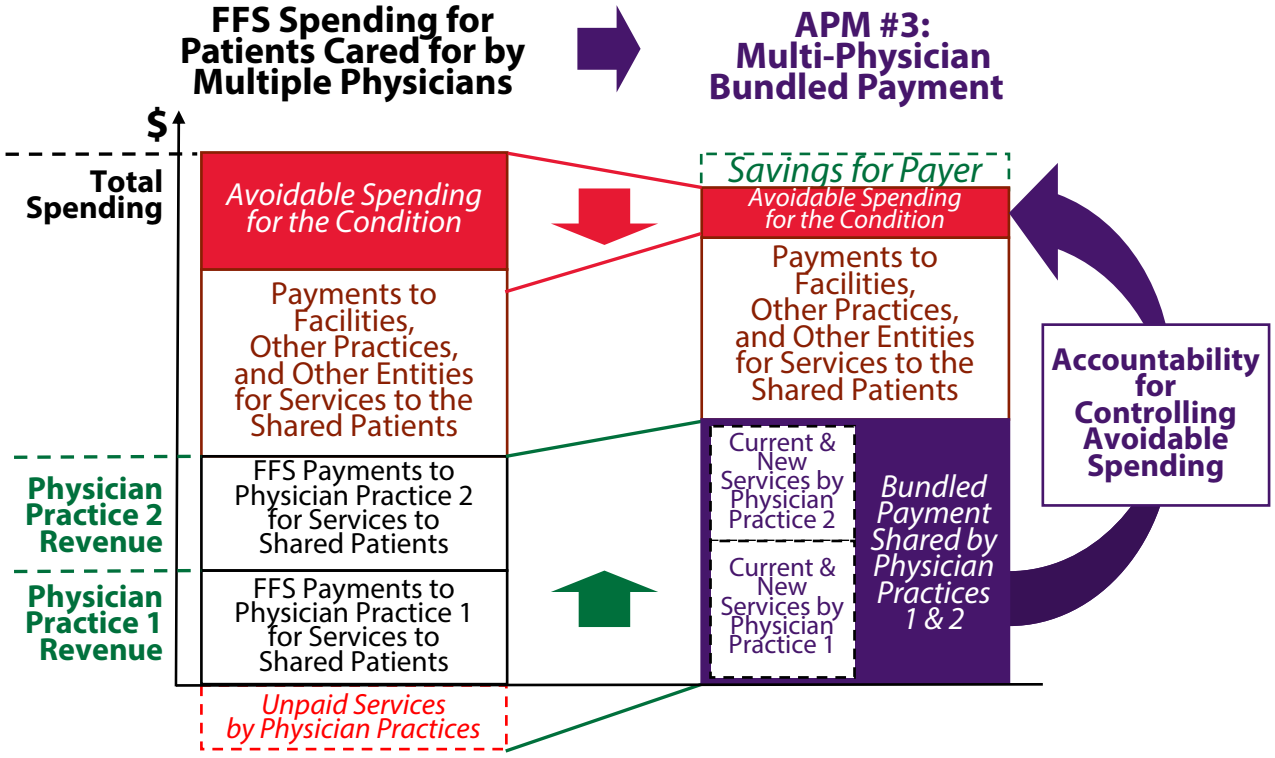
Benefits of the APM:

- Patients would benefit because the physicians delivering their care could work together in a more coordinated way and use the additional resources and/or flexibility under the bundled payment to deliver different types or combinations of services that cannot currently be provided.
- The payer would benefit because the new payment would enable the physicians to deliver care more efficiently, order fewer or lower-cost services from other providers, and/or reduce the number of complications for their patients.
- The physician practices would benefit by having the resources and flexibility to deliver the most appropriate services to patients in a coordinated way without con-

cern about which services will generate more revenue for the individual practices.

Examples:

- **Bundled Payment for Diagnosis of Non-Urgent Chest Pain.** Under this APM, primary care practices and cardiologists would work together to accurately diagnose individuals with newly reported mild chest pain that does not warrant emergency treatment. A group of primary care practices and a cardiology practice would receive a monthly payment to support use of the American College of Cardiology appropriate use criteria for determining the most appropriate tests to order when patients report new chest pain. The cardiologists would help the primary care physicians implement the criteria and the primary care physicians would contact the cardiologists by telephone or email for assistance in determining what to do for "gray area" cases. The monthly payment would cover the cost of any electronic decision support system incorporating the appropriate use criteria, the primary care physicians' time in applying the criteria, and the cardiologists' time in consulting with the PCPs. Primary care practices and cardiology practices would continue to receive standard E&M payments for office visits with patients in addition to the new bundled payment. The monthly payments would be increased or decreased based on the rate of adherence to the criteria in ordering tests and/or the rate of utilization of high-cost diagnostic tests. (This is a type of payment model being considered to support the SMARTCare project developed by the American College of Cardiology.[13])
- **Bundled Payment for Collaborative Treatment of Allergic Asthma.** Under this APM, primary care practices and allergy specialists would work together to develop and implement a treatment plan for patients with allergic asthma. The primary care and allergy practices would bill payers for a payment for each patient with diagnosed allergic asthma. The payment would support the development of appropriate immunotherapy treatment by the allergy practice and administration of the treatments by the primary care practice with telephone support from the allergy practice. The rate at which asthma control medications are used and the frequency of exacerbations would be measured to assess whether patient outcomes had improved and total costs had been reduced.
- **Bundled Payment for Integrated Behavioral and Physical Health Care.** Under this APM, primary care practices and psychiatry practices would jointly receive a payment to support (1) screening of patients for behavioral health problems in the primary care practice office and (2) either brief interventions in the primary care practice office or referral for treatment by the psychiatrist when appropriate. The bundled payments would support the additional time spent by primary care providers to screen patients for behavioral health needs, the hiring of behavioral health specialists to work in the primary practice (or to be available through a tele-health link) to provide immediate brief interventions for patients with a positive screening, and training, phone consultations, and supervision by psychiatrists.



APM #4: PHYSICIAN-FACILITY PROCEDURE BUNDLE

Goal of the APM:

Give a physician greater ability to choose the most appropriate hospital or other facility to deliver a particular procedure and to work with the facility to improve efficiency and quality in delivering that procedure.

