MILLIMAN WHITE PAPER

Opportunities for care coordination through innovative technologies

New flexibility for telehealth, virtual visits, and remote patient assessment and monitoring under MSSP ACO and PFS proposed rules

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This summer the Centers for Medicare and Medicaid Services (CMS) issued two proposed rules that will create mechanisms for some providers to receive payment for telehealth and other non-face-to-face services, as well as care coordination using enabling telecommunications technologies.

Together, the changes proposed in the calendar year (CY) 2019 Medicare Physician Fee Schedule (PFS) and the Medicare Shared Savings Program (MSSP) proposed rules have the potential to enable new provider interventions that strengthen care access and coordination for a much broader set of both patients.[1, 2] In this paper we will describe these changes in detail, as well as the possible implications for providers and MSSP ACOs in particular. This paper is the fourth in a series of white papers Milliman is writing on the MSSP proposed rule.

Medicare telehealth services – Current policy

"Telehealth" is often used to broadly refer to the use of telecommunication technologies to furnish healthcare services. However, Medicare telehealth services specifically refer to a set of Part B-covered services specified under section 1834(m) of the Social Security Act. By law, Medicare fee-for-service (FFS) telehealth services under the PFS are currently subject to the following conditions:

- Provided using real-time, interactive audio and video
- Geographic restrictions on originating site (beneficiary location)
- Setting restrictions on distant site (provider location)
- Provider restrictions (and possibly further limitations due to state licensure laws)
- Limitations on type of visits[3]

Originating sites must be located in a health professional shortage area that is either outside of a Metropolitan Statistical Area (MSA) or within a rural census tract. Originating sites are limited to a practitioner's office, critical access hospital (CAH), rural health clinic (RHC), federally qualified health center (FQHC), hospital, hospital-based or CAH-based renal dialysis center (including satellites), skilled nursing facility (SNF), or community mental health center (CMHC).

Some inherently non-face-to-face services not listed among the Medicare-approved telehealth services may still be eligible for separate FFS payment. For example, as discussed further below, remote patient monitoring (CPT 99091), which is the "collection and interpretation of physiological data," may be paid separately, provided that other conditions established by CMS are met (e.g., initial face-to-face visit with the practitioner for a new patient or patient not seen within one year by that practitioner prior to the remote monitoring service; beneficiary consent documented in the medical record).

CURRENT WAIVERS OF MEDICARE TELEHEALTH RULES

Under the existing Next Generation ACO Model, CMS has waived the geographic and originating site requirements for Medicare telehealth services. In addition, beginning in 2018, the Next Generation ACO Telehealth Waiver was expanded to include asynchronous telehealth services for teledermatology and teleophthalmology, which provides physician payment for the receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation.

MSSP ACOs do not have such flexibility because no telehealth waivers are currently available to them.

[1] DHSS. CMS. July 27, 2018. Proposed Rule Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program. Federal Register. Vol. 83, No. 145.

[2] DHSS. CMS. August 17, 2018. Proposed Rule: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success. August 17, 2018. Federal Register. Federal Register. Vol. 83, No. 160.

[3] A list of currently approved Medicare telehealth services is available through the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html.

Changes to telehealth services under MSSP proposed rule

For 2020, CMS proposes:

- To allow expanded use of telehealth by ACOs that take on two-sided risk under prospective attribution
- To expand use of telehealth, which means that CMS will remove the geographic and originating site restrictions

The Bipartisan Budget Act of 2018 provides certain ACOs the ability to expand the use of telehealth. Under CMS's proposal, beneficiaries in urban locations may be served through telehealth. The beneficiary's place of residence may also be an originating site. According to CMS, "This new flexibility will expand access to high-quality services in a manner that is convenient for patients."[4]

More specifically, CMS proposes to make these telehealth flexibilities available to practitioners billing though the tax identification number (TIN) of an ACO under performance-based risk (i.e., ACOs in levels C, D, and E of the BASIC track and ACOs in the ENHANCED track) that has selected prospective assignment. CMS does not believe that ACOs that participate under the preliminary prospective assignment with retrospective reconciliation method meet the definition of an applicable ACO as specified in the statute, although it requests comments on its interpretation of this provision.

