AMA

Accelerating the adoption of value-based care

The essential role of Current Procedural Terminology (CPT®)

Research collaboration led by

manatt

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Collaborators

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Executive summary

The shift towards value-based care (VBC) has led to a reimagining of the traditional definition of health care delivery—including what types of services are delivered, how those services are delivered, and by whom they are delivered—all with the objective of supporting better outcomes at lower costs. The American Medical Association (AMA) set out to understand the Current Procedural Terminology (CPT®) code set's role in VBC. From a series of interviews with VBC provider organizations, health plans, integrated delivery systems, health technology organizations, VBC enablement organizations and others, the AMA gathered market perspectives on how CPT plays into VBC arrangements today, including where it is supportive and where there may be opportunities for continued evolution. The key findings are that CPT serves as the common language for VBC today and is a critical enabler of the three pillars of VBC success going forward:

PILLARS OF VBC SUCCESS	CPT'S ROLE
Pillar 1: Population health and quality management	• Drives identification of patients for targeted clinical intervention. • Supports payer quality improvement efforts.
Pillar 2: Cost management	• Supports spend benchmarking, risk adjustment and budgeting. • Enables identification of high-cost events and high-cost patient cohorts. • Enables provider network management.
Pillar 3: Alternative payment model (APM) contracting	• Is foundational for patient attribution. • Enables innovative digitally enabled care bundles. • Facilitates contracting between companies offering digitally enabled care and payers.

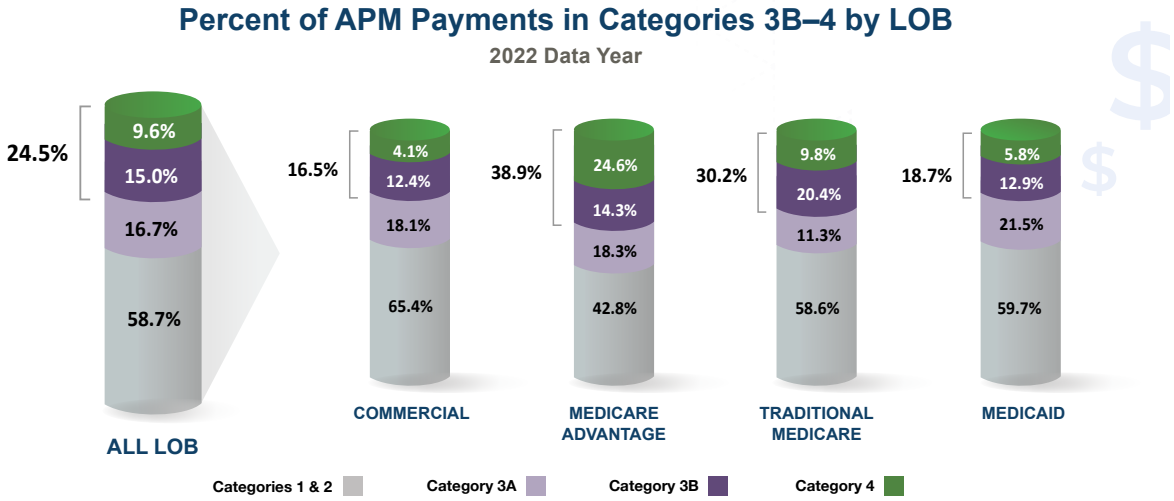
Stakeholders also shared ideas for evolving the code set to accelerate adoption of VBC delivery, including:

1. **Evolving CPT codes to reflect new types of practitioners delivering health care services**
2. **Supporting new care delivery models with bundled service codes**
3. **Considering how CPT might address new types of health care services being delivered**

The AMA and the CPT Editorial Panel are committed to progressing the code set to ensure it continues to evolve in ways that support the delivery of high-value care to patients, and meets the needs of physicians, health professionals, health systems, policymakers and payers.

Introduction

VBC models—especially those that seek to optimize quality and outcomes while minimizing costs—deliver real value. With a decade of performance results, Medicare Accountable Care Organizations (ACOs) have outperformed non-ACO physician groups on quality and have generated year-over-year savings for the Medicare Trust Fund.[1] However, adoption has been slow. In 2022, 90% of all US health care payments flowed through arrangements built on a fee-for-service architecture, while only 10% were in population-based payment arrangements. Overall, a quarter of payments flowed through two-sided financial risk contracts.[2]



Source: HCP-LAN apm-infographic-2023.pdf (hcp-lan.org).

