Center for Connected Health Policy
The National Telehealth Policy Resource Center

Proposed Rule: Episode Payment Models

On July 25, CMS proposed three new Episode Payment Models (EPMs) that would reward hospitals that work together with physicians and other providers to avoid complications, prevent hospital readmissions and speed recovery. Under the new model, 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.

Comment Deadline: October 3, 2016

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 posits in the proposed regulation, may expand access to this service.

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

The Policy

The regulation proposes to make the following changes to Medicare's telehealth policy for EPMs:

- Medicare telehealth requirement that an originating site be located in a rural health professional shortage area or non-Metropolitan Statistical Area would be waived.
- The patient's home would qualify as an eligible originating site for a distant site provider. In this case there would be no originating site facility fee.
- Does not apply when telehealth is 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. provider, originating sites besides the patient's home, service restrictions).

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New CPT Codes

In the proposed regulation, CMS explains 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 is therefore proposing a specific set of HCPCS G-codes to describe E/M services furnished to EPM beneficiaries in their homes via telehealth. They envision the services to be most similar to outpatient E/M codes, and therefore propose to create a parallel structure and set of descriptors to report office or other outpatient visits (CPT codes 99201-99205 for new patient visits and CPT codes 99212-99215 for established patient visits). Payment rates will include resource costs typically incurred when services are furnished via telehealth, which they believe creates efficiencies and limits resource costs to those related to professional time, intensity and malpractice risk to marginal levels.

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 proposal 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).

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. Additionally, although the purpose of the new 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.