Components of the APM:

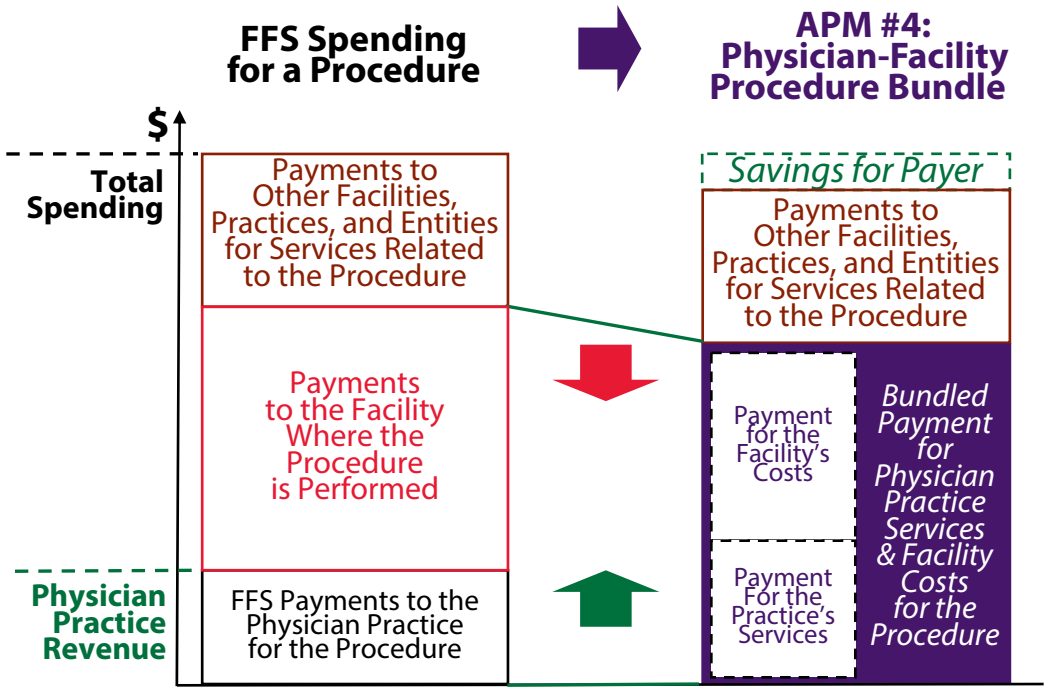
1. **Single Bundled Payment for the Physician and Facility Services.** A single payment is made for the physician services and the services of the hospital or other facility where the physician performs services as part of a particular treatment for a patient's health problem. The physician practice and the facility have the flexibility to use the bundled payment for services that are not currently eligible for payment as well as for services for which they can currently bill. The physician practice and the facility can divide the bundled payment in ways that are different from what they would have received for the same services under current payment systems.
2. **Bundled Payment Replaces Current Fee-for-Service Payments to the Physician and Facility.** The physician practice no longer bills for individual CPT® codes for the services covered by the bundled payment, and the facility no longer bills for the relevant services under the applicable payment system (e.g., a hospital would not bill under the Inpatient Prospective Payment System if the bundle applied to inpatient care, and it would not bill under the Outpatient Prospective Payment System if the bundle applied to outpatient care.)
3. **Payment Made to an Alternative Payment Entity Designated by the Participating Providers.** An "Alternative Payment Entity" is designated to receive the bundled payment and allocate it between the physician practice and facility. This entity could be the physician practice, the hospital or other facility where the procedure is performed, a Physician-Hospital Organization that is jointly owned by physicians and the hospital, or a newly formed entity.
4. **Facility-Independent Payment or Facility-Specific Payment.** Since many treatments can be delivered in multiple types of facilities (e.g., in a hospital inpatient unit, a hospital outpatient department, an ambulatory surgery center, a physician office, etc.), the bundle could be "facility-independent," i.e., the payment would be the same regardless of which type of facility is used for the treatment. Alternatively the bundled payment could be "facility-specific," with the payment amount differing depending on the specific facility where the treatment is delivered.
5. **Payment Amounts Stratified Based on Patient Needs.** The Alternative Payment Entity submits a bill to a payer for payment for services delivered to an eligible patient using a code from a family of new bundled codes that designate the service provided. Payment amounts are assigned to codes based on differences in the expected costs of the services delivered by both the physician and the facility. If the codes are facility-specific, each code is defined based on patient characteristics that are expected to affect the types of services performed by the physician and the facility, but the code is not based explicitly on the actual services delivered. If the codes are facility-independent, then the codes are also defined based on patient characteristics that are expected to affect the type of facility used for a patient, but the payment is not based explicitly on which facility was actually used.
6. **Outlier Payments for Patients with Unusually High Needs.** A supplemental payment would be made for patients who need an unusually large number of services or unusually expensive services as part of the treatment.
7. **Measurement of Appropriateness/Quality/Outcomes.** In order to ensure that patients continue to receive appropriate, high quality services under the bundled payment, the physician and facility agree to document the application of appropriate use criteria (if such criteria exist) or to measure quality and/or outcomes for the patients and compare those measures to benchmarks.
8. **Adjustment of Payment Amounts Based on Performance.** The amounts paid for the bundled codes are reduced if the providers fail to apply appropriate use criteria or if quality or outcome measures are significantly below benchmark levels.
9. **Updating Payments Over Time.** The bundled payment amounts would be increased each year based on inflation, and the payment amounts would be periodically adjusted based on an assessment of the costs of delivering the procedure to ensure that the bundled payments are adequate but no higher than necessary.

Benefits of the APM:

- The patient would benefit by being able to receive high quality care at the lowest-cost facility and to receive coordinated and efficient care from the physician and facility staff.
- The payer would benefit because the Alternative Payment Entity could accept a lower payment for the bundle than the total amounts that would have been paid separately to the physician and facility under current payment systems.
- The physician practice could benefit by using the bundled payment to cover the costs of services that are not current billable or do not receive adequate compensation, and by receiving compensation for changes in the physician's services that reduce the costs of the services delivered by the facility.