CMS also proposes to provide a 90-day grace period that functionally acts as an extension of beneficiary eligibility to receive telehealth services after a beneficiary loses assignment to the ACO. This 90-day coverage provides additional time for the ACO to receive quarterly exclusion lists from CMS and communicate beneficiary exclusions to its ACO participants and providers/suppliers. The ACO may not charge beneficiaries for whom telehealth services are not paid because the beneficiary was not prospectively assigned to the ACO or was not in the 90-day grace period. CMS expects that the ACO should have had procedures in place to confirm that the requirements for providing telehealth services were satisfied before the telehealth service was provided.

CMS does not propose to allow payment of telehealth services delivered through asynchronous technologies.

Changes to non-face-to-face services under PFS proposed rule

VIRTUAL CHECK-IN VISITS

For the 2019 PFS, CMS proposes to provide a $14 payment for a brief virtual check-in by phone with a patient to determine if a visit to the office is necessary in order increase efficiency for practitioners and convenience for beneficiaries. If an office visit is required, CMS will not make a separate payment for the virtual visit.

CMS proposes to create a new Health Care Common Procedure Coding System (HCPCS) code to bill for virtual check-in visits to established patients. Payment for these phone assessments (which CMS does not consider telehealth services) would be bundled when the virtual visit originates from a related evaluation and management (E/M) service provided within the previous seven days by the same physician. Similarly, where the "check-in" leads to an E/M in-person visit with the same physician, the virtual visit would be bundled into payment for the E/M visit. The rule notes that certain components of medication-assisted therapy (MAT) for opioid use disorders could be carried out virtually and states that these new virtual check-in visits can allow a practitioner to assess the patient's condition and determine whether an office visit is required. The virtual visit payment of $14 in the first year would be substantially lower than the proposed $92 payment for E/M in-person visits. CMS seeks comment on whether audio-only telephone interactions are sufficient compared with interactions that are enhanced with video or other kinds of data transmission.

CHRONIC CARE REMOTE PHYSIOLOGIC MONITORING

For the 2019 PFS, CMS proposes to provide separate payment for certain remote physiologic monitoring services to further promote care management activities.

The American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel created three new codes for 2019 to report services for remote monitoring of physiologic parameters (e.g., weight or blood pressure): initial set-up and patient education on the use of the equipment, a 30-day supply of the monitoring device including daily recordings or programmed alert transmissions, and 20 minutes or more per month of treatment management of the remote physiologic management services by physicians or clinical staff that requires interactive communication with the patient or caregiver.

INTERPROFESSIONAL CONSULTATION

For the 2019 PFS, CMS proposes to provide separate payment for interprofessional or "peer-to-peer" internet consultations (sometimes also called "e-consults") as part of its efforts to reflect medical practice trends in primary care and patient-centered care management within the PFS.

CMS proposes to provide payment for two new CPT codes created by the AMA CPT Editorial Panel for CY 2019 and four existing CPT codes for e-consults of various durations that include "assessment and management services conducted through telephone, internet, or electronic health record consultations furnished when a patient's treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a consulting physician or qualified healthcare professional with specific specialty expertise to assist with the diagnosis and/or management of the patient's problem

[4] Centers for Medicare and Medicaid Services. August 9, 2018. CMS Proposed "Pathways to Success," an Overhaul of Medicare's ACO Program. Available at: https://www.cms.gov/newsroom/press-releases/cms-proposes-pathways-success-overhaul-medicares-aco-program.

without the need for the patient's face-to-face contact with the consulting physician or qualified healthcare professional." The proposed rule discussion recognizes the value of team-based approaches and consultation to better manage patients with chronic or complex conditions. Instead of the current approach of generating a new specialist visit to ensure that the specialist is engaged in patient care, these new services are intended to promote more efficient communication between the treating and the consulting providers.

