CENTER FOR CONNECTED HEALTH POLICY
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FACT SHEET

# FINAL RULE - EPISODE PAYMENT MODELS

On Dec. 20, 2016, CMS finalized their rule on Episode Payment Models (EPMs) which would reward hospitals that work together with physicians and other providers to avoid complications, prevent hospital readmissions and speed recovery. Under the new models, acute care hospitals in certain geographic areas will participate in retrospective episode payment models targeting care for Medicare fee-for-service beneficiaries receiving services during acute myocardial infarction (AMI), coronary artery bypass graft (CABG) and surgical hip/femur fracture treatment (SHFFT). All care within 90 days of hospital discharge will be included in the episode of care under the waiver. The rule also finalized updates to the Comprehensive Care for Joint Replacement Model.

The first performance period for the new models will begin on July 1, 2017, with an end date of December 31, 2021.

## BACKGROUND

In a previous Medicare bundled payment model, the Comprehensive Care for Joint Replacement (CCJR) model, CMS waived the telehealth geographic requirement, allowing care to be delivered via telehealth in non-rural areas. It also allowed the home visit to qualify for reimbursement. As a result of CCJR, CMS has determined that usage of the telehealth waiver and home visit were minimal, and therefore believe that allowing for the same telehealth waivers under the Episode Payment Models waiver will also be minimal.

CMS also noticed that very few home visits are currently occurring due to the significant resources it takes a physician to physically visit a home. Allowing the patient's home to serve as an eligible originating site for telehealth, CMS states in the final rule, may expand access to this service.

CMS plans to monitor patterns of utilization of telehealth services under the EPMs to track possible overutilization or reduction in medically-necessary care, and face-to-face visits with providers.

## THE POLICY

**The final rule makes the following changes to Medicare's telehealth policy for EPMs:**

- Waives the Medicare telehealth requirement that an originating site be located in a rural health professional shortage area or non-Metropolitan Statistical Area.
- The patient's home would qualify as an eligible originating site when telehealth services are being furnished in the EPM beneficiary's home or place of residence during the episode, unless the descriptor for the HCPCS code precludes delivering the service in the home. The diagnosis code must also not be excluded from the EPM episode definition. In this case, there would be no originating site facility fee.
- Telehealth cannot be used to meet the face-to-face requirement needed for home health certification.

All other telehealth restrictions in the Social Security Act would still apply (i.e. eligible provider, originating sites besides the patient's home, service restrictions).

### *New CPT Codes*

CMS states that they do not believe that the kinds of E/M services furnished to patients outside of health care settings via real-time interactive communication technology are accurately described in current E/M Codes. CMS therefore finalized a new specific set of HCPCS G-codes to describe E/M services furnished to EPM beneficiaries in their homes via telehealth. The new codes have a parallel structure and set of descriptors to the E/M office or other outpatient visits codes (CPT codes 99201-99205 for new patient visits and CPT codes 99212-99215 for established patient visits). Descriptions for each of the new codes (G9864-G9872), and the crosswalk to the corresponding CPT code is available in the final rule. The new codes will be payable beginning July 1, 2017, which is the start date of the EPM performance year.

CMS states that they will consider new CPT codes as they are released according to their usual processes and will specifically evaluate whether they may be used in the future to report home telehealth visits for EPM beneficiaries or in the CJR model.

## 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. 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 rule makes no exception for such a provider. The policy would also only apply to entities participating in the EPMs which would be limited to acute care hospitals in certain geographic areas. It will also be limited to Medicare fee-for-service beneficiaries receiving services for 90 days following hospital discharge for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or surgical hip/femur fracture treatment (SHFFT).

In response to comments calling for greater expansion of telehealth services, specifically to not limit it to "interactive telecommunications systems" or allow for additional providers to provide services under the models, CMS' response indicated that it was not the intent of the waiver "to fundamentally change the scope of telehealth requirements for payment under Medicare. Rather, we proposed to waive certain existing telehealth requirements to provide participant hospitals with additional tools to improve episode quality and efficiency given the constraints on physician time for in-person visits at distant locations or in the beneficiary's home."

Although the purpose of the new G-codes are to better capture the scope of services being delivered when telehealth is used, it also further separates telehealth as a separate service, instead of a normal part of delivering care. Medicare has also created new G-codes to more accurately capture critical care consultations delivered through telehealth, as outlined in the CY 2017 Physician Fee Schedule. The addition of these codes may set a precedent to continue expanding these telehealth-specific codes both within Medicare and by the American Medical Association (AMA), who has already created a new telehealth modifier, and is exploring the development of additional telehealth-specific codes.

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### *For further resources on the new EPM Model see the following:*

**Episode Payment Model Final Rule:**
https://www.federalregister.gov/documents/2017/01/03/2016-30746/medicare-program-advancing-care-coordination-through-episode-payment-models-epms-cardiac

**Episode Payment Models; General Information:**
https://innovation.cms.gov/initiatives/epm

**CMS Fact Sheet on the Final Rule:**
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-20.html

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