Examples:

- **Bundled Payments for Hospital Admissions.** Under this APM, a single payment would be made to a Physician-Hospital Organization (PHO) to cover both the physician services and the hospital services during a hospital admission. The physician practice and the hospital involved in the bundle would not bill separately for their services for any patient who was eligible for the bundled payment. (This payment model was successfully implemented by CMS for orthopedic and cardiac procedures as part of the Medicare Acute Care Episode Demonstration.[14])
- **Facility-Independent Bundled Payment for Surgery.** Under this APM, a surgery practice would receive a single, bundled payment to cover both the surgeon's costs for performing the surgical procedure and the costs of the facility used to perform the surgery. The bundled payment would be the same regardless of where the surgery was performed, so if patients could safely receive surgery in an outpatient setting or ambulatory surgery center rather than an inpatient setting (or in the physician's office rather than an outpatient hospital setting), the payer could pay less for the bundle while the surgery practice would earn more for performing the procedures. The surgery practice or the entity managing the payment would have the flexibility to pay more for services in the outpatient setting than the standard amount paid under the current payment system if that would enable a patient to be safely treated at a lower overall cost. The bundled payment would be higher for patients who have characteristics that would increase the likelihood that the patient would need to receive surgery in a higher-cost setting. Complication rates and patient-reported outcomes (such as pain and level of function) would be measured and reported, and payments would be reduced if patients were experiencing more complications or if outcomes worsened.
- **Facility-Independent Bundled Payment for Normal Vaginal Delivery.** Under this APM, an obstetrics practice would receive a single, bundled payment to cover both the obstetrician's time for labor and delivery and the payment to the facility where the delivery occurs. The bundled payment would be the same regardless of where the delivery occurred, so if a subset of mothers could safely deliver in a birth center rather than a hospital, the obstetrics practice could charge less for the bundled payment while earning more for performing deliveries. The obstetrics practice would have the flexibility to pay the birth center more than the standard amount it would have received under the current payment system if that would enable more babies to be safely delivered at the birth center at a lower overall cost.



APM #5: WARRANTIED PAYMENT FOR PHYSICIAN SERVICES

Goal of the APM:

Give physicians adequate payment and flexibility to redesign care in a way that will prevent complications and reduce the spending needed to treat them.

Components of the APM:

This APM differs from the previous APMs by using a single bundled payment to cover the costs of *unplanned* physician services to treat complications in addition to the costs of services that are planned as part of a patient's treatment. (If the procedure resulting in a complication was delivered in a facility, APM #5 could be combined with APM #4 - Physician-Facility Treatment Bundle to include the costs of facility services associated with treatment of complications as well as the physician services.)

1. **A Single Payment for Both a Planned Service and Treatment of Avoidable Complications.** The physician practice can bill and be paid for a warrantied version of a service the physician performs, and the physician practice receives a higher payment than what is currently paid under the current payment system for delivering the same type of service without a warranty. The physician practice is responsible both for delivering the initial service and for providing or paying for the additional physician services needed to treat specific types of complications arising from the initial service. The physician practice no longer bills separately for the services delivered to treat the complications covered by the warranty. If the treatment for the complication is delivered by a physician practice other than the physician practice that delivered the initial service, the payer reduces the payment to the physician practice that delivered the initial service by the amount paid to the physician who treated the complication.
2. **Payment Amounts Stratified Based on the Risk of Complications.** The physician practice bills for the warrantied service by choosing a code from a family of new service codes. Each code is defined based on patient characteristics that are expected to result in a significantly higher or lower rate of complications.
3. **Measurement of Quality/Outcomes.** The rate of complications covered by the warranty would be reported so that patients could choose physician practices with lower rates of complications. (There is no need to explicitly adjust the payment amount based on the rate of complications; the physician practice's operating margins would automatically be lower if complication rates are higher, because the cost of treating the complications would increase but the warrantied payment would remain the same.)
4. **Updating Payments Over Time.** The warrantied payment amounts would be increased each year based on inflation, and the payment amounts would be periodically adjusted based on an assessment of (1) the costs of delivering care to the patients and (2) the achievable rate of complications, in order to ensure that the payments are adequate but no higher than necessary.

Benefits of the APM:

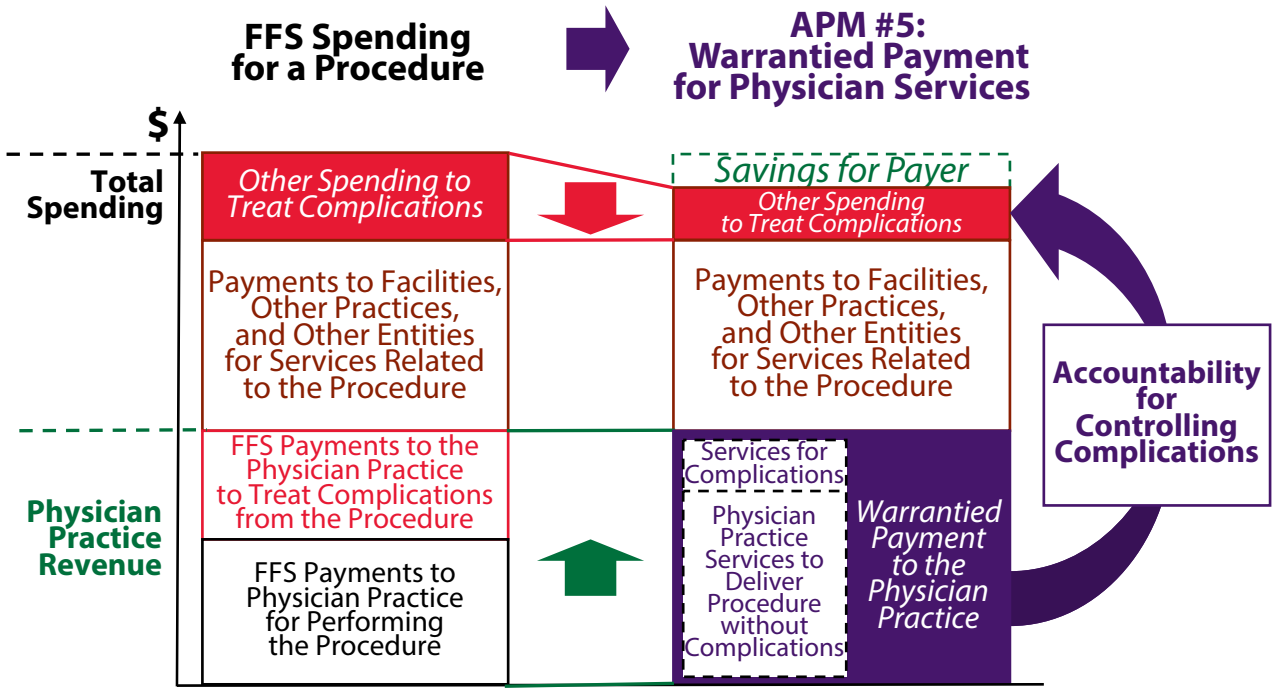
- The patient would benefit by being able to receive care with fewer complications and lower overall costs.
- The payer would benefit by paying less for the warrantied service that it would have paid for the combination of the planned services and treatment of complications at current complication rates.
- The physician practice would benefit by having the flexibility to deliver care differently if it would reduce complication rates, and to be paid more for delivering higher-quality care.