FIGURE 1: SUMMARY OF CURRENT VERSUS PROPOSED POLICY

CURRENT POLICY	PROPOSED POLICY
MSSP ACOs experience geographic location restrictions for Medicare telehealth services	▪ Beginning in 2020, waived for Medicare telehealth services for ACOs under performance-based risk models that select prospective beneficiary assignment. ▪ 90-day grace period extends beneficiary eligibility when a beneficiary who was initially on the ACO's list of prospectively assigned beneficiaries loses ACO assignment. ▪ **Implication:** Payment may made for Medicare telehealth services provided to beneficiaries in MSAs.
MSSP ACOs have originating site restrictions for Medicare telehealth services	▪ Beginning in 2020, waived for Medicare telehealth services for ACOs under performance-based risk models that select prospective beneficiary assignment. ▪ 90-day grace period extends beneficiary eligibility when a beneficiary who was initially on the ACO's list of prospectively assigned beneficiaries loses ACO assignment. ▪ **Implication:** Payment may made for Medicare telehealth services provided at a beneficiary's residence.
MSSP ACOs are not paid for services provided by asynchronous technologies as Medicare telehealth services Next Generation ACOs may be paid for teledermatology and teleophalmology provided by asynchronous technologies	No change
Brief communication technology-based service, e.g., virtual check-in payment is bundled into payment for related E/M visit, with no separate payment	▪ Beginning in 2019, newly created HCPCS Code GVCI1 can be used to bill for a brief non-face-to-face check-in to assess whether the patient's condition necessitates an E/M visit. ▪ Service may be paid separately as long as the check-in does not immediately follow or precede an E/M visit. If not, its payment is bundled into the E/M visit payment. ▪ **Implication:** Payment may be made for brief virtual check-ins that may avoid an office or telehealth visit and provide a more timely patient assessment.
Remote evaluation of pre-recorded patient information, e.g. assessment of images payment is bundled into payment for related E/M visits, with no separate payment	▪ Beginning in 2019, newly created HCPCS Code GRAS1 can be used to bill for use of patient-transmitted information conducted via pre-recorded ''store and forward'' video or image technology to evaluate a patient's condition. ▪ Similarly to virtual check-in, service is to assess whether the patient's condition necessitates an E/M visit, and may be paid separately as long as an E/M visit does not immediately follow or precede the assessment. If not, its payment is bundled into the E/M visit payment. ▪ **Implication:** Payment may be made for video or images transmitted to a physician for evaluation that may avoid an office or telehealth visit and provide a more timely patient assessment.
Interprofessional or peer-to-peer consultation—e.g., e-consults—payment is bundled into payment for related E/M visit by treating practitioner, with no separate payment to treating or consulting practitioner unless the patient has a separate E/M visit with the consulting practitioner	▪ Beginning in 2019, established CPT codes 99446, 99447, 99448, 94449 and newly created CPT codes 994X0 and 994X6 can be used to bill for telephone/internet assessment and management services provided by consultative physicians at the request of treating physicians. All services, including the four CPT codes that were previously bundled, may be paid separately. ▪ **Implication:** Payment may be made for physician consultation that may avoid a separate office or telehealth visit with that physician and provide a more timely consultant's assessment that may improve treatment management.
Remote patient monitoring (CPT 99091)—e.g., collection and interpretation of physiologic data that is digitally stored and transmitted to physician—may be separately paid; payment for supplying the monitoring device, days of recording, and monitoring treatment management services is bundled into payment for related E/M and collection/interpretation services	▪ Beginning in 2019, newly created CPT codes 990X0, 990X1, 994X9 can be used to bill for the initial setup and patient education about the monitoring device; 30 days of remote monitoring with daily recording or alert transmission; and monthly monitoring treatment management services requiring interactive communication with the patient. These services may be separately paid. ▪ **Implication:** Payment may be made for several additional resource-intensive services that are required for high-quality chronic care remote patient monitoring, potentially making the regular use of these services in chronic care patient management more feasible and useful.

Note: ACO participants, which include providers/suppliers, are the entities that are paid. The ACOs themselves are not paid directly for services. In this table and throughout this paper, we use the term "ACOs" to refer to the ACO participants, meaning the providers/suppliers that are eligible for payment.

REMOTE PROFESSIONAL EVALUATION OF PATIENT-TRANSMITTED INFORMATION

For the 2019 PFS, CMS proposes to provide a separate payment for a physician's use of recorded video and/or images captured by a patient in order to evaluate a patient's condition, provided that the evaluation does not result in a subsequent E/M visit. The proposal is part of its efforts for reflect within the PFS the progression of technology and its impact on the practice of medicine in recent years and to increase access to services for Medicare beneficiaries.