In addition to the Affordable Care Act in 2010, which incentivized the migration from fee-for-service reimbursement to value-based payment, there have been strong forces promoting the development of new value-based models of care. The COVID-19 pandemic prompted a surge in the use of digital technologies, as well as a greater awareness of the importance of social drivers of health. Innovative care models that have since emerged, including digitally enabled models, aim to deliver value by improving convenience and access for patients, addressing unmet social needs and promoting enhanced patient self-management, thereby improving outcomes and reducing cost.

The AMA has continued to develop robust educational content, best practices and playbooks for physicians to encourage broad adoption of innovative VBC models. For this research, **the AMA set out to understand the CPT® code set's role in VBC**. The AMA gathered various stakeholder perspectives, including VBC provider organizations, health plans, integrated delivery systems, VBC enablement organizations, health technology organizations and others.[3] This issue brief is the culmination of these conversations, highlighting how CPT serves as the common language for VBC today and identifying areas for evolution. The AMA and the CPT Editorial Panel are committed to progressing the code set to ensure it continues to evolve in ways that support the delivery of high-value care to patients, and meets the needs of physicians, health professionals, health systems, policymakers and payers.

Background on CPT® codes

Current Procedural Terminology (CPT) is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other qualified health care professionals. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians and other qualified health care professionals, patients and third parties.

Under the authority of the AMA, the CPT Editorial Panel is entrusted with the task of maintaining the CPT code set by revising, updating, or modifying CPT codes, descriptors, rules and guidelines. Comprised of 21 volunteer physicians and other qualified health professionals appointed by the AMA Board of Trustees, the CPT Editorial Panel is an independent body that maintains an open process and convenes meetings three times per year to solicit the direct input of practicing physicians; federal agencies—including the Centers for Medicare and Medicaid Services, the Food and Drug Administration, and the Centers for Disease Control and Prevention—medical device manufacturers; developers of the latest diagnostic tests; and clinical advisors from over 100 societies representing physicians as well as other qualified health care professionals. The Panel evaluates proposals for new codes, revises existing codes, and removes outdated codes to ensure the CPT code set remains relevant and comprehensive.

CPT® continues to evolve to support the shift to VBC

The CPT code set, as a globally recognized nomenclature for describing physician-patient interaction, is well-adopted by physician practices, health systems and payers across the United States. In recent years, the code set has evolved to support VBC models that emphasize care management activities (e.g., principal care management, chronic care management (CCM) and complex chronic care management); collaboration across specialties (e.g., collaborative care models (CoCM)); and transitions across care settings (e.g., transitional care management (TCM)).

The CPT Editorial Panel also approved a series of codes to support delivery of digitally enabled care including virtual consultations, remote physiologic and therapeutic monitoring, and interprofessional telephone/internet/electronic consultations (typically referred to as "e-consults").

> "The Psychiatric Collaborative Care Model CPT codes have directly helped grow integrated behavioral health models."
>
> **VBC enablement organization stakeholder**

Case study #1: Sentara Health

Sentara Health is among the largest not-for-profit integrated health care delivery systems in the country with 12 hospitals in the Virginia and Northeastern North Carolina areas. Sentara Health Plans cover more than 1 million members in Virginia and Florida through group, individual, Medicaid and Medicare (including Special Needs) plans.

Sentara Health participates in all levels of risk-bearing value-based care arrangements including traditional fee-for-service, shared savings with upside and downside risk, and population-based capitated payments.

Sentara Health leverages CPT codes for transitional care management and chronic care management, and soon will use the CPT codes for remote patient monitoring. It refined its clinical care management workflows and built the technological and operational muscles to scale its care management function, enabling it to migrate up the risk spectrum and away from pure fee-for-service reimbursement. Developing the care management model involved significant staff training, workflow development and information technology investment. Once Sentara was confident in its workflows and satisfied with the observed health outcome improvements, it evolved these models into value-based care arrangements.