Examples:

- **Warranty for Surgery.** Under this APM, a surgery practice would bill for a warrantied payment for surgery. The payment would be higher than the standard surgical fee, but the surgery practice would not bill for a separate fee if the patient required a second surgery to address a complication. If specific types of patient characteristics are known to significantly increase the risk of complications, a higher level of payment would be made for patients with those characteristics. The types of complications covered by the warranty would be specified, and if a different type of complication or problem occurred that required a second surgery, the surgery practice could bill separately for that surgery. If a different surgeon performed the surgery for a complication covered by the warranty, the payment to that surgeon would be deducted from the payment to the surgery practice of the surgeon who delivered the initial warrantied surgery. (A warrantied payment focused solely on the physician practice would not be expected to cover the payment to the hospital if a second surgery was needed; however, a multi-provider bundled payment could be defined that included both the payment to the surgeon and the hospital, as described in APM#4.)
- **Warranty for Repeat Colonoscopy.** Under this APM, a gastroenterology practice would bill for a warrantied payment for colonoscopy. The payment would be higher than the standard colonoscopy fee, but the gastroenterology practice would not bill for an additional fee if a repeat colonoscopy was needed due to an incomplete procedure or to address post-polypectomy bleeding.

Difference from Other Payment Models:

In contrast to penalties that reduce payments when complications occur, the warranty approach provides greater upfront resources so that care can be redesigned to reduce complications. In addition, although no additional payment is made when complications occur, the cost of treating some complications is built into the warrantied payment amount, so the physician practice is not financially penalized when a small number of complications occur, but it is rewarded if it can eliminate most or all complications.



APM #6: EPISODE PAYMENT FOR A PROCEDURE

Goal of the APM:

Give physicians and other providers the ability to deliver all of the care during and after delivery of a particular procedure or treatment in a coordinated, efficient way.

Components of the APM:

This APM involves a single bundled payment for multiple services delivered by multiple providers over a period of time, including services needed to address complications that patients may experience as a result of treatment.

1. **Payment for a Complete "Episode of Care" Associated With a Procedure or Treatment.** An "episode of care" would be defined based on the time needed to deliver a particular procedure or treatment and any follow-up services needed, as well as a period of time in which most complications would be expected to occur. For example, the episode of care for a procedure or treatment delivered during an inpatient hospital admission is typically defined as the length of the hospitalization (and potentially a period of time before the hospital admission occurs) plus a fixed period of time after discharge (e.g., 30 days or 90 days). This means that the length of the episode can vary from patient to patient depending on the number of days involved in delivering the treatment. (Although payments for management of chronic conditions are also sometimes labeled "episode payments," these are more appropriately called Condition-Based Payments and are described under APM #7.)
2. **Bundled Payment For All Related Services Delivered During the Episode By All Providers.** The episode payment is a bundled payment that covers all services delivered by all providers during the episode that are related to the procedure or treatment, including services delivered by all physicians to the patient as part of the treatment or procedure, the services delivered by the hospital or other facility where the physician services are performed, and any services delivered by physicians or other providers after completion of the treatment that are needed for recovery from the treatment (e.g., post-acute care services after discharge from the hospital).
3. **Warrantied Payment for Treatment of Complications Occurring During the Episode.** The episode payment also covers any services delivered to treat specific types of complications related to the treatment or procedure, such as hospital readmissions for complications related to the treatment.
4. **Patient Agreement to Use the Provider Team for the Episode Services.** In order to receive the benefits of the more coordinated and flexible care, the patient would need to agree to only use the providers on the team participating in the Episode Payment for all services related to the procedure or treatment.
5. **Bundled Payment Paid to an Alternative Payment Entity.** An Alternative Payment Entity would be designated or created to serve as the recipient of the episode payment. Depending on the type of procedure or treatment, this could be a physician practice, a hospital, a Physician-Hospital Organization, or some other organizational entity governed by physicians.
   - **Prospective Payment:** If the episode payment is paid "prospectively," the providers would no longer bill the payer for the services they deliver that are covered by the episode payment, but they would instead be paid by the Alternative Payment Entity using the revenues that entity receives from the payer via the episode payment.
   - **Retrospective Reconciliation:** An alternative approach to implementing the episode payment is "retrospective reconciliation." The episode payment is treated as a budget, the providers continue to bill the payer for their individual services and they are paid by the payer under the existing payment systems, and those payments are totaled by the payer and compared to the budget. Then, if the fee-for-service billings are less than the budget, the payer pays the difference between the billings and the budget to the Alternative Payment Entity; if the fee-for-service billings total more than the budget, the Alternative Payment Entity must return the difference to the payer.
   - **Hybrid Prospective/Retrospective Payment.** A third alternative is for a subset of the providers to be paid by the payer under the current payment systems; these payments would be deducted by the payer from the episode payment and then the balance would be paid to the Alternative Payment Entity. The remaining providers would no longer bill directly for their individual services but would be paid through the Alternative Payment Entity using the revenues from the episode payments.
6. **Payment Amounts Stratified Based on Patient Needs.** The designated Alternative Payment Entity bills the payer for services to an eligible patient by choosing a code from a family of new bundled service codes. Each code would be defined based on patient characteristics that are expected to need combinations of services with similar total costs.[15]
7. **Outlier Payments and Risk Corridors for Patients with Unusually High Needs.** A supplemental payment (an outlier payment) would be made by the payer to the Alternative Payment Entity for patients who need an unusually large number of services during an episode. In addition, a supplemental payment (a risk corridor payment) would be made if an unusually large number of patients had above average needs for services during episodes.[16]
8. **Measurement of Appropriateness/Quality/Outcomes.** In order to ensure that patients continue to receive appropriate and high quality services under the episode payment arrangement, the participating providers would agree to document the application of appropriate use criteria (if such criteria exist) and/or to measure quality and/or outcomes for the patients and compare the measures to benchmarks.