CMS proposes to create a new HCPCS code for remote evaluation of for physician evaluation of patient-transmitted photo or video information conducted via pre-recorded "store and forward" video or image technology. When the review of the patient-submitted image and/or video results in an E/M in-person visit with the same physician, the remote service would be bundled into that office visit. Similarly, when the remote service originates from a related E/M service provided within the previous seven days by the same physician, the remote service would be bundled into that previous E/M service. CMS seeks comment as to whether these services should be limited to established patients or whether there are certain cases, like dermatological or ophthalmological services, where it would be appropriate for a new patient to receive these reviews.

Clinical scenarios for ACOs' use of new flexibilities

These proposed regulations, which both allow for flexibility for Medicare telehealth services and add new separately payable codes for non-face-to-face services, present opportunities for ACOs to leverage these services to improve efficiencies, care coordination, and care management. Consider the following examples:

- An ACO has the goal of reducing unnecessary SNF utilization. An ACO-assigned patient is recently discharged home from an acute care hospital following hospitalization for an acute cardiac event. The home health care worker notes that there is clinical deterioration post-discharge. A physician conducts a remote video-assisted E/M visit with the patient who is at home, which may be paid as a Medicare telehealth service. The care plan, including medications, is adjusted. Further deterioration that would have required an SNF stay is avoided.
- An ACO is interested in avoiding unnecessary physician office visits. An otherwise healthy beneficiary who is an established patient assigned to the ACO is concerned that she has an upper respiratory infection. She does not have a car, lives alone, and would have to make arrangements with a family member to drive her to a doctor's appointment. The physician conducts a brief virtual visit and is able to prescribe fluticasone and recommend over-the-counter medications. An in-person E/M office visit or Medicare telehealth visit is avoided.
- An ACO is interested in better managing care for patients with dual (physical and mental health) diagnoses, including seeking appropriate, timely specialist expertise in treatment management decisions. An assigned patient with diagnoses of diabetes, hypertension, and depression attends an in-office visit with her ACO-participating family practitioner who treats her for all of these conditions and has previously prescribed medication for each condition. She discusses her pattern of low glucose levels and states that she has not been eating regularly but is taking all medications as prescribed. The practitioner discusses the importance of eating predictably when taking insulin to avoid low glucose levels. The patient then shares that she has become more depressed since her younger sister recently died. Her physician consults with a psychiatrist by phone and adjusts all of her medications accordingly in the office visit. As a result, an appointment with the specialist is avoided and the treatment of all conditions takes their interactions into consideration. In addition, care delays that impact the patient's physical and mental health—from having to wait for a specialist appointment—are avoided, while diabetes and depression management are optimized to prevent worsening of the patient's symptoms.
- An ACO is interested in reducing unnecessary emergency department (ED) visits. An assigned patient has chronic anxiety and severe depression. In the last few weeks, he finds himself feeling more withdrawn and anxious. His clinical psychologist who participates with the ACO is more than an hour away. The thought of traveling to the office and sitting in the waiting room increases the patient's stress and anxiety level. He calls the psychologist's office and is able to make an appointment for a Medicare telehealth live video visit within 24 hours. The psychologist evaluates his symptoms and provides 45 minutes of psychotherapy. They also discuss medication adherence and strategies to help the patient take medications as prescribed by his psychiatrist. The ability to undergo treatment by the psychologist in the comfort of the patient's home allows him to obtain care when he needs it. This empowers him to better manage his health and avoid potential exacerbation of his mental health conditions.
- An ACO is interested in enhancing the remote patient monitoring services it currently offers as part of its care management and transition program for patients following a cardiac event or stroke. An assigned patient is discharged following cardiac surgery and is provided a Bluetooth blood pressure cuff, a Bluetooth scale, and a secure mini-tablet with an app that captures and securely transmits data to a remote care manager. The provider is able to bill for the time it takes to set up the equipment and train the patient on how to use the devices and upload data in real time, as well as the clinical staff time spent monitoring the data over each month and communicating with the patient. While the collection and interpretation of remote patient monitoring data that is digitally

stored and transmitted to the physician has previously been paid separately under the PFS, as of 2019, the provider may bill and be paid separately for several more relevant services, including setup and patient education, each 30 days of remote monitoring and daily recording, and monthly monitoring treatment management services that involve interactive communication with the patient.

Opportunities and challenges from an ACO perspective

While the new availability of separate payment for these services that use telecommunications technology may help to improve access and quality of care, there are legitimate concerns regarding impacts to utilization and revenue.