> "We have a vision for what the optimal clinical model looks like with integrated physicians, pharmacists and nurses. We know these models are best supported under value-based care, but we'll never get to value-based care unless we can learn along the way while still leveraging fee-for-service to a certain degree in order to facilitate payment... We needed the additional codes to get there, and in that respect CPT has been instrumental to this process of achieving our vision and adoption of value-based care."
>
> **Dan Dickinson, MD, MPH, Vice President, Complex Care Solutions, Sentara Ambulatory Services Division, Sentara Health**

Today, the CPT code set serves as a critical enabler of three key pillars of VBC success:

1. Population health and quality management
2. Cost management
3. Alternative payment model contracting

And plays a critical role across the full spectrum of risk models:

CPT code set serves as a critical enabler of three key pillars of VBC success

HCP-LAN CATEGORY	1: FEE FOR SERVICE—NO LINK TO QUALITY OR VALUE	2: FEE FOR SERVICE—LINK TO QUALITY AND VALUE			3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE			4: POPULATION-BASED PAYMENT			
HCP-LAN Sub-category		A: Foundational payments for infrastructure and operations	B: Pay-for-reporting	C: Pay-for-performance	A: APMS with shared savings	B: APMs with shared savings and downside risk	N: Risk-based payments NOT linked to quality	A: Condition-specific population-based payment	B: Comprehensive population-based payment	C: Integrated finance and delivery system	N: Capitated payments NOT linked to quality
Pillar 1: Population health and quality management											
Drives identification of patients for targeted clinical intervention	●	●	●	●	●	●	●	●	●	●	●
Supports payer quality improvement efforts			●	●	●	●	◐	●	●	●	●
Pillar 2: Cost management											
Supports spend benchmarking, risk adjustment and budgeting				●	●	●	●	●	●	◐	◐
Enables cost management and operating insights	●	●	●	●	●	●	●	◐	◐	◐	◐
Pillar 3: Alternative payment model contracting											
Is foundational for patient attribution		●	◐	●	●	●	●	●	●	●	●
Enables innovative digitally enabled care bundles	●	●	●	●	●	●	●	●	●	●	●
Facilitates contracting between companies offering digitally enabled care and payers	●	●	●	●	●	●	●	●	●	●	●

Key: ● CPT critical to this function; ◐ CPT supportive of this function; Blank: Function is not relevant for this model.

Rows informed by: A Playbook of Voluntary Best Practices for VBC Payment Arrangements - AHIP-AMA-NAACOS.

VBC pillar 1: Population health and quality management

- **CPT® drives identification of patients for targeted clinical intervention.** The intent of VBC models is to deliver the right care in the right setting at the right time to prevent costly downstream health care resource utilization—such as emergency department visits or hospital admissions. Understanding which patients are at risk for escalation is critical to developing population health interventions that will drive value. CPT codes provide detailed information on the types of services rendered to whom and when—which cannot be achieved through ICD-10 and Diagnosis Related Group (DRG) codes alone—enabling health care providers to accurately identify patient populations, group them into cohorts for care management, and tailor care strategies accordingly.
- **CPT supports payer quality improvement efforts.** CPT-coded raw claims data gives payers unmatched insight into provider performance and health care quality across the payer's membership. This is especially valuable, as payers do not typically have direct visibility into provider electronic health record or practice management systems. These data and insights can support both targeted provider education on opportunities to improve VBC delivery and contract performance management.

> "CPT provides actionable insight by helping effectively sort our customer segments into disease verticals for targeted value-based care enablement because the data includes specificity on timing of interventions that other data lack. We have leveraged groupers based on CPT codes to successfully identify patients receiving orthopedic care who are good candidates for our VBC care model pathways."

VBC enablement organization stakeholder

> "Thanks to CPT codes for transition care management (TCM) services, we were able to identify a correlation between practices that had strong transitions of care programs and lower hospital re-admissions rates through our claims data analysis process. We then provided feedback to physician practices struggling with hospital readmissions on how transition care management services can have a positive impact on readmission rates."

Payer organization stakeholder

Case study #2: Horizon Healthcare Services

Horizon Healthcare Services is the largest insurer in New Jersey and offers health plans to individuals, families and employers across the state with access to more than 75,000 providers and every New Jersey hospital. Horizon is dedicated to enhancing the health and well-being of its nearly 3.7 million members through innovative programs, such as patient-centered care initiatives, wellness programs and disease management services, while also placing a strong emphasis on community engagement and supports by partnering with a variety of community-based organizations.