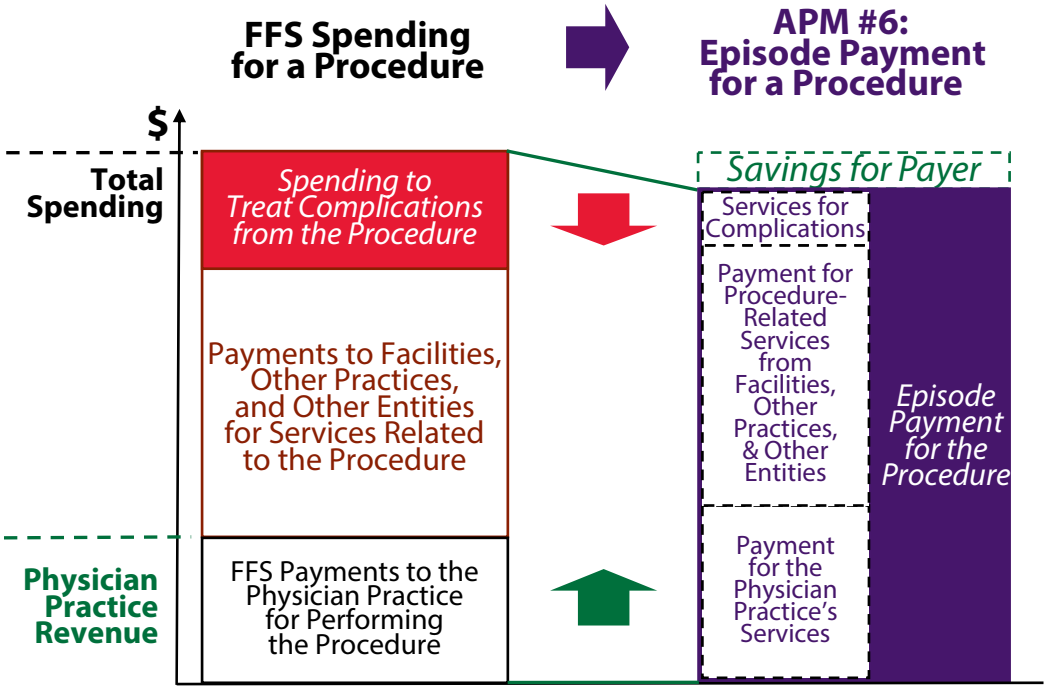
9. **Adjustment of Payment Amounts Based on Performance.** The amounts paid for the episodes would be reduced if the providers failed to apply appropriate use criteria or if quality or outcome measures were significantly below benchmark levels.
10. **Updating Payments Over Time.** The episode payment amounts would be increased each year based on inflation, and the payment amounts would be periodically adjusted based on an assessment of the costs of delivering the procedure or treatment to ensure that the payments are adequate but no higher than necessary.

Benefits of the APM:

- The patient would benefit by receiving more coordinated care and by the ability to receive different types or amounts of services than are possible under the current payment system.
- The payer would benefit by paying less for the episode payment than it would have expected to spend in total for all of the services delivered during the episode under the current payment and delivery system.
- The physician practice and other providers would benefit by having the flexibility to deliver care differently if it would reduce costs and complication rates and they could be paid more for delivering higher-quality, lower-cost care.

Examples:

- **Bundled Payment for Colonoscopy.** Under this APM, a gastroenterology practice would receive a single payment to cover all of the services associated with delivery of a screening colonoscopy – the services of the gastroenterologist performing the colonoscopy, the services of an anesthesiologist or nurse anesthetist if one was used, and the facility fee for the facility where the colonoscopy was performed. The payment would be the same regardless of which facility is used to perform the colonoscopy. The payment would also cover any repeat colonoscopies performed due to incomplete procedures or polypectomy bleeding. (The colonoscopy bundle developed by the American Gastroenterological Association includes all of these costs.[17])
- **Episode Payment for Joint Surgery.** Under this APM, a surgery practice, Physician-Hospital Organization, or health system would receive a single payment (or a defined budget) for all of the costs involved in performing hip or knee surgery during an inpatient hospital admission, delivering rehabilitation services after surgery, and treating any post-operative complications. The payment amount would be higher for patients with comorbidities and functional limitations that would require more inpatient or post-acute care. The payment amount would be adjusted based on measures of quality and outcomes for the patients. [18]



APM #7: CONDITION-BASED PAYMENT

Goal of the APM:

Give physicians and other providers who are delivering care to patients for an acute or chronic condition the flexibility and accountability to deliver the most appropriate treatment for the patient's condition in a coordinated, efficient, high-quality manner.

Components of the APM:

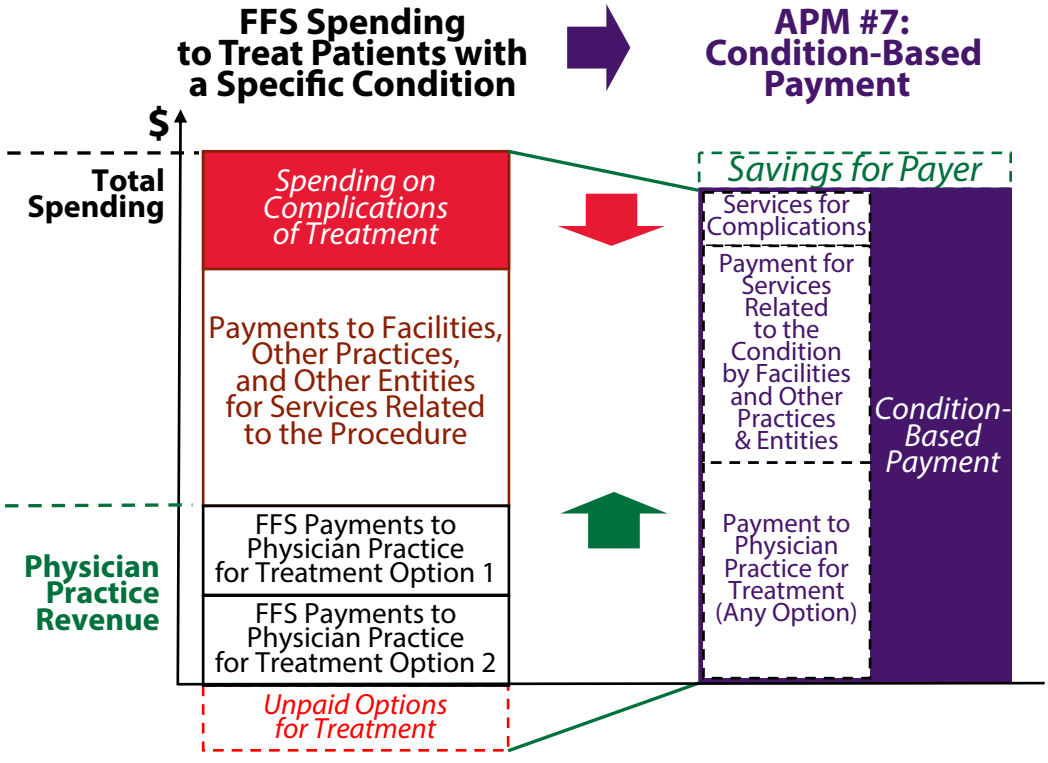
1. **Payment Based on the Patient's Health Condition.** The physician practice (or an Alternative Payment Entity designated by the practice) can bill and be paid for managing the care of a specific health condition (or combination of conditions), rather than having payment tied to the delivery of specific procedures or treatments.
2. **Payment Covering Multiple Treatment Options Delivered by the Physician and Other Providers.** The Condition-Based Payment covers all services delivered by the physician or by other providers that are related to the condition during a defined period of time. For an acute condition, the time period would end when the acute condition is resolved; for a chronic condition, a fixed time period could be defined (e.g., a month or a year) or the time period could end when the nature or severity of the patient's condition changes (e.g., the chronic condition becomes significantly more severe). The physician practice (or the Alternative Payment Entity receiving the payment) has the flexibility to use the payment for services that are currently eligible for fee-for-service payments, for services that are not currently eligible for payment, and for services delivered by individuals or organizations that are not currently eligible to be paid directly.
3. **Patient Agreement to Use the Provider Team for Services Related to the Condition(s).** In order to receive the benefits of the more coordinated and flexible care, the patient would need to agree to only use the providers on the team participating in the Condition-Based Payment for all services related to their condition.
4. **Payment Paid to an Alternative Payment Entity**
   - **Prospective Payment:** If the condition-based payment is paid "prospectively," the physician practice and other providers would no longer bill the payer for the services they deliver that are covered by the Condition-Based Payment, but they would instead be paid by the Alternative Payment Entity using the revenues that entity receives from the payer via the episode payment.
   - **Retrospective Reconciliation:** An alternative approach to implementing the Condition-Based Payment is "retrospective reconciliation." The Condition-Based Payment is treated as a budget, the providers continue to bill the payer for their individual services and they are paid by the payer under the existing payment systems, and those payments are totaled by the payer and compared to the budget. Then, if the fee-for-service billings are less than the budget, the payer pays the difference between the billings and the budget to the Alternative Payment Entity; if the fee-for-service billings total more than the budget, the Alternative Payment Entity must return the difference to the payer.
   - **Hybrid Prospective/Retrospective Payment.** A third alternative is for a subset of the providers to be paid by the payer under the current payment systems; these payments would be deducted by the payer from the Condition-Based Payment and then the balance would be paid to the Alternative Payment Entity. The remaining providers would no longer bill directly for their individual services but would be paid through the Alternative Payment Entity using the revenues from the Condition-Based Payments.
5. **Payment Amounts Stratified Based on Patient Needs.** The designated Alternative Payment Entity bills a payer for services to an eligible patient by choosing a code from a family of new "condition-based" codes. Each code would be defined to describe patients with characteristics who would be expected to need combinations of services with similar total costs, and the payment for each code would be based on the expected costs of services for patients with the characteristics associated with that code.
6. **Outlier Payments and Risk Corridors for Patients with Unusually High Needs.** A supplemental payment (an outlier payment) would be made by the payer to the Alternative Payment Entity for patients who need an unusually large number of services to address the condition(s). In addition, a supplemental payment (a risk corridor payment) would be made if an unusually large number of patients had above average needs for services.
7. **Measurement of Appropriateness/Quality/Outcomes.** In order to ensure that patients continue to receive appropriate and high quality services under the Condition-Based Payment arrangement, the Alternative Payment Entity would agree to document the application of appropriate use criteria (if such criteria exist) and/or to measure quality and/or outcomes for the patients and compare the measures to benchmarks.
8. **Adjustment of Payment Amounts Based on Performance.** The Condition-Based Payment amounts would be reduced if the providers failed to apply appropriate use criteria or if quality or outcome measures were significantly below benchmark levels.
9. **Updating Payments Over Time.** The Condition-Based Payment amounts would be increased each year based on inflation, and the payment amounts would be periodically adjusted based on an assessment of the costs of delivering care to the patients with the condition to ensure that the payments are adequate but no higher than necessary.

Benefits of the APM:

- The patient would benefit by receiving more coordinated care for their health problem and by the ability to receive different types or amounts of services than are possible under the current payment system.
- The payer would benefit by paying less for care of the patient's condition than the payer would have expected to spend in total for all of the services delivered for the condition under the current payment system.
- The physician practice and other providers would benefit by having the flexibility to deliver care in ways that would reduce costs and complication rates and they could be paid more for delivering higher-quality, lower-cost care.