One concern-which is not unique to ACOs-is related to whether improved, convenient access to care (especially for lower-acuity services) may increase unnecessary utilization, rather than substitute for higher-cost services in more expensive settings. A recent study evaluating patterns of utilization and spending among patients with commercial insurance and acute respiratory illness found that a relatively small proportion (12%) of telehealth visits were substitutes for face-to-face visits, and approximately 88% of telehealth visits were new utilization, with a resulting $45 annual increase in healthcare spending per telehealth user.[5] However, in terms of quality of care, there is sufficient evidence and consensus regarding effectiveness of telehealth for certain situations, including "remote monitoring, communication, and counseling for patients with chronic conditions, and psychotherapy as part of behavioral health," according to a recent systematic review by AHRQ.[6] ACOs will be well advised to leverage this new flexibility and payment opportunities and do so in a manner consistent with existing guidelines and evidence.[7, 8, 9, 10] Where evidence is lacking or mixed, data collection and evaluation to assess impact on quality, access, operational efficiencies, and costs would be invaluable.

The proposed rules also raise specific questions for ACOs' and practitioners' consideration:

- The virtual visits are intended to facilitate check-ins to monitor health and potentially avoid unnecessary in-person visits. For providers, no additional payment is available if the virtual visit occurs right before or after an E/M visit. As mentioned, these five- to 10-minute check-ins would be paid at $14 per visit, which is substantially lower than the $92 payment proposed by CMS for an in-person E/M visit. The proposal raises the question of whether there is sufficient incentive to engage the patient through virtual visits if higher revenue potential from E/M visits is reduced. In light of the potential loss in practice revenue, ACO participants would need incentives in terms of a portion of shared savings from the ACO to make up for the shortfall. Operationally speaking, how will practices fit these visits into the workflow?
- For ACOs with preliminary prospective assignment, the 90-day grace period for Medicare telehealth services provides some protection against Medicare nonpayment but will require complete and timely communication among all participating providers/suppliers to prevent a situation where the provider/supplier does not get paid after the service is furnished. Providers may be reluctant to offer these telehealth services unless the ACO guarantees payment if Medicare does not pay.
- Interestingly, teledermatology and teleopthalmology are services eligible for payment for Next Gen ACOs under the existing Next Generation ACO Telehealth Expansion Waiver. However, these services would not be separately paid under the new MSSP telehealth rules because they are not considered Medicare telehealth services. Notably, if images are transmitted to a dermatologist or ophthalmologist by the patient, separate payment may be made for remote evaluation of this pre-recorded information under the new HCPCS code proposed by CMS for this service, as long as an E/M visit does not immediately precede or follow the evaluation of the images. The PFS does not provide separate payment for patient data (e.g., images) collected by a treating practitioner that are stored and forwarded to an ophthalmologist or dermatologist for review at a later time. However, payment for the collection, transmission, and evaluation of that data would be bundled into payment for the treating practitioner's E/M visit and interprofessional consultation services if treatment advice is requested by the treating practitioner.

[5] Ashwood, S., Mehrotra, A., Cowling, D., Uscher-Pines, L. (2017). Direct-to-consumer telehealth may increase access to care but does not decrease spending. Commercial Insurer Innovation. 485-491.

[6] Totten AM, Womack DM, Eden KB, McDonagh MS, Griffin JC, Grusing S, Hersh WR. Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews. Technical Brief No. 26. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No.16-EHC034-EF.

[7] American Psychological Association. Joint Task Force for the Development of Telepsychology Guidelines for Psychologists. Guidelines for the Practice of Telepsychology. December 2013. American Psychologist Vol 68 No. 9: 791-800.

[8] Mistry H. Systematic review of studies of the cost-effectiveness of telemedicine and telecare. Changes in the economic evidence over twenty years. J. Telemed. Telecare. 2012;18:1–6. doi: 10.1258/jtt.2011.110505.

[9] American Telemedicine Association (ATA). ATA Teledermatology Guidelines Work Group and the ATA Practice Guidelines Committee. April 2016. Practice Guidelines for Dermatology.

[10] ATA. ATA Primary and Urgent Care Guidelines Work Group and the ATA Practice Guidelines Committee November 2014. Practice Guidelines for Live, On Demand Primary and Urgent Care