Horizon participates in many value-based arrangements with health systems and physician practices throughout New Jersey, and relies on CPT data to attribute members to physicians, provide insights into service delivery, identify areas of high spend, evaluate contractual performance and target areas for physician education.

Without access to electronic health record data, Horizon relies on raw claims data and the associated CPT codes as a critical source of information which drives the administrative function and success of their value-based arrangements.

Care management and case management population health services have become more commonly delivered as part of value-based care delivery models. As this change has occurred, it's become important for payers like Horizon to monitor the investments which practices are making in care delivery enhancement and team-based care to understand the direct impact on quality. Horizon has utilized claims data analysis by leveraging CPT codes to understand what work is being delivered and by whom to tailor value-based arrangements to incentivize high-value services that drive outcomes.

> **"In many instances, CPT codes on physician-billed claims are the only data set available to payers for practices to clearly provide evidence of the services they provided. This tracking is an essential part of effective value-based care delivery and accurately monitoring performance."**
>
> **Jamie Reedy, MD, MPH, Chief Population Health Officer & SVP, Health Solutions, Horizon Healthcare Services**

Additionally, Horizon leverages Category II CPT codes to capture and analyze data related to its quality improvement programs. Category II codes track key quality metrics, such as blood pressure and HbA1c levels.

VBC pillar 2: Cost management

- **CPT® supports spend benchmarking, risk adjustment, and establishment of budgets under shared savings and capitated arrangements.** In most alternative payment models where the physician practice is held accountable for cost of care for an attributed population, performance targets are calculated through retrospective claims data analysis powered by CPT codes. Once utilization and spend benchmarks are established for the attributed population, CPT codes enable tracking spend against budget. For instance, in shared savings arrangements, physician practices rely on CPT-based data to forecast expenses relative to benchmarks and assess the likelihood of achieving savings.

> "CPT drives internal data analysis which determines how to most effectively spend capitation payments received prospectively under alternative payment models such as ACO REACH to best manage the current cohort while using learnings from the performance and outcomes of the prior cohort."

VBC enablement organization stakeholder

> "With fully capitated alternative payment models, we lose some line-item specificity into spend. While CPT codes are not required to pursue reimbursement in some of these alternative models, they remain important to us for knowing individual value units going into the product being delivered."

VBC provider organization stakeholder

- **CPT enables identification of high-cost events and high-cost patient cohorts.** Codes can be leveraged to identify outliers in resource utilization within a given cohort of patients and inform the development of clinical protocols and workflows to better manage subsequent patient cohorts.

> "CPT helps us know exactly when and where in the VBC journey high-spend events are happening, so the next cohort approach can be adjusted."

VBC enablement organization stakeholder

Case study #3: Coastal Carolina Health Care

Coastal Carolina Health Care (CCHC) is a physician-owned, 60-provider, multi-specialty group practice in Eastern North Carolina. It has a large primary care practice, in addition to an ambulatory surgery center, sleep lab, urgent care and imaging center across its 18 practice locations. CCHC is a participant in Coastal Carolina Quality Care—one of the very first ACOs to be established nationwide.

CCHC has nearly 22,000 attributed lives in its ACO and VBC arrangements across all payer types. CCHC attributes its success (close to 14% savings rate in 2022 performance year[4]) in VBC arrangements in part to the administrative benefits of CPT's role in providing line-level insights into service delivery and productivity.

CCHC and Coastal Carolina Quality Care CEO Stephen Nuckolls views CPT as "the building block upon which we keep track of the work that is done across the practice." The line-level insights offered by CPT codes are critical to understanding physician productivity. They also drive benchmarking and budget forecasting for the practice which support CCHC's continued high performance in its VBC arrangements with Medicare and commercial payers.

- **CPT enables provider network management.** For risk-bearing entities, CPT codes provide visibility into cost-efficient, high-quality providers, which can in turn guide network design and contracting strategy.