Examples:

- **Condition-Based Payment for Joint Osteoarthritis.** Under this APM, a physician practice (or an entity designated by the physician practice) would bill for and receive a payment for patients with serious osteoarthritis of the hip or knee. The physician practice would have the flexibility to use the payment for whatever types of service would achieve the greatest benefit for the patient, including physical therapy or surgery, and the practice would also have the flexibility to pay more or less for services than under existing payment systems. The amount of the payment would be higher for patients with more severe osteoarthritis, comorbidities, or other characteristics that would increase the likelihood that the patient would need more extensive or expensive services, but the payment would not be higher simply based on the type of services delivered, whether surgery was used, or the facilities used for services. Complication rates and patient-reported outcomes would be measured and reported, and payments would be reduced if these measures indicated poor quality of care.
- **Condition-Based Payment for Chronic Disease Management.** Under this APM, a primary care practice or a partnership between a primary care practice and specialty practice would bill for a monthly payment for management of a patient's chronic disease, such as asthma, COPD, diabetes, or heart failure. The payment would cover all of the physicians' services related to the chronic disease, including office visits, all tests and therapies ordered for treatment of the disease, and the costs of ED visits or hospital admissions for exacerbations of the disease. Payments would be risk-stratified based on the severity of the patient's condition and other patient characteristics that would increase their need for services and the risk of exacerbations.[19]
- **Condition-Based Payment for Post-Acute Care Following a Hospitalization.** Under this APM, one payment would cover all of the post-acute care services needed following a hospitalization (e.g., for back surgery). Higher payments would be made for patients with characteristics that increase their need for more post-acute care services or higher-cost post-acute care settings, but the payment would not be higher simply based on the type of services delivered. The physician would have the flexibility to order different types of post-acute care than are available under the current payment system, e.g., if patients could safely be discharged to home with some short-term home care services, the physician and other providers who were managing the payment would have the flexibility to deliver and pay for those services even if they were not eligible for payment under current payment systems. Post-acute care providers could be paid more or less than current payment rates based on the actual costs of services for specific patients. Readmission rates and patient outcomes would be measured and payments would be reduced if these measures indicated a deterioration in the quality of care. [20]



III. CHOOSING AN APPROPRIATE ALTERNATIVE PAYMENT MODEL

A. Matching the APM to the Opportunities, Barriers, and Capabilities of Physician Practices

The "right" APM for a particular specialty or a particular physician practice in that specialty will depend on the types of patients and conditions that specialty cares for, the opportunities that exist for improving their care, the barriers the physicians face under the current payment system, and any barriers that exist that are unrelated to payment (e.g., restrictions in laws or regulations). Table 2 shows which APMs address specific improvement opportunities and payment barriers. In general, several different APMs could be used to address the same combination of opportunities and barriers, but one of the models may be more feasible for a particular physician practice given its size or relationships with other providers.

If simply paying for a service that is not currently paid for under the fee-for-service payment system could enable a physician practice to deliver significantly better care at lower overall cost, then APM #1 would be a sufficient payment reform to overcome the barriers that exist, and there would be no need to force the practice to find ways to manage a larger or more complex bundled payment. There are many ways in which the quality of healthcare can be improved and spending can be reduced through the actions of individual physician practices, and it is important that Medicare and other payers create both small and large APMs that enable all types of physician practices to improve care in ways that are feasible for those practices.

B. Combining Multiple APMs

The seven APMs listed in this report can not only be used as individual payment models, but they can also be used as "building blocks" to create additional APMs. For example:

- if physicians from two different specialty practices are involved in delivering a procedure at a facility (e.g. a surgery practice and an anesthesiology practice that deliver surgeries at a hospital), a bundled payment could be created involving the two practices and the hospital; this Alternative Payment Model would combine the elements of both APM #3 (Multi-Physician Bundled Payment) and APM #4 (Physician-Facility Procedure Bundle).
- if a physician practice and hospital wanted to redesign an inpatient procedure in ways that would both reduce the costs of delivering the procedure and reduce the complication rate, they could create a bundled and warrantied payment for the hospital procedure. This APM would combine the elements of APM #4 (Physician-Facility Procedure Bundle) and APM #5 (Warrantied Payment for Physician Services). This might be more feasible for the physician practice and hospital to implement than the full Episode Payment defined in APM #6, since the latter would also require taking accountability for the costs of post-acute care services after discharge.

The biggest Alternative Payment Model of all – a risk-adjusted global payment – can be created by combining Condition-Based Payments (APM #7) for each type of patient health problem into a single overall structure. This enables using the most appropriate risk adjustment structures for each type of patient condition, rather than trying to create one single risk adjustment system that addresses all of the differences in needs for patients with diverse conditions.

C. Using APMs for Provider Compensation Inside of Other APMs

Finally, the seven APMs in this report can also be used to help allocate payments in larger bundles among the participating providers in an appropriate way.[21] For example:

- If a physician practice or an Alternative Payment Entity accepts a Condition-Based Payment (APM #7) to manage care for a particular health problem, and if there is a choice of multiple procedures for treating the patient's condition, the Alternative Payment Entity will need a way to pay the specific providers who deliver the specific procedure that the physician and patient choose to use. The Alternative Payment Entity could do this by defining Episode Payments for each procedure using APM #6, and using those Episode Payments to pay the providers who deliver the procedure the patient chooses.
- If a physician practice or an Alternative Payment Entity accepts an Episode Payment for a Procedure (APM #6), it could use the other APMs to pay individual providers (other physician practices or facilities) for the components of the episode that they deliver. For example, if an Episode Payment is defined for a hospital procedure that includes post-acute care services, a Physician-Facility Procedure Bundle (APM #4) could be used to pay the physician practice and the facility for the portion of the episode that is delivered in the hospital, and a Condition-Based Payment (APM #7) could be used to pay for the post-acute care portion of the episode.

If a physician practice or other provider organization is accepting a risk-adjusted global payment for a population of patients, it could use the revenues from that payment to make Condition-Based Payments to the physicians and other providers involved in managing the care of patients with different types of health problems. In this way, Physician-Focused Payment Models could help multiple physician practices work together to successfully form and manage Accountable Care Organizations.

