

SMARTCARE: AN ALTERNATIVE PAYMENT MODEL FOR DIAGNOSIS AND TREATMENT OF STABLE ISCHEMIC HEART DISEASE

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EXECUTIVE SUMMARY

Goals

SMARTCare provides tools to help physicians and patients make evidence-based decisions about appropriate testing and treatment, materials for educating patients about testing and treatment choices, and methods for monitoring outcomes that can enable physicians and cardiovascular care providers to improve patient care and reduce costs. Widespread implementation of SMARTCare would enable patients with chest pain and other symptoms associated with heart disease to be accurately diagnosed with fewer and less expensive tests than are used today, it would enable many patients with ischemic heart disease to improve their symptoms and reduce their risk of heart attacks without undergoing expensive and risky heart procedures, and it would likely save hundreds of millions of dollars in the process.

However, the current fee-for-service payment system creates four barriers that prevent successful implementation of SMARTCare:

- Physicians are not paid adequately for the time needed under SMARTCare to properly evaluate patients' symptoms and determine the most appropriate diagnostic tests, to educate patients about the benefits and risks of testing and treatment options, and to engage in a shared decision-making process with patients in order to define an effective treatment plan.
- There is no payment for the costs of implementing and maintaining decision support tools, producing and distributing patient education materials, and maintaining and analyzing registry data required as part of SMARTCare.
- There is only limited payment for the types of support services patients need to successfully follow effective medical therapy regimens that can reduce symptoms, prevent heart attacks, and avoid expensive invasive procedures.
- Because current payments are based on the number and types of tests and invasive procedures delivered, cardiologists and hospitals will not be able to support the fixed costs of high-quality cardiac testing and treatment services if there is a significant reduction in the number of tests and procedures performed.

The SMARTCare Alternative Payment Model is designed to overcome these barriers.

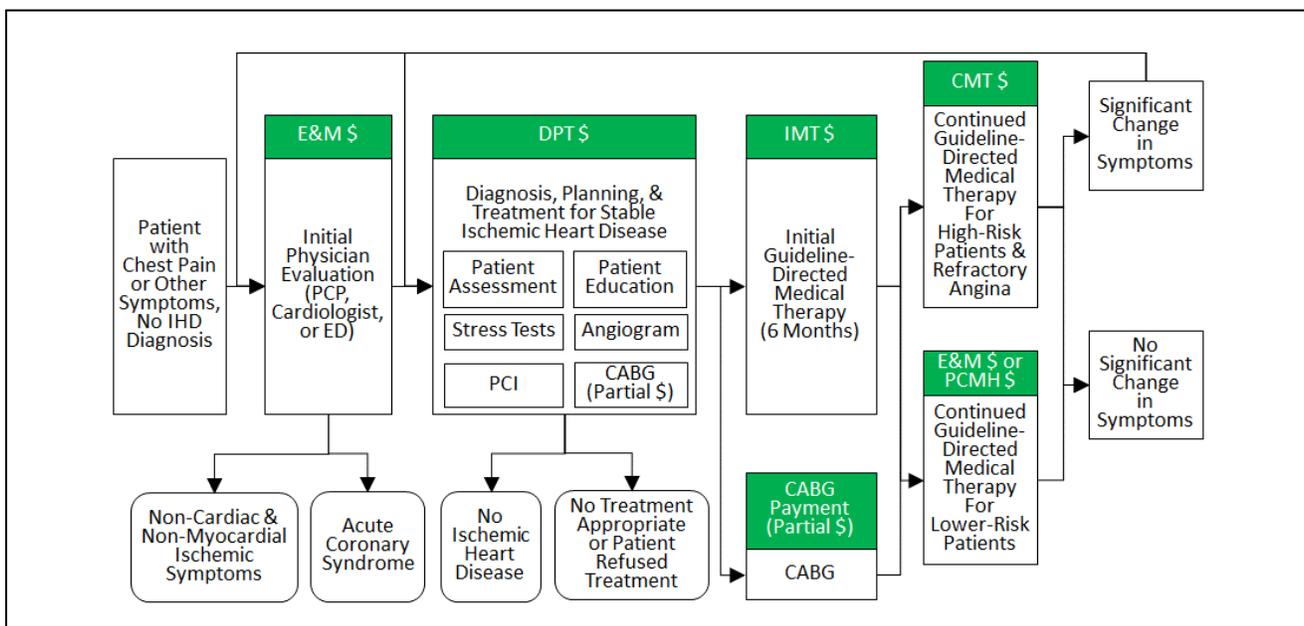
Components of the SMARTCare Alternative Payment Model (APM)

Under the SMARTCare APM, a team of cardiologists and other physicians and providers could receive three new payments to support improved diagnosis and treatment of patients with suspected and diagnosed stable ischemic heart disease. These payments would replace some, but not all, of the payments currently available under traditional fee-for-service payment systems.

1. **Payment for Diagnosis, Evaluation, and Treatment of Stable Ischemic Heart Disease (DPT Payment).** A SMARTCare Team would receive a “bundled” budget/payment to support all of the costs associated with evaluation, testing, diagnosis, and treatment planning for patients with suspected stable ischemic heart disease (IHD) and patients with known IHD whose symptoms have not responded to medical therapy or have recently worsened. The DPT payment would serve as an overall budget for any fee-for-service payments for office visits, stress tests, and imaging studies related to stable ischemic heart disease until completion of the diagnosis and treatment planning process. In addition, if the patient is determined to be

appropriate for a revascularization procedure and chooses to receive it, the cost of a percutaneous coronary intervention (PCI) and a portion of the cost of Coronary Artery Bypass Graft (CABG) surgery would be paid for through the DPT. Higher amounts would be paid for patients with more risk factors and more severe symptoms, and payments would be adjusted based on the quality of care delivered.

2. **Payment for Initial Guideline-Directed Medical Therapy for Stable Ischemic Heart Disease (IMT Payment).** A SMARTCare Team, cardiology practice, or primary care practice could receive a monthly IMT payment for up to six months to supervise Guideline-Directed Medical Therapy for a patient who has been diagnosed with new or worsened stable ischemic heart disease and who is either not appropriate for revascularization or who has chosen not to pursue revascularization at the current time. The payment would replace Evaluation & Management (E&M) payments and could be used to support not only face-to-face visits between physicians and the patient, but also telephone and email contacts with the patients, education and self-management support services from non-clinicians, and other services that would enable the patient to successfully obtain and use appropriate medications and other non-invasive therapies to manage their symptoms and to reduce the risk of a heart attack. Higher amounts would be paid for patients with more severe disease or symptoms and/or serious comorbidities. The provider would be accountable for total spending on the patient’s cardiovascular care and for the outcomes of the services delivered.
3. **Payment for Continued Guideline-Directed Medical Therapy for High-Risk IHD Patients (CMT Payment).** A SMARTCare Team, cardiology practice, or primary care practice could receive a monthly CMT payment to supervise continued Guideline-Directed Medical Therapy for patients who are at high risk of a myocardial infarction or who have refractory angina, but who are not candidates for revascularization or choose not to pursue revascularization. The CMT payment would replace Evaluation & Management (E&M) payments. A higher amount would be paid for patients with more severe disease or symptoms and/or serious comorbidities. The provider would be accountable for total spending on the patient’s cardiovascular care and for the outcomes of the services delivered.



I. GOALS OF THE SMARTCARE APM

A. Opportunities to Improve Care and Reduce Spending

Chest pain is a difficult condition to accurately diagnose. Many patients experience symptoms that are consistent with ischemic heart disease but they do not have heart disease at all or if they do have heart disease, it is not serious enough to warrant significant intervention. The most reliable method of determining the presence of disease and the patient's risk of heart attack is a cardiac catheterization, but this is an expensive, invasive procedure that carries risks of serious complications. Although there are a number of non-invasive tests and imaging studies that can help a physician in detecting the presence of ischemic heart disease, these non-invasive tests often suggest that disease is present when it is not, or that disease is more severe than it actually is, particularly when the tests are used with patients who do not have significant heart disease.

Because of a combination of factors, including inadequate payment for the time needed by physicians to adequately assess a patient's symptoms and to help patients evaluate the benefits and risks of different tests and treatments, a lack of understanding by patients and many physicians about the accuracy of diagnostic tests, and misperceptions about the ability of cardiovascular procedures to prevent heart attacks, many patients receive stress tests and imaging studies that later turn out to have been unnecessary, and some patients undergo expensive and risky revascularization procedures that have no greater benefits in improving their symptoms and reducing their risk of heart attack than could have been achieved through medications alone.