> "When care is delivered outside our network, we rely on CPT and claims data to understand what services were delivered."
>
> Integrated delivery system organization stakeholder

VBC pillar 3: Alternative payment model contracting

- **CPT® supports patient attribution.** Claims data is foundational for defining the patient population for which a practice, ACO or system is accountable under alternative payment models. Practices and payers typically define this population through a process known as attribution. There are a variety of attribution models, but many assign patients based on where they receive the plurality of their primary care. Assessing plurality of care can only be completed through review of CPT-based claims data.
- **CPT codes are being used as building blocks for developing innovative, digitally enabled care bundles.** Asynchronous care modalities, such as patient messaging platforms and remote patient monitoring tools, have broadened the scope of patient-physician interactions. These models have seen increased adoption since the COVID-19 pandemic, with many digital health companies coming to market in the last five to ten years. Several digitally enabled care companies interviewed noted that their models do not fit neatly within the current fee-for-service reimbursement construct. These companies use CPT codes to define with payers a bundle of services they will provide to patients over a defined period and use a CPT-coded encounter to trigger reimbursement for such a bundle. These services may cross provider types (e.g., physicians, nurses, coaches, peers), and may be multi-modal (e.g., in-person and digital), and synchronous (e.g., face-to-face, telephone, video) or asynchronous (e.g., text/chat). This contracting model gives physicians and their care teams the ability to engage with patients digitally on a frequent basis to support patient self-management, helping improve access, clinical outcomes and experiences without triggering co-pays for every single interaction.
- **CPT enables contracting through pre-existing channels between companies offering digitally-enabled care and payers.** Without CPT built into the fabric of payer operations, payers and companies offering digitally enabled care would have to develop bespoke mechanisms for contracting and reimbursement. Codes enable payers to reimburse digital health companies through existing reimbursement channels, thereby accelerating the contracting process and potentially enhancing the willingness of payers to engage in pilots with companies offering promising new care delivery models designed to improve health outcomes. It also makes the interaction available for claims analysis, cost management and quality improvement.

Areas for continued CPT® evolution

In addition to identifying how CPT codes support VBC today, interviewees surfaced a variety of ideas and opportunities for the CPT code set to support accelerated adoption of VBC models, including:

1. **Evolving CPT codes to reflect new types of practitioners delivering health care services**, such as medical specialists, behavioral health specialists, other clinicians, coaches and peer support specialists, in team-based care models engaging both with the patient directly and with each other to ensure the patient receives the most coordinated care from the physician-led team.
2. **Supporting new care delivery models with bundled service codes**, such as for care models that rely on interaction with patients across multiple modalities (e.g., in-person, video, telephone, text/chat) and frequent brief patient interactions in-between visits.
3. **Considering how CPT might address new types of health care services being delivered**, such as how to best account for the delivery of social drivers of health (SDOH) services.

The AMA is committed to exploring these recommendations. Additionally, the CPT Editorial Panel actively reviews code change requests, monitors the health care delivery landscape, and hears from experts to ensure the code set is reflective of current medical practice and continues to evolve to support VBC delivery and payment.

Conclusion

Physicians and health systems in VBC models, VBC enablement companies, payers and digital health companies all spoke to the essential role the CPT® code set plays in supporting VBC today. It is a critical enabler of effective population health and quality management, cost management and alternative payment model contracting. As new models of VBC emerge—that involve greater use of multidisciplinary teams, digital tools and high frequency patient interactions—the AMA and the CPT Editorial Panel remain committed to evolving the code set to ensure it responds to the needs of physicians, health professionals, health systems, policymakers and payers.

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Endnotes

1 Centers for Medicare & Medicaid Services (CMS). Participation Continues to Grow in CMS' Accountable Care Organization Initiatives in 2024; Jan. 29, 2024. www.cms.gov/newsroom/press-releases/participation-continues-grow-cms-accountable-care-organization-initiatives-2024. Accessed Sept. 19, 2024.

2 Health Care Payment Learning & Action Network (HCPLAN). 2023 Measurement Effort; Oct. 30, 2023. https://hcp-lan.org/apm-measurement-effort/2023-apm/. For an orientation to value-based payment models, see https://hcp-lan.org/apm-framework/. Accessed Sept. 19, 2024.

3 Interviews were conducted with over 40 individuals across 34 organizations.

4 CMS Data. Performance Year Financial and Quality Results. Performance Year Financial and Quality Results - Centers for Medicare & Medicaid Services Data (cms.gov). Accessed Sept. 19, 2024.