TABLE 2

Opportunity to Improve Care and Reduce Total Spending	Barrier(s) in the Current Payment System	Potential Solutions Through Alternative Payment Models
Help patients better manage health problems and risk factors in ways that avoid the need for hospitalizations	Lack of payment or inadequate payment for proactive outreach, care management, rapid response to problems, and non-hospital treatment options	APM #1: Payment for a High-Value Service APM #2: Condition-Based Payment for Physician Services APM #3: Multi-Physician Bundled Payment APM #7: Condition-Based Payment
Reduce unnecessary testing and visits to specialists	Insufficient payment to allow time for good diagnosis No payment to support phone or email contacts between physicians to develop good diagnoses and treatment plans	APM #1: Payment for a High-Value Service APM #2: Condition-Based Payment for Physician Services APM #3: Multi-Physician Bundled Payment
Use lower-cost procedures and services to treat patient conditions	Loss of physician revenue when fewer services or less-expensive services are performed, even though most costs and savings are associated with the corresponding payments to hospitals or other providers, not the physician practice	APM #2: Condition-Based Payment for Physician Services APM #7: Condition-Based Payment
Reduce the total cost of delivering a specific procedure or treatment in a hospital or other facility	Separate payments to the physician and hospital (or other facility) prevent compensating physicians for additional time or costs needed to reduce costs for the hospital/facility	APM #4: Physician-Facility Procedure Bundle
Use lower-cost providers or facilities for services ordered as part of treatment	Lack of payment or inadequate payment for use of lower-cost facilities or providers in conjunction with the physician's treatment services	APM #4: Physician-Facility Procedure Bundle APM #6: Episode Payment for a Procedure APM #7: Condition-Based Payment
Reduce the number of avoidable complications and the cost of treating avoidable complications	Inadequate payment for services needed to prevent complications or reduce the cost of treating complications	APM #1: Payment for a High-Value Service APM #5: Warrantied Payment for Physician Services APM #6: Episode Payment for a Procedure APM #7: Condition-Based Payment

ENDNOTES

1. Yong PL, Saunders RS, Olsen L. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Institute of Medicine. 2010. Available at http://iom.nationalacademies.org/Reports/2011/The-Healthcare-Imperative-Lowering-Costs-and-Improving-Outcomes.aspx.
2. For a more detailed discussion of the components needed for a successful Alternative Payment Model, see Miller HD. *The Building Blocks of Payment Reform: Designing Payment Systems that Support Higher-Value Health Care*, available at http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf.
3. For a more detailed discussion of the problems with pay-for-performance, value-based purchasing, and shared savings programs, see Miller HD, *Measuring and Assigning Accountability for Healthcare Spending*, available at http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf.
4. Under the Medicare Access and CHIP Reauthorization Act (MACRA), physicians' participation in Alternative Payment Models is measured based on the proportion of their revenues or patients associated with services furnished through an "Alternative Payment Entity." An Alternative Payment Entity is an entity that participates in an Alternative Payment Model and either (1) bears financial risk for monetary losses under the alternative payment model that are in excess of a nominal amount, or (2) is a medical home expanded under the statutory authority granted to the Center for Medicare and Medicaid Innovation.
5. American Society of Clinical Oncology, *Patient-Centered Oncology Payment: Payment Reform to Support Higher Quality, More Affordable Cancer Care*, May 2015. Available at: http://www.asco.org/sites/www.asco.org/files/asco_patient-centered_oncology_payment_final_2.pdf.
6. Although a payment model could be defined that bundles two or more services that are always delivered as part of a patient's treatment, this would not create any real flexibility or cost savings, since the combined payment would presumably be the same as the sum of the individual payments if the same combination of services is always provided.
7. If the out-of-pocket costs to the physician practice differed significantly for the different services (e.g., some used more expensive supplies or drugs than others), the Condition-Based Payment could be designed to cover only the physician's time for the different services, and smaller fee-for-service payments could continue to be made to cover the out-of-pocket costs the physician practice incurs to deliver the services. This would avoid financially penalizing the physician practice for choosing a service that would be less expensive for the payer but cost the practice more to deliver.
8. This is similar to what payers do today in paying a global surgical fee instead of paying separately for the surgical procedure and the surgeon's visits with patients after surgery.
9. This is different from traditional primary care capitation, which replaces all E&M payments for all patients and is not risk-adjusted or limited to chronic disease patients.
10. A more detailed description of how this APM could be structured to better support the work of primary care practices is included in *Patient-Centered Primary Care Payment*, which is available from the Center for Healthcare Quality and Payment Reform.
11. Falit BP, Chernew ME, Mantz, CA. Design and Implementation of Bundled Payment Systems for Cancer Care and Radiation Therapy. *International Journal of Radiation Oncology, Biology, and Physics* 89(5): 950-953, 2014.
12. See pages 15-16 of *Patient-Centered Oncology Payment: Payment Reform to Support Higher Quality, More Affordable Cancer Care, op cit*.
13. More detail on how this APM could be structured is included in *Provider Payment and Patient Benefits to Support SMART-Care*, which is available from the Center for Healthcare Quality and Payment Reform. More information on SMARTCare is available at http://www.betterheartcare.org
14. See Impaq International, *Evaluation of the Medicare Acute Care Episode (ACE) Demonstration,* May 31, 2013. Available at https://downloads.cms.gov/files/cmmi/ACE-EvaluationReport-Final-5-2-14.pdf .
15. The categories would be defined differently from the way Diagnosis Related Groups are defined, since they would need to capture differences in the types of post-acute care needed and in the risk of readmission as well as differences in the costs of inpatient care.
16. For a more detailed discussion of outlier payments and risk corridors in Alternative Payment Models, see *The Building Blocks of Payment Reform: Designing Payment Systems that Support Higher-Value Health Care*, available at http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf
17. Brill JV et al. A Bundled Payment Framework for Colonoscopy Performed for Colorectal Cancer Screening or Surveillance. *Gastroenterology* 2014; 146:849-853.
18. For a detailed discussion of how to structure an Episode Payment for joint surgery, see *Bundling Better: How Medicare Should Pay for Comprehensive Care (for Hip and Knee Surgery and Other Healthcare Needs)*, available at http://www.chqpr.org/downloads/BundlingBetter.pdf.
19. More detail on how this APM could be structured to better support care of heart failure patients by cardiology practices and primary care practices is available in *Better Payment for Cardiovascular Care*, which is available from the Center for Healthcare Quality and Payment Reform.
20. Model 3 of the CMS Bundled Payments for Care Improvement (BPCI) program creates a virtual bundle for post-acute care costs and readmissions after discharge from an inpatient stay in a hospital. For more detail, see https://innovation.cms.gov/initiatives/BPCI-Model-3/.
21. Additional detail on how smaller bundled payments can be used as compensation structures for providers within larger Alternative Payment Models is available in *The Building Blocks of Payment Reform: Designing Payment Systems that Support Higher-Value Health Care*, available at http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf.

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