Research and demonstration projects have demonstrated that chest pain and other symptoms can be accurately diagnosed with fewer and less expensive tests than are used today, and that many patients with ischemic heart disease can improve their symptoms and reduce their risk of a heart attack without undergoing expensive and risky invasive procedures or surgery. If these approaches could be implemented more widely, patients could receive more accurate diagnoses and more effective treatments more quickly than they do today, saving hundreds of millions of dollars in the process.

B. Resolving Barriers to Better Care in the Current Payment System

SMARTCare provides tools to help physicians and patients make evidence-based decisions about appropriate testing and treatment, materials for educating patients about testing and treatment choices, and methods for monitoring outcomes that can enable physicians and cardiovascular care providers to achieve better outcomes at lower costs. However, there are several significant problems with the current fee-for-service payment system that make it impossible for most healthcare providers to implement SMARTCare in a financially sustainable way:

- **Physicians are not paid adequately for the time needed under SMARTCare to properly evaluate patients' symptoms and determine the most appropriate diagnostic tests, to educate patients about the benefits and risks of testing and treatment options, and to engage in shared decision-making with patients to define an effective treatment plan.** Low payments for office visits make it financially infeasible for primary care physicians or cardiologists to spend adequate time carrying out a physical examination and assessing the patient's symptoms, applying evidence-based guidelines to determine the appropriate options for testing and treatment, and discussing the options with patients to achieve the best decision.

It is easier, safer, and better financially for a physician to simply order a stress test or angiogram than to determine one is not necessary.

- **There is no payment for the costs of implementing and maintaining decision support tools, producing and distributing patient education materials, and maintaining and analyzing registry data required as part of SMARTCare.** Although decision support tools can reduce the amount of time needed for physicians to determine the most appropriate testing and treatment options, and patient education materials can help reduce the amount of time physicians and their staff need to explain the benefits and risks of various options to patients, these tools and materials are expensive, and physicians must pay for them out of their current revenues.
- **There is only limited payment for the types of support services patients need to successfully follow effective medical therapy regimens that can reduce symptoms, prevent heart attacks, and avoid expensive invasive procedures.** Fee for service payments are only available for face-to-face office visits between physicians and patients; there is no payment for calls and emails between patients and physicians to enable quick responses when symptoms change or when medications have side effects, and there is no payment for nurses and other healthcare professionals to educate patients about their condition and to follow up with them to ensure they are able to adhere to their treatment plan. If patients' symptoms persist because they do not use medications appropriately, they are more likely to pursue a revascularization procedure.
- **Because current payments are based on the number and types of tests, imaging studies, and invasive procedures that are currently delivered, cardiologists and hospitals will not be able to support the fixed costs of high-quality cardiac testing and treatment services if there is a significant reduction in the number of tests and procedures performed.** A community needs to have ready access to high quality cardiac testing and treatment facilities, since studies have shown that death and disability can be prevented through both rapid intervention in the case of heart attacks and through early detection and treatment of coronary artery disease. There are significant fixed costs associated with creating and maintaining imaging and cardiac catheterization laboratories so they are available when needed, but currently, the revenues to support these fixed costs are only generated when tests and procedures are performed. Consequently, a facility without a sufficient volume of tests and procedures may not be able to cover its costs. Similarly, a physician needs to perform a certain number of tests and procedures to generate the revenue needed to cover the fixed costs of maintaining a practice. Currently, the same amount is paid for tests and procedures regardless of the volume, even though the cost will differ depending on the volume. As a result, a testing/treatment facility (such as a hospital) or a physician practice could be financially harmed if SMARTCare results in a significant reduction in the number of tests or procedures.

Clearly, an Alternative Payment Model is needed to overcome these barriers so that SMARTCare can be used to ensure patients receive the right testing and treatment based on the nature and severity of their heart problems.

II. OVERVIEW OF SMARTCARE PAYMENTS

The SMARTCare Alternative Payment Model (APM) is intended to (1) support accurate diagnosis of individuals who have symptoms of, or significant risk factors for, stable ischemic heart disease, but who do not have symptoms indicative of acute coronary syndrome or an acute myocardial infarction, and (2) support evidence-based medical therapy for patients diagnosed with stable ischemic heart disease.

Under the SMARTCare APM, a team of cardiologists and other physicians and providers could receive three new payments to support improved diagnosis and treatment of patients with suspected and diagnosed stable ischemic heart disease. These payments would replace most, but not all, of the payments currently available under traditional fee-for-service payment systems for eligible patients.

A. New Payments Under SMARTCare

1. Payment for Diagnosis, Planning, and Treatment of Stable Ischemic Heart Disease (DPT Payment)

A SMARTCare Team would receive a “bundled” DPT Payment to support the costs associated with evaluation, testing, diagnosis, and treatment planning, and the cost of revascularization if it is needed, for patients who have new or worsened symptoms consistent with stable ischemic heart disease (but who are not experiencing an acute coronary syndrome).

The DPT Payment would be designed to cover:

- (a) the time members of the SMARTCare Team spend in evaluating the patient’s symptoms and discussing testing and treatment options with the patient;
- (b) the costs of performing and interpreting stress tests and imaging studies, including cardiac catheterizations, that are used in order to determine the existence and severity of ischemic heart disease;
- (c) a portion of the cost of a revascularization procedure if the patient is determined to be appropriate for the procedure and chooses to have it after engaging in a shared decision-making process with the SMARTCare Team. If a percutaneous coronary intervention (PCI), i.e., an angioplasty or stent placement, is used, the SMARTCare Team would be expected to either deliver or pay for the procedure using only the funds from the DPT Payment. If the patient receives coronary artery bypass graft (CABG) surgery, the payer would make an additional payment to the SMARTCare Team (or to the team that performs the surgery) equal to the difference between the standard fee-for-service payments for the CABG and the standard fee-for-service payment for the PCI.

The members of the SMARTCare Team would continue to bill for fee-for-service payments for any office visits, stress tests, imaging studies, or cardiac catheterizations that are performed in order to determine a diagnosis and treatment plan for a patient and for a PCI if it is performed, but a reconciliation would be performed after all of those claims have been paid in order to ensure that the SMARTCare Team received no more and no less than the amount of the DPT Payment. If the patient receives a CABG, the team performing the CABG would be paid as they normally would be, and an amount equivalent to the payment for a PCI would be deducted from the DPT Payment. SMARTCare Teams would have the option of receiving the DPT Payment as a lump sum prospective payment instead of through payments for individual services followed by reconciliation.

There would be three levels of DPT payments, with higher amounts of payment for patients with characteristics indicating a higher probability/risk of more severe ischemic heart disease, since these patients would be more likely to need more expensive testing and imaging studies, and they would more likely be appropriate candidates for and receive revascularization. Payment amounts at each level would be adjusted based on quality and outcome measures. In contrast to the current fee-for-service payment system, the amount of the DPT Payment would not be based on how many or what types of tests or procedures were performed, but instead the payment amount would be based on the patients' risk factors, symptoms, and clinical findings and on the quality of care delivered.

2. Payment for Initial Guideline-Directed Medical Therapy for Stable Ischemic Heart Disease (IMT Payment)

For patients who have been diagnosed with new or worsened stable ischemic heart disease and who (a) are not appropriate for revascularization, (b) are appropriate but have chosen not to pursue revascularization at the current time, or (c) have received a revascularization procedure and require medication to manage symptoms and reduce the risk of repeated coronary artery blockages, a SMARTCare Team, cardiology practice, or primary care practice could receive a monthly IMT payment for up to six months to assure optimal implementation and monitoring of Guideline-Directed Medical Therapy for the patient.

In contrast to the current fee-for-service payment system, the IMT payment would be designed to give the provider adequate, flexible resources to support not only face-to-face visits between physicians and the patient, but also telephone and email contacts with the patients, education and self-management support services from non-clinicians, and other services that would enable the patient to successfully obtain and use appropriate medications, lifestyle changes, and other non-invasive therapies to manage and monitor their symptoms and to reduce the risk of a heart attack.

The payment would replace Evaluation & Management (E&M) payments for face-to-face visits with the provider related to ischemic heart disease and any other cardiovascular condition during the six month period.

There would be three levels of payment, with a higher payment amount for patients with more severe disease or symptoms and/or serious comorbidities. The provider would be accountable for total spending on the patient's cardiovascular care and for the outcomes of the services delivered.

3. Payment for Continued Guideline-Directed Medical Therapy for High-Risk IHD Patients (CMT Payment)

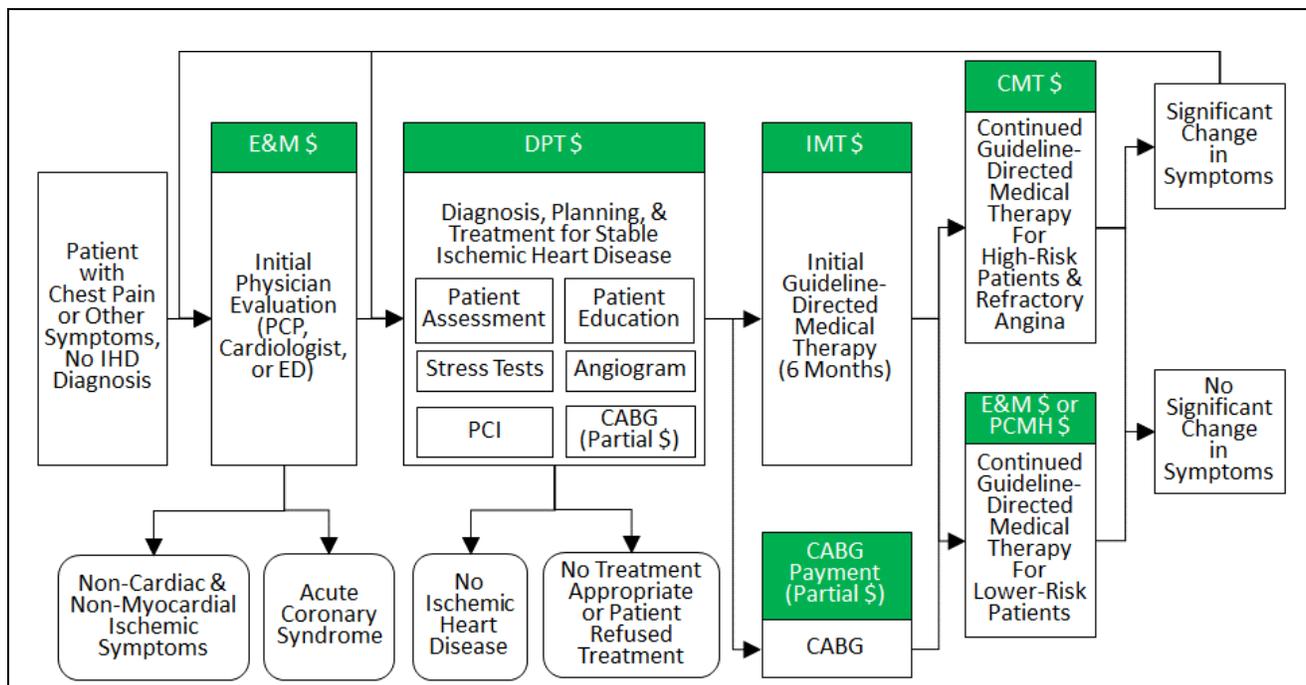
For patients who are at high risk of a myocardial infarction or who have refractory angina, but who are not candidates for revascularization or choose not to pursue revascularization, a provider could receive a monthly CMT payment to supervise continued Guideline-Directed Medical Therapy after the completion of the initial six months of treatment supported by IMT Payments. The CMT payment would enable the provider to serve as a "specialty medical home" for these patients.

The CMT payment would replace Evaluation & Management (E&M) payments for face-to-face visits with the provider that also related to ischemic heart disease and any other cardiovascular condition during the six month period. There would be two levels of payment, with a higher payment amount for patients with more severe disease or symptoms and/or serious comorbidities. The provider Team would be accountable for total spending on the patient's cardiovascular care and for the outcomes of the services delivered.

B. Continued Payments for Other Services Related to Ischemic Heart Disease

In addition to the new DPT, IMT, and CMT payments, SMARTCare Teams and providers providing care for patients with IHD would continue to receive separate payments for the following services:

- Initial Evaluation of Symptoms.** Primary care physicians, emergency physicians, and cardiologists (including physicians on the SMARTCare Team) would continue to be paid separately for an initial evaluation to determine (a) that the patient was not experiencing an acute coronary syndrome and (b) that the patient’s symptoms were consistent with ischemic heart disease and required evaluation through the DPT-supported services. The payment for this initial evaluation would be through a standard Evaluation & Management Services payment, a Primary Care Medical Home payment, or another Alternative Payment Model. If the evaluation to rule out an acute coronary syndrome is performed by a physician on the SMARTCare Team, then the physician would bill for an E&M Service payment for that initial evaluation, and then the SMARTCare Team could also bill for the DPT payment if the patient was determined to be eligible.
- Primary Care Management of Low-Risk Patients.** After a patient with low-risk SIHD successfully completes six months of Guideline-Directed Medical Therapy, their ongoing care would generally be delivered by their primary care physician or, if they do not have a PCP, by a cardiologist on the SMARTCare Team. This ongoing care would be supported by standard payments under the Physician Fee Schedule, by a Primary Care Medical Home Program, or another Alternative Payment Model for long-term management of chronic cardiovascular disease.



C. Payments for Tests and Imaging Studies Ordered or Performed by Others

Ideally, all diagnostic testing and imaging services for patients with suspected or confirmed stable ischemic heart disease would be ordered by and performed by members of a SMARTCare Team. However, to address situations in which primary care physicians order stress tests without consulting a cardiologist and situations in which testing and imaging providers are not part of the same organizations as cardiologists, the following rules would apply:

- Any stress test, imaging study, or cardiac catheterization performed at a physician office, hospital, or other facility that is part of a SMARTCare Team, regardless of who ordered the procedure, would be paid for through the DPT payment unless there was documentation that it was performed for an acute coronary syndrome or for an indication other than ischemic heart disease. If a stress test or imaging study is ordered by a primary care physician or other provider who is not part of the SMARTCare Team, the SMARTCare Team could refuse to perform the test or imaging study if the Team did not feel it was necessary or appropriate for the patient.
- The cost of any stress test, imaging study, or cardiac catheterization ordered by a physician who is part of a SMARTCare Team (for a patient insured by a payer using SMARTCare payments), regardless of where the procedure was performed, would be paid for through the DPT payment to the SMARTCare Team, unless there was documentation that the test or procedure was ordered for an acute coronary syndrome or for an indication other than ischemic heart disease, in which case the test or procedure would be paid for through fee-for-service.

If a patient receives a stress test, imaging study, or cardiac catheterization from a non-SMARTCare provider that was ordered by a non-SMARTCare provider without documentation of acute coronary syndrome or an indication other than ischemic heart disease, payment for that procedure would depend on the accessibility of SMARTCare providers and the benefit design in the patient's health insurance. The health insurance plan could choose not to cover such a test at all or it could charge the patient a higher cost-sharing amount for such a test if it is reasonable to expect that the patient could have seen a member of the SMARTCare Team to carry out the diagnosis and treatment planning process. (Because an acute coronary syndrome would have already been ruled out before a patient could participate in SMARTCare, the decision about which SMARTCare Team to use would not need to be made on an emergency basis.)

If a patient receives a stress test or imaging study that was ordered and delivered by non-SMARTCare providers, and the patient then comes to a SMARTCare Team for diagnosis and treatment planning, the SMARTCare Team would not be responsible for the cost of the initial test/study. If the SMARTCare Team would not have ordered the stress test or imaging study on its own (e.g., for a low-risk or asymptomatic patient), but there was a positive finding on the test or study, then the SMARTCare Team will receive a higher DPT payment than it would otherwise have received because of the need to confirm the finding from the test/study.

D. Encouraging Participation by Independent Primary Care Physicians

Currently, a large proportion of stress tests are ordered by primary care physicians, and some primary care practices perform treadmill stress tests even if they do not perform other types of cardiac tests or imaging studies. Many of these tests are unnecessary and false positive results can lead to additional tests and procedures. Although payers could discourage primary care practices from ordering or performing these tests and encourage them to refer all patients with suspected ischemic heart disease

to SMARTCare Teams, this may not be practical in many communities, particularly in rural areas. Moreover, most patients who present with chest pain symptoms are found to be low-risk patients, so it would be desirable if low-risk patients could be identified and managed by the primary care physician, so that referrals to a cardiologist would be made only for patients who need more expert evaluation or additional testing.

However, in order for a primary care practice to perform this initial screening, it would need to use some of the same kinds of decision support tools that a SMARTCare Team would use to determine the patient's pre-test probability of ischemic heart disease and to assess the severity of their symptoms. There is both a financial cost to license these tools and time required to use them, and it would be unreasonable to expect primary care practices to incur these costs without financial support. It would also be unlikely that practices would be able to install and use the tools properly without technical support from a SMARTCare Team.

To address this, primary care practices and SMARTCare Teams could enter into contractual arrangements in which the primary care practices would receive financial and technical support from the SMARTCare Team for making initial assessments of patient risk and symptoms, and the SMARTCare Team would then complete the assessment and treatment planning process for patients who met a minimum threshold of symptoms and risk factors.

E. Episode Length for Diagnosis, Planning, and Treatment Payment

There are multiple steps involved in diagnosis, planning, and treatment of patients who may have ischemic heart disease, and the length of time required to complete these steps will vary from patient to patient. For some patients, the severity of symptoms or the findings on initial tests may cause a SMARTCare Team to complete all of the steps within a few hours or days. For other patients, all of the steps needed to determine a diagnosis, decide on a treatment plan, and initiate the chosen treatment may take weeks or even months.

The Diagnosis, Planning, and Treatment (DPT) Payment would be designed to cover all visits, tests, and imaging studies that the patient received in order for the SMARTCare Team to complete the process of determining a diagnosis and preparing a treatment plan through a shared decision-making process with the patient. Any visits, tests, or imaging studies that were performed or ordered by a SMARTCare Team within one year after the initial visit with the patient would be paid for through the DPT Payment. In addition, if the patient received a revascularization procedure, the procedure would be paid for through the DPT Payment if it was performed within 6 months following the completion of the patient's treatment plan, unless the procedure was performed following a diagnosis of an acute myocardial infarction (AMI) or documented acute coronary syndrome (ACS).

III. DETAILS OF PAYMENT FOR DIAGNOSIS AND TREATMENT PLANNING

A. Physicians and Providers Eligible to Receive SMARTCare DPT Payments

In order to be eligible to receive a SMARTCare Diagnosis, Planning and Treatment (DPT) Payment, a physician practice, health system, or joint venture of multiple provider organizations would need to be designated as a SMARTCare Team. In order to receive the designation, the provider would need to agree to:

- meet minimum quality standards defined in Section III-H, including implementing SMARTCare decision-support and shared decision-making tools;
- accept the SMARTCare DPT payment as payment in full for *all* of the services in the categories defined in Section III-C for any eligible patient who received at least one of those services from members of the SMARTCare Team;
- agree that the SMARTCare payment would also cover any of the services in the categories defined in Section III-C if they were ordered for an eligible patient by a member of the SMARTCare Team for an eligible patient but were delivered by a provider who is not a member of the SMARTCare Team; and
- report information on appropriate use, quality, utilization, and outcomes as defined in Section III-H.

Ideally, the SMARTCare Team would include primary care physicians, cardiologists, and one or more hospitals who collectively deliver a full range of cardiac testing and treatment services to patients with ischemic heart disease. However, an independent cardiology practice could also serve as a SMARTCare Team if the practice receives the necessary support from payers and if it develops relationships with other providers to deliver services not provided by the practice. Because the DPT Payment is a bundled payment intended to cover a range of services, the SMARTCare Team would need to be able to control whether those services were delivered to the patients and it would need to know the amount that would be paid for those services.

B. Patients Eligible for the SMARTCare DPT Payment

A SMARTCare Team would be eligible to receive a SMARTCare DPT Payment for a patient who:

- has not been treated for ischemic heart disease and who is experiencing chest pain or other symptoms consistent with stable ischemic heart disease (e.g., exercise-induced angina);
- has been or is being treated for stable ischemic heart disease and is now experiencing a significant worsening of symptoms; OR
- is being evaluated for surgery or another procedure where cardiac risk needs to be assessed.

A patient who met one or more of the above criteria would be **excluded** from eligibility for the SMARTCare DPT Payment if:

- the symptoms they experience at any point are indicative of acute coronary syndrome (ACS);
- the testing or imaging performed results in a determination that they have experienced an acute myocardial infarction within the previous month or they are at imminent risk of an AMI;
- they have problems with one or more heart valves that warrant a corrective procedure;
- they received Coronary Artery Bypass Graft surgery during the preceding six months; OR
- they have had a heart transplant or surgical correction of cyanotic congenital heart disease

For patients meeting the exclusion criteria, the SMARTCare Team would be paid for any services delivered to those patients through standard fee for service payments or through a different alternative payment model.

In order for the SMARTCare Team to receive the DPT Payment for an eligible patient, and in order for the patient to benefit from the enhanced services available through the payment, the patient would be asked to agree to receive all cardiac testing and imaging services related to stable ischemic heart disease from the members of the SMARTCare team, or from other providers designated by the Team, until the Team completes the process of developing a treatment plan for the patient. However, if a patient sought a test or treatment service for stable ischemic heart disease from a physician or provider that was not part of the SMARTCare Team without an order or referral from the SMARTCare Team, the SMARTCare Team would not be held responsible for the cost of that test or treatment. Moreover, if the patient was experiencing the symptoms of an acute coronary syndrome, the patient would be encouraged to receive evaluation, testing, and treatment at an emergency room, and the patient's health insurance plan would pay for those services separately.

A patient would be free to change to a new SMARTCare Team at any time if the patient was not satisfied with the quality of care they were receiving. If the patient changed to a new SMARTCare Team before the initial Team had completed the testing needed to render a diagnosis, the initial Team would be paid on a fee-for-service basis for any tests or procedures it delivered, and it would no longer be eligible to receive a DPT Payment for that patient.

A SMARTCare Team could only receive a second DPT Payment for the same patient if a diagnosis and treatment plan had been completed as part of the first DPT Payment and if either:

- at least 6 months had passed since the original diagnosis and treatment plan was completed; or
- the patient reports more severe symptoms and they qualify for a higher category SMARTCare payment than during the previous diagnosis and treatment planning process. (For example, the SMARTCare Team received a Level 2 DPT Payment during the previous diagnosis and

treatment planning process, but the patient qualifies for a Level 3 DPT Payment when they are re-evaluated two months later.)

C. Services and Costs Covered by the SMARTCare DPT Payment

Services/Costs Included

The SMARTCare DPT Payment would serve as a budget designed to be sufficient, on average across a group of eligible patients with similar cardiac risk characteristics, to cover the costs of any or all of the following services as needed to determine a diagnosis and agree on a treatment plan for stable ischemic heart disease:

- All visits and phone or email contacts with cardiologists and other members of the SMARTCare Team for the purposes of diagnosis of an eligible patient's symptoms, planning for treatment of their ischemic heart disease, and referral to other physicians for treatment of conditions other than IHD.
- All laboratory tests, electrocardiograms, stress tests, and diagnostic imaging studies, including cardiac catheterizations, received by an eligible patient for the purposes of diagnosis and treatment planning for stable ischemic heart disease. Laboratory tests, imaging studies, and angiograms delivered in conjunction with an emergency room visit for a patient determined to have the symptoms of acute coronary syndrome would be paid for separately.
- The costs of the shared decision-making tools and the time that members of the SMARTCare Team spend in educating patients about ischemic heart disease and the options available for treating it.
- The costs of the decision support tools and registries needed to support SMARTCare.
- The time required for cardiologists and primary care physicians on the SMARTCare Team to use SMARTCare tools.
- The time spent by SMARTCare cardiologists to communicate with patients' primary care providers and other physicians in developing a diagnosis and treatment plan.
- A portion of the cost of a revascularization procedure if it is deemed to be appropriate for the patient and if the patient chooses to receive the procedure. If a percutaneous coronary intervention (PCI), i.e., an angioplasty or stent placement, is used, the SMARTCare Team would be expected to either deliver or pay for the procedure using only the funds from the DPT Payment. If the patient receives coronary artery bypass graft (CABG) surgery, the SMARTCare Team (or to the team that performs the surgery) would receive an additional payment equal to the difference between the standard fee-for-service payments for the CABG and for the PCI. (Because the amount paid for a CABG is much larger than what is paid for a PCI, requiring the DPT payment to cover the full cost of either approach could create an undesirable incentive to do a PCI when a CABG would be better for the patient.)

Services/Costs Excluded

The SMARTCare payment would **not** be expected to cover the following services for eligible patients; these services would continue to be billed and paid for separately:

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- A visit with a primary care physician, emergency physician, or cardiologist to determine that the patient was eligible for the DPT Payment and that the patient did not require treatment for an acute coronary syndrome.
 - Laboratory tests, stress testing, imaging, or angiography when used for diagnosis of symptoms other than chest pain or cardiac and myocardial ischemic symptoms or when used as part of treatment for a non-cardiac condition.
 - Testing, imaging, or angiography that resulted in a diagnosis of a myocardial infarction or a cardiac condition other than stable ischemic heart disease.
 - A visit with a cardiologist who is not part of the SMARTCare Team for a second opinion regarding the diagnosis and/or treatment plan recommended by the SMARTCare Team.
 - The difference between the standard payment for coronary artery bypass graft (CABG) surgery and a PCI.
 - Prescription medications for treatment of ischemic heart disease.
 - Services associated with Guideline-Directed Medical Therapy for patients who qualify (as described in Section IV).

D. Stratification of DPT Patients

Individuals experiencing the types of symptoms associated with stable ischemic heart disease differ significantly in the frequency and severity of the symptoms they experience, the ease with which a diagnosis for their symptoms can be determined, the ability of different treatments to resolve their symptoms, and the ability of different treatments to slow or reverse their disease and to prevent heart attacks. These factors can affect three things:

1. the amount of time that the SMARTCare Team would need to spend in determining a diagnosis and discussing treatment options with the patient;
2. the number, types, and cost of tests and imaging studies that would be needed to establish a diagnosis and define an appropriate treatment plan; and
3. the outcomes that can be achieved for the patient in terms of both symptoms and heart attacks.

To address these differences in time, resources, and outcomes, patients receiving services supported by the DPT Payment would be stratified into the three categories shown in Table 1. These three categories would be based on (1) the American College of Cardiology's Appropriate Use Criteria categories for testing and imaging for stable ischemic heart disease, and (2) the results of any testing and imaging studies that are performed, including cardiac catheterization.

- Level 1 represents patients for whom ACC Appropriate Use Criteria did not indicate that testing was "appropriate" and for whom no testing is performed or, if testing was performed, the tests did not indicate that the patient was likely to be at significant risk of a heart attack.
- Level 2 represents patients for whom ACC Appropriate Use Criteria indicated that testing was "appropriate" but who did not undergo cardiac catheterization as a result of the testing or, if they did, the study did not show severe coronary artery blockage. In addition, Level 2 would include patients for whom testing was not "appropriate" but who did undergo testing and the tests showed that the patient had high risk of a coronary artery blockage.
- Level 3 represents patients who underwent cardiac catheterization (regardless of whether ACC Appropriate Use Criteria indicated the procedure was "appropriate") and a serious coronary artery blockage was found.

The payments for the higher-numbered DPT billing codes would be higher than the payments for the lower-numbered billing codes, since patients who met the criteria for the higher-numbered billing codes would be more likely to receive stress tests, cardiac catheterizations, and revascularization than patients who only met the criteria for the lower-numbered billing codes.

The actual payment amounts for the different codes (or their relative values) would be determined using the process described in Section III-I. The amount of the Level 1 Payment would be intended to adequately support the time and decision-support tools that the SMARTCare Team would need to fully evaluate the patient's symptoms in order to determine that no further testing was needed and to develop an appropriate plan for addressing the patient's symptoms and risk factors.

Although the SMARTCare would likely initially be paid for the specific tests and services it delivered (as explained in Section III-E), the ultimate payment to the SMARTCare Team would be based on the DPT Category, not on the number or types of services or procedures performed.

Table 1
Payment and Performance Subcategories for
Evaluation of Stable Ischemic Heart Disease

Payment Category	Billing Code	Appropriateness of Stress Testing Based on ACC Criteria	Results of Testing/Imaging
Level 1	xx001	Not Appropriate	No Testing or Low Risk Findings
Level 2	xx002	Not Appropriate	High or Intermediate Risk Findings
		Appropriate	
Level 3	xx003	N/A	FFR <0.75 or IFR <0.85 in left main coronary artery or in 2+ vessels

The category definitions in Table 1 could serve as part of the overall system of “patient condition groups” Congress required be created under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

For example:

- A patient comes to a SMARTCare Team physician complaining of chest pain symptoms that are consistent with stable ischemic heart disease. The physician conducts a thorough history and physical on the patient, and after applying ACC Appropriate Use Criteria, the physician determines that it is unlikely that the patient has sufficiently severe heart disease to warrant further testing or an invasive procedure. However, the patient does have risk factors that could lead to more serious heart problems in the future. The physician educates the patient about these risk factors, and then helps the patient develop a plan for lifestyle modifications and other actions that could significantly reduce their risk. The patient is classified as a Level 1 patient, and the Level 1 payment provides sufficient payment to enable the physician to spend adequate time evaluating the patient, applying the Appropriate Use Criteria, educating the patient about risk factors, and helping the patient develop a plan for reducing their risk of heart disease.
- A second patient comes to a SMARTCare Team physician complaining of chest pain consistent with stable ischemic heart disease. The patient is classified as a Level 1 patient based on their low risk score and mild symptoms. Despite the fact that further testing of any kind is not considered appropriate, the physician orders a cardiac catheterization, and the angiogram indicates no significant narrowing of the coronary arteries. The SMARTCare Team would only receive a Level 1 payment for this patient, even though an expensive angiogram was performed.
- A third patient comes to a SMARTCare Team physician complaining of chest pain consistent with stable ischemic heart disease and the patient is classified as a Level 1 patient based on their risk score and symptoms. However, the physician is concerned about the nature of the

symptoms and orders a cardiac catheterization, and significant blockage of the coronary arteries is found. The SMARTCare Team would receive a Level 3 payment for this patient, since the angiogram confirmed the physician's suspicion that the patient had a higher risk than the risk assessment tools indicated.

- A fourth patient comes to a SMARTCare Team and is classified as a Level 2 patient because the ACC Appropriate Use Criteria indicate that stress testing is appropriate based on their high pre-test probability of ischemic heart disease and the problematic symptoms they are experiencing. Stress testing is performed and indicates that the patient is likely to have significant ischemic heart disease. However, after discussion with the physician about the risks and benefits of treatment, the patient concludes that he would not agree to a revascularization procedure even if an angiogram indicated it would be appropriate. The physician prescribes medication for the patient to help relieve his symptoms and to reduce the risk of AMI, but orders no further testing (since it would not change the course of treatment). The SMARTCare Team would receive a Level 2 payment for this patient.
- A fifth patient comes to a SMARTCare Team and is deemed appropriate for stress testing based on their history and symptoms. Stress testing returns a high risk result and the patient receives a cardiac catheterization. The catheterization shows only limited blockage of the coronary arteries ($\text{FFR} > 0.75$ or $\text{IFR} > 0.85$), but the physician inserts a stent in order to provide the patient with symptom relief. The SMARTCare Team would receive a Level 2 payment for this patient, since the patient was at low risk of a heart attack and could have received medication therapy instead of a stent.

E. Payment of Claims and Disbursement of the DPT Payment

1. Implementation Through Retrospective Reconciliation

In order to facilitate the ability of both payers and the members of SMARTCare Teams to participate in the SMARTCare Alternative Payment Model, the default approach to implementing the DPT Payments would be through use of a “retrospective reconciliation” methodology. Under this approach, all physicians and other providers on the SMARTCare Team would continue to file fee-for-service claims for all of the visits, tests, and procedures they delivered to eligible patients, and they would be paid for those claims in the same way other providers are paid. The DPT payment would be treated as a “virtual budget” for all of these payments, and the reconciliation process would ensure that ultimately, on average, the SMARTCare Team received no more and no less than the amount of the DPT Payment for those eligible patients.

This process would work as follows:

Step 1: Submission of Claims for Individual Services Delivered to DPT Patients

The physicians and providers on the SMARTCare Team would submit claims forms using appropriate CPT or HCPCS codes describing all services that were delivered to a patient who is eligible for DPT Payment, including all of the services that are listed in Section III-C.

In order to enable SMARTCare Teams to engage in a shared decision-making process with patients, a new CPT or HCPCS code would be created so that SMARTCare Teams could bill directly for this service for patients who were eligible for the DPT Payment (e.g., xxx04). The payment amount for the new SMARTCare Shared Decision-Making Payment billing code would be designed to cover the time and materials involved in the shared decision-making process. The SMARTCare Shared Decision-Making Payment would not represent an increase in spending, since it would ultimately be reconciled against the DPT Payment.

Step 2: Triggering the DPT Payment Reconciliation Process.

When the SMARTCare Team completed the diagnosis and treatment planning process, it would submit a claim to the payer with one of the DPT codes listed in Table 1. This would represent a certification by the SMARTCare Team that the patient met the eligibility criteria described in Section III-B and the characteristics for the appropriate Level listed in Table 1. If the treatment plan included a revascularization procedure, the DPT claim would be filed after the revascularization procedure had been performed and a claim had been submitted for that procedure.

If the SMARTCare Team delivered one of the services listed in Section III-C to a patient who met the exclusion criteria described in Section III-B, the SMARTCare Team would include a new code (xxx00) on the claim form to indicate that the patient was not eligible for the DPT Payment and a standard fee-for-service payment should be paid for the service with no reconciliation.

If the payer received a claim from a physician or other provider on a SMARTCare Team for one of the services listed in Section III-C but did not receive a claim for one of the DPT codes within 6 months, the payer would assign the patient to the Level 1 DPT payment. Similarly, if a physician or other

provider who is not on the SMARTCare Team submitted a claim for one of the services listed in Section III-C that was ordered by a physician on a SMARTCare Team, the payer would assign the patient to a Level 1 DPT payment.

If two SMARTCare Teams both filed a DPT claim for the same patient during the same window of time, the DPT payment would be assigned to the provider who had separately billed for the most expensive test or treatment.

Step 3: Reconciliation of Claims Payments

The payer would make the following calculations and adjustments to payments:

- The payer would determine the DPT Payment amount based on the DPT Level to which the patient had been assigned.
- The payer would tabulate all payments it had made for claims for any of the individual services described in Section III-C that had been delivered to the patient up to six months prior to the date that the claim indicates the treatment plan was completed.
- If the cumulative payments for the individually billed services were less than the DPT payment amount, the SMARTCare Team would receive a payment equal to the difference.
- If the cumulative payments that had already been made exceeded the DPT payment amount, the SMARTCare Team would be required to refund the difference to the payer.

Although these calculations would be done on a patient-by-patient basis, the actual payments could be cumulated across all of a particular payer's patients seen by the SMARTCare Team over the six month period covered by the payments, and the SMARTCare Team would only be required to make a refund to the payer if the total claims paid for testing and procedures for all of those patients exceeded the total applicable SMARTCare payments for those patients. For SMARTCare Teams with small numbers of patients, a longer reconciliation period could be used in order to smooth out the inherent patient-to-patient variation in actual expenses compared to the budget defined by the SMARTCare payment amounts.

If the payer received a claim for one or more of the services described in Section III-C within 6 months after the date of the DPT Payment claim, a second reconciliation would be performed to adjust for the payments made for those additional services.

In contrast to many "shared savings" payment models, the DPT Payment amount would be established before the beginning of the year, so that the SMARTCare Team would know exactly the amount of resources they would be receiving for each patient prior to the delivery of care.

2. Prospective Payment Approach to SMARTCare Payment

If the members of the SMARTCare Team delivered all or most of the services that would be supported by the DPT payment (i.e., the services listed in Section III-C) and if the Team had the organizational ability to accept and allocate a bundled payment among the Team members, then the Team could receive a "prospective" DPT Payment. The Team would not submit claims to payers for individual services to eligible patients, but instead would receive the payment amount associated with the DPT Level assigned to the patient. (Alternatively, claims could still be submitted for individual services in order for both the payer and SMARTCare Team to track what services the patient received, but no payment would be made for these claims.)

If the payer received a claim from a non-SMARTCare Team provider for delivery of one of the services listed in Section III-C to a patient for whom a DPT Payment had been triggered, the payer would pay that claim, but the SMARTCare Team would be responsible for reimbursing the payer for the payment. As an alternative, the payer and SMARTCare Team could agree that the payer would withhold a portion of the DPT payment until the end of the six month DPT time period, and then adjust the remaining payment based on the amount of any claims paid to other providers.

If a physician or provider on the SMARTCare Team needed to perform one of the services described in Section III-C for a patient who was not eligible for the DPT payment, a claim with the xxx00 code would need to be submitted to explicitly indicate that the patient was not eligible and that the service should be paid separately from SMARTCare.

F. Protecting Payers and SMARTCare Teams Against Excessive Risk

Payers, SMARTCare Teams, and patients will naturally be concerned about whether the DPT Payment amounts will be higher than necessary or too low to support appropriate patient care. This will be particularly true when the DPT Payments are first implemented, because there will be limited experience on which to determine the appropriate payment amounts for each of the four DPT Payment Levels. Moreover, although the DPT Payments will provide flexibility for SMARTCare Teams to redesign the way they deliver care, significant changes will take time to implement.

To address this, “risk corridors” would be established, i.e., limits on the amount by which the DPT payments can differ from the total amount that would have been paid for the actual services delivered to the patients. This could be done under either the retrospective reconciliation or prospective payment options, using a methodology similar the process under retrospective reconciliation. The risk corridor limits could increase over time as experience was gained in setting the DPT Payment Levels accurately.

- The total amount that was paid (or would have been paid) for the individual services delivered to eligible patients during a specific period of time would be determined based on the claims that were filed.
- This total would be compared to the total DPT payments that were paid or payable to the SMARTCare Team for the eligible patients.
- If the total amount that was or would have been paid for the individual services delivered exceeded the total DPT payments by more than 2%, the SMARTCare Team would receive an additional payment equal to 50% of the amount in excess of 2%. If the total amount that was or would have been paid exceeds the total DPT payments by more than 4%, the SMARTCare Team would receive an additional payment equal to 100% of the amount in excess of 4%.
- Conversely, if the total DPT Payments exceeded the amount that was or would have been paid for the individual services by more than 2%, the SMARTCare Team’s DPT payments would be reduced by an amount equivalent to 50% of the amount in excess of 2%. If the total DPT Payments exceeded the amount that was or would have been paid for the individual services by more than 4%, the SMARTCare Team would repay (or not receive) 100% of the payments in excess of 4%.

G. Patient Cost-Sharing

The patient's cost-sharing for testing, imaging, and other services should be based in part on the payment amounts for the actual tests and procedures the patient received, rather than as a flat percentage of the DPT Payment amount. Although the DPT Payment would be designed to reduce spending for a purchaser or health plan across a population of patients compared to what the payer would have spent if payments had been made based on the number and types of services, an individual patient would be penalized if he or she had to pay cost-sharing based on average spending even though they used fewer or lower-cost services than average for their payment category. Conversely, patients might demand that physicians order more expensive tests than were necessary if the cost to the patient were the same regardless of what tests were actually used. However, cost-sharing should be limited for patients who need expensive tests or procedures so that they do not avoid receiving them solely to avoid the cost.

If possible, the cost-sharing amounts for individual services should not be set using either a flat copayment per service or a fixed percentage of the total payment as is the case in most common benefit designs. Instead, the cost-sharing amount for an individual service should be based on the value that service has in achieving good outcomes for the patient. For example, if the SMARTCare Team is paid an additional amount for engaging in a shared decision-making process with a patient, the patient should not have to contribute a portion of the payment because the service will likely help to discourage unnecessary testing and treatment, saving more money overall than the cost-sharing amount would contribute.

H. Accountability for Outcomes

1. Minimum Quality Standards

The SMARTCare Team would be required to meet the following standards in order to bill for the DPT Payment for a patient. These standards would apply to the full 6 month period in which the DPT Payment is billed; they would not need to be repeated or re-documented during each month.

- Have at least one face-to-face visit with the patient and a physician on the SMARTCare Team;
- Utilize the American College of Cardiology's Appropriate Use Criteria in determining what types of tests, if any, should be ordered.
- Obtain and score a Seattle Angina Questionnaire before the treatment plan is completed;
- Obtain and score a decision quality assessment when the treatment plan is completed;
- Determine a diagnosis for the patient's symptoms and document the basis for the diagnosis;
- Document the presence of any major comorbidities or other factors that would affect the appropriate treatment options for the patient;
- Using a shared decision-making process in partnership with the patient and the patient's family or significant others, develop a written treatment plan for the patient that is consistent with guidelines promulgated by the American College of Cardiology and that the patient is willing to follow.
- Make a follow-up contact with the patient via phone, email, or office visit six months after a diagnosis was determined and a treatment plan was agreed upon, in order to reassess the patient's symptoms using the Seattle Angina Questionnaire and reassess the patient's evaluation of the quality of the decision-making process (or document in the patient's records that reasonable attempts were made to contact the patient);
- Submit data on each patient to the relevant registries managed by the American College of Cardiology (NCDR-PCI and PINNACLE), including the High Value Concentrated SMARTCare Measures.
- Agree to public reporting of the High Value Concentrated SMARTCare Measures

2. Performance-Based Payment

Outcome Measures

The following four outcome measures would be calculated on a quarterly basis for patients eligible for DPT payments:

1. % of patients with an emergency department visit for chest pain during the time period in which the services covered by the DPT Payment were delivered and for six months after the treatment plan was completed;
2. % of patients with a hospital admission for acute coronary syndrome or AMI during the same time period;

3. % of patients triggering a new DPT Payment during the six months following the completing of a treatment plan supported by a previous DPT Payment; and
4. % of patients reporting worsening of symptoms six months after the treatment plan was completed.

The first three measures would be calculated by the payer based on claims data; the fourth measure would be calculated by the SMARTCare Team based on the results of the Seattle Angina Questionnaire administered six months after the claim for DPT Payment was filed. These measures would be calculated separately for patients in each the three categories defined in Section IV-D. If there are fewer than 10 patients in a category who have completed a six month episode during a calendar quarter, the measure would be calculated based on the prior six or twelve months of data.

Performance Standard

The average performance on each of the outcome measures in each patient category would be calculated for all SMARTCare Teams during the most recent 6 months for which data are available. These averages would serve as the performance standard for SMARTCare Teams during the current year.

Determination of Performance Ratings

A SMARTCare Team's performance on each of the outcome measures would be rated by comparing the Team's performance to the performance standard for the current year in each patient category. As long as the Team's performance on a measure was within normal statistical variation around the applicable standard, the Team's performance would be deemed "good performance." If performance was significantly better than this range, it would be deemed "excellent performance," and if it was significantly worse, it would be deemed "poor performance." If there were too few patients in a category to compute a reliable rating, the Team would be deemed to have "low volume" in that category and the Team's payment would be treated the same as if it had been rated "good performance."

The SMARTCare Team's overall performance would be determined based on its performance on all four measures for all patient categories. If the Team's performance on any one of the measures for any patient category was "poor," the Team's overall performance would be deemed "poor." If the Team's performance on at least three of the four measures for at least three of the four categories was deemed "excellent" and performance on the remaining measures was "good," then the Team's overall performance would be deemed "excellent."

Adjustment of Payment Based on Performance

The SMARTCare Team would receive the default payment level for the DPT for each eligible patient in a particular category during the next year if the Team's overall performance during the most recent measurement period was "good." The payment would be increased during the following year if the overall performance rating was "excellent." Similarly, the payments would be reduced during the subsequent year if performance on one or both of the measures was "poor."

The maximum increases and decreases would initially be $\pm 4\%$ and then would increase over time to $\pm 9\%$.

Minimum Standard of Performance

If a SMARTCare Team received “poor” ratings for two or more categories of patients, the Team could be dropped from the SMARTCare payment program.

3. Appropriate Determination of Patient Eligibility

If the SMARTCare Team performs cardiac catheterization procedures, the Team would be required to report on the findings from angiograms performed on all patients who were not determined eligible for the SMARTCare DPT payment. If a significantly higher-than-average proportion of such patients had low-risk findings, further analysis would be performed to determine whether patients were inappropriately being determined ineligible for DPT payments, and if so, the SMARTCare Team could be dropped from the SMARTCare program.

I. Determining DPT Payment Amounts

Setting Initial Payment Amounts

The initial payment amounts of each of the SMARTCare payments would be determined using the following steps:

- 1. Estimate Expected Utilization of Services for Each Category of Patient.** For each of the three DPT payment categories defined in Section IV-D, the expected number and types of tests and services would be estimated based on national or local data where appropriate use criteria have been applied. It is expected that the number of tests performed would be significantly reduced under SMARTCare compared to current levels.
- 2. Determine the Average Cost of Each Service at the Expected Total Levels of Utilization Across All DPT Payment Categories.** The current fees for each individual service are based on the historical average cost of delivering services at current levels of service volume. However, because there are significant fixed costs associated with cardiovascular testing and imaging facilities and equipment, the average cost will increase as the volume of services decreases. The new average cost would need to be estimated at the expected levels of utilization.
- 3. Calculate the Total Expected Cost of Delivering the Expected Number and Types of Services for Each Category of Patient.** For each category of patients, the expected number of each type of service that would be delivered to the patients would be multiplied by the new expected average cost of that service, and the products would be summed to estimate the total expected cost of services in that category.
- 4. Calculate the Payer's Current Spending Per Eligible Patient at Current Levels of Utilization.** This could be determined either by (a) multiplying current utilization rates by current payment amounts and summing the products, or (b) calculating the total average spending per patient on the types of services covered by SMARTCare.
- 5. Set Payment Amounts for Each DPT Payment Level.** The payment amounts for each DPT Payment category would be set at an amount that is higher than the expected cost of delivering services in that category that was determined in Step 3 (so that the SMARTCare Team providers have a positive operating margin), but such that the total expected spending across all categories would be less than the current spending calculated in Step 4 (so that the payer saves money). If the expected spending is higher than current spending, then the expected utilization levels or average costs of delivering services will need to be revised downward. In contrast to many "shared savings" payment models, these calculations would be performed before SMARTCare services are first delivered, so that both the SMARTCare Team and the payer would know how much would be paid for patients in each category.

Adjusting Payment Levels Over Time

The calculations used to determine initial payment levels would be based on both the state of knowledge about appropriate care and the costs for delivering appropriate volumes of testing and imaging services at the time the calculations were made. Since both the evidence about appropriate use and the technology used for diagnosis and treatment are rapidly evolving, it will be important for purchasers/payers and SMARTCare Teams to regularly review how payment levels and program rules should be modified based on new evidence and new technology. In addition, the payment levels

should be adjusted annually based on normal inflation in wages, the cost of supplies, etc. This is similar to what is currently done in the Medicare Physician Fee Schedule – each year, the prior year’s fee levels are updated for inflation, and periodically, the fee levels are adjusted if there is information indicating that the fees are significantly higher or lower than the cost of delivering care.

As described in Section III-F, there would be limits (“risk corridors”) on how much the total cost of the services actually received by patients could differ from the DPT payment amounts, particularly in the initial years of the program. These limits would protect both purchasers/payers and SMARTCare providers from any errors in calculations or from the impacts of any assumptions used in generating estimates that prove not to reflect the reality of patient or provider needs in the local market. The magnitude of the limits would depend on the size of the provider, the accuracy and timeliness of the data used to determine the payment levels, the number and types of patients who would be included, etc. The initial risk corridor could be very narrow, when uncertainty is highest about how many patients would fall into each category and what the appropriate levels of utilization would be, and then the size of the risk corridor could be increased in future years (i.e., larger differences would be allowed between the SMARTCare payments and the payments that would have been made under fee for service) after better data are generated through the SMARTCare coding and billing process and after the providers have an opportunity to redesign their care processes and better estimate their costs.

IV. DETAILS OF PAYMENTS FOR SUPPORTING MEDICAL THERAPY

A. Physicians Eligible to Receive the Payments

SMARTCare Teams that are eligible to receive Diagnosis, Evaluation, and Treatment of Stable Ischemic Heart Disease (DPT) Payments would also be eligible to receive the Initial Guideline-Directed Medical Therapy (IMT) Payment and the Continued Guideline-Directed Medical Therapy (CMT) Payment.

B. Eligible Patients

Initial Guideline-Directed Medical Therapy (IMT): A SMARTCare Team, cardiology practice, or primary care practice could receive the IMT Payment each month for up to six months for a patient who:

- was eligible for the DPT Payment at any point during the previous six months;
- received a diagnosis of ischemic heart disease from a SMARTCare Team; and
- has agreed to receive Guideline-Directed Medical Therapy as part of the treatment plan developed by the SMARTCare Team

Continued Guideline-Directed Medical Therapy (CMT): A SMARTCare Team, cardiology practice, or primary care practice could receive the CMT Payment each month for a patient who:

- received services supported by the IMT Payment for a period of six months immediately prior to receiving services supported by the CMT Payment;
- has agreed to continue receiving Guideline-Directed Medical Therapy as part of the treatment plan developed by the SMARTCare Team; and
- either:
 - is classified as a patient at high risk of a heart attack, or
 - has had no improvement in symptoms from assessment made during the diagnostic process preceding initiation of the IMT-supported services

In order for a provider (the SMARTCare Team, cardiology practice, or primary care practice) to receive the IMT or CMT payment for an eligible patient, and in order for the patient to benefit from the enhanced services available through the payment, the patient would be asked to agree to receive all of the patient's cardiovascular care from the provider, or from other providers it designates, during the month in which the IMT or CMT payment is being made. A patient could switch to a new provider at the beginning of any month.

Before agreeing to accept the patient, the provider could ask the patient to sign a statement agreeing to adhere to the treatment plan that the SMARTCare Team developed in collaboration with the patient in order to maximize the provider's ability to deliver care that achieves the best possible outcomes at the most affordable cost.

C. Structure of Payments and Services Covered

The provider would receive an IMT or CMT Payment each month to support the following services:

- supervision of the patient's treatment;
- evaluation of and response to changes in the patient's symptoms;
- evaluation of and responses to changes in any medication side effects; and
- revisions to the patient's treatment plan as necessary

All other services, including medications, tests, imaging studies, and procedures would continue to be paid for separately, but spending on these services would be included in the accountability measures described in Section IV-H.

The IMT and CMT Payments would replace current payments for Evaluation & Management (E&M) services payments. The provider receiving the payment would no longer bill the patient's payer (or the patient) for office visits or other E&M services during a month for which the IMT or CMT payment was billed. The provider would have the flexibility to use the IMT and CMT payments in ways that are not currently permitted or adequately supported with Evaluation & Management services payments, e.g., the payments could support non-face-to-face communications between physicians and patients (such as phone calls and emails), services delivered to patients by nurses and other practice staff, longer visits for higher-need patients, open time on the practice schedule to treat patients experiencing side effects of medications, etc.

The IMT and CMT payments would only replace E&M payments for those office visits related to cardiovascular issues. If a patient eligible for the IMT or CMT payments visits the provider for a non-cardiovascular health problem, those visits would still be paid for separately under the regular physician fee schedule (or under an alternative payment model designed for those other health problems).

D. Stratification of Payments and Performance Measures on Patient Characteristics

Patients with ischemic heart disease differ significantly in their risk of adverse events, the frequency and severity of the symptoms they experience, and the other health problems they have. These factors can affect the time and resources needed from the provider, the spending on medications and other services received by the patient, and the outcomes that can be achieved for the patient.

To address this, payment amounts and performance measures for the IMT and CMT Payments would be stratified into the categories shown in Table 2. (Patients with the characteristics for Level 1 would only qualify for the IMT Payment, not the CMT payment.)

Table 2
Payment and Performance Subcategories for
Initial and Continued Care for Stable Ischemic Heart Disease

Category	Billing Code for IMT	Billing Code for CMT	Patient Characteristics
Level 1	xxx21	N/A	• Low-Intermediate Risk of AMI
Level 2	xxx22	xxx32	• High Risk of AMI OR • Low-Intermediate Risk of AMI and Lack of Improvement in Symptoms on Medication Therapy
Level 3	xxx23	xxx33	• High Risk of AMI and Major Comorbidities

These category definitions could also serve as part of the overall system of “patient condition groups” Congress required be created under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

A patient would qualify as having “major comorbidities” if he or she had any of the following conditions:

- Smoking
- Obesity
- Depression/anxiety

At the end of each month in which a patient was eligible for an IMT or CMT Payment, the provider would bill the payer for the payment category that best described the patient’s characteristics during the month.

E. Accountability for Quality, Spending, and Outcomes

The provider would accept accountability for specific aspects of the quality of care delivered to the patient, for spending on cardiovascular care services the patient receives, and for the outcomes achieved for the patient during the months in which the Team is receiving the IMT or CMT Payment.

1. Minimum Quality Standards

The provider would be required to meet the following standards in order to bill for the IMT or CMT Payment for a particular patient:

- Have at least one face-to-face visit with the patient every 3 months. For Level 3 patients, the patient should be seen every month.

- Make at least one contact with the patient via phone or email each month in which a face-to-face visit does not occur.
- Administer the Seattle Angina Questionnaire (short form) each month
- In partnership with the patient and family, maintain a written treatment plan that is consistent with guidelines developed by the American College of Cardiology.

2. Performance-Based Payment

Performance Measures for Service Utilization and Spending

The provider's performance would be assessed based on a measure of utilization/spending for patients during the months in which the IMT and CMT Payments were paid. This measure would be the sum of three components:

1. Standardized monthly spending per patient on laboratory testing and imaging related to ischemic heart disease.
2. Standardized monthly spending per patient on medications related to ischemic heart disease.
3. Standardized monthly spending per patient on urgent care visits, Emergency Department visits, and hospitalizations related to acute coronary syndrome or ischemic heart disease.

Spending would be "standardized" by establishing a "standard" price for each type of test, imaging study, medication, urgent care visit, emergency department visit, and hospital admission, multiplying that price by the actual utilization of tests, imaging studies, medications, urgent care and ED visits, and hospital admissions, and then summing the products. The standard price would be calculated by:

- Calculating the average amount paid by the payer during the most recent 12-month period for which data are available in the local market for the types of medications, ED visits, and hospitalizations that are received by patients with rheumatoid arthritis and rheumatoid arthritis-like symptoms; and then
- Increasing these amounts by an estimate of the increase in prices from the previous period to the current year.

Use of this price-standardized spending measure avoids putting the provider at risk for changes in the prices charged by or amounts paid to drug manufacturers/wholesalers, pharmacies, laboratories, testing facilities, hospitals, urgent care centers, etc. while still holding the provider accountable for avoiding overutilization of medications and services, particularly the most expensive medications and services. Basing standardized prices on a prior period enables a performance target to be established prior to the beginning of the year, as discussed in more detailed below.

This standardized spending measure would be calculated separately for patients in each of the categories defined in Table 2, in order to compare spending levels across providers for patients with similar characteristics. If there are fewer than 10 patients in a category, the current year average would not be used for comparison purposes; however, if performance information from the prior year were available and the combined number of patients was sufficient to calculate a reliable estimate, the combined average would be used.

In order for the provider to be accountable for performance on utilization and spending, the provider would need to receive timely disaggregated information from the payer on each of the categories and the factors affecting them.

Outcome Measures

The following four outcome measures would be calculated for patients eligible for IMT and CMT payments:

1. % of patients with an emergency department visit for chest pain
2. % of patients with a hospital admission for acute coronary syndrome or AMI
3. % of patients triggering a new DPT Payment
4. % of patients reporting worsening of symptoms

The first three measures would be calculated by the payer based on claims data; the fourth measure would be calculated by the provider based on the results of the Seattle Angina Questionnaire administered. These measures would be calculated separately for patients in each the three categories defined in Table 2. If there are fewer than 10 patients in a category, the measure would be calculated over a long period of time.

Performance Standards

The average performance on the utilization/spending measure and each of the outcome measures in each patient category would be calculated for all providers receiving the IMT or CMT payments during the most recent 12 months for which data are available. These averages would serve as the performance standard for the provider during the current year.

Determination of Performance Ratings

A provider's performance on the utilization/spending measure and each of the outcome measures would be rated by comparing the provider's performance to the performance standard for the current year in each patient category. As long as the provider's performance on a measure was within normal statistical variation around the applicable standard, the provider's performance would be deemed "good performance." If performance was significantly better than this range, it would be deemed "excellent performance," and if it was significantly worse, it would be deemed "poor performance." If there were too few patients in a category to compute a reliable rating, the provider would be deemed to have "good performance" in that category.

The provider's overall performance would be determined based on its performance on all five measures for all applicable patient categories. If the provider's performance on any one of the measures for any patient category was "poor," its overall performance would be deemed "poor." If the Team's performance on at least three of the five measures for each of the applicable categories was deemed "excellent" and performance on the remaining measures was "good," then the provider's overall performance would be deemed "excellent."

Adjustment of Payment Based on Performance

The provider would receive the default payment level for the DPT for each eligible patient in a particular category during the next year if the provider's overall performance during the most recent measurement period was "good." The payment would be increased during the following year if the overall performance rating was "excellent." Similarly, the payments would be reduced during the subsequent year if performance on one or both of the measures was "poor."

The maximum increases and decreases would initially be $\pm 4\%$ and then would increase over time to $\pm 9\%$.

Minimum Standard of Performance

If a provider received "poor" ratings for any category of patients for several months in a row, the Team could be dropped from the SMARTCare payment program.