

Proposed Rule: Comprehensive Care for Joint Replacement Model

The Center for Medicare and Medicaid Services (CMS) proposed the creation and testing of a new payment model to be called the Comprehensive Care for Joint Replacement (CCJR) Model.

Comment Deadline: September 8, 2015

Proposed Concept

The CCJR model is “to promote quality and financial accountability for episodes of care surrounding a lower-extremity joint replacement (LEJR) or reattachment of a lower extremity procedure” by testing “whether bundled payments to acute care hospitals for LEJR episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.” Benefits CMS sees from this model include:

- Improving the coordination and transition of care;
- Improving the coordination of items and services paid for through Medicare Fee-For-Service (FFS);
- Encouraging more provider investment in infrastructure and redesigned care processes for higher quality and more efficient service delivery; and
- Incentivizing higher value care across the inpatient and post-acute care spectrum spanning the episode of care.

The CCJR model will be tested for five years from January 1, 2016 to December 31, 2020.

Participating Hospitals

All hospitals paid under Inpatient Prospective Payment System (IPPS) and in the selected geographic regions will be required to participate in the model (some very limited exceptions will apply). The participating hospitals would be the episode initiators and bear the financial risk under the model. The geographic areas will be selected through a stratified random sampling methodology based upon a criteria of historical wage adjusted episode payments and population size.

During the five years of the model testing, hospitals and other providers will be paid according to the usual Medicare FFS payment systems. After the completion of a performance year, the Medicare payments for services to a beneficiary during the episode will be combined to calculate an actual episode payment amount (the sum of related Medicare claims payments for items and services furnished to a beneficiary during a CCJR episode). The actual episode payment will be reconciled against an established CCJR target price. If the amount is positive, it will be paid to the hospital. If the amount is negative, CMS will require payment from the hospital (the difference between the target price and the actual amount). Repayments to CMS will not take place until Year 2 of the model. CMS also proposes limiting how much a hospital can gain or lose in the model.

Telehealth

Recognizing that home visits may be an important part in the treatment of patients under this program, but perhaps not feasible should those visits take place in-person, CMS proposes to waive certain currently existing restrictions on the use of telehealth in the Medicare program. Specifically, CMS proposes in the CCJR program to waive:

- Geographic restrictions that require a patient to be located in a rural health professional shortage area (HPSA); a non-Metropolitan Statistical Area (MSA); or telehealth demonstration program.
- Allow patients to be in their home or place of residence when services are received.

Services provided will still need to be among those currently approved for reimbursement by Medicare if provided via telehealth and must be a service that the CCJR model will reimburse. However, in the proposed regulations, CMS noted that the current evaluation and management (E/M) codes currently used to bill for telehealth do not describe real-time services delivered via telehealth to patients outside of a health care setting, specifically the patient home, and if the location of the practitioner is unspecified. Therefore, CMS proposes for the CCJR model to create a specific set of HCPCS G-codes to describe the E/M services furnished in the CCJR beneficiaries' homes via telehealth. The proposed codes would be similar to the office/outpatient E/M codes and have similar payment rates.

CMS expresses a concern that the presence of licensed clinical staff be in the beneficiary's home through a separately paid home visit or through home health services. For example, during level 4 or 5 E/M visits, CMS expects it would be typical to have auxiliary clinical staff present with the patient. Therefore, those auxiliary clinical staff visits would be reported on the same claim with the same date of service as the telehealth encounter. The physician would be required to document the auxiliary clinical staff was available onsite during the visit and if not, document why such a high-level visit did not include such personnel.

For home health services paid under the home health prospective payment system (HHPPS), telehealth cannot be used to substitute for in-person home health visits. Additionally, while telehealth can be used to meet the "face-to-face" requirement for certification by a physician or an allowed nonphysician practitioner for home health services, the aforementioned waiver of telehealth restrictions on geography and facility location do not apply.

The CCJR model will not cover any additional costs such as technology purchases, training, set up, etc. Additionally, the facility fee will not be covered for the originating site if there is no facility involved (i.e., if the originating site is the beneficiary's home).

Analysis

Although current Medicare geographic restrictions on telehealth services will be waived and the home will be an eligible originating site under this program, other Medicare telehealth restrictions will still be in place including the type of provider who may provide services. Other health care professionals who may assist a beneficiary as he or she recovers at home, such as a physical therapist, are not eligible telehealth providers under the Medicare program. This proposal makes no exception for such a provider.

Additionally, the proposal calls for CMS to create a specific set of HCPCS G-codes. While the codes are to be similar to office/outpatient E/M codes and have similar payment rates, it is unknown what exactly these codes would entail or the reimbursement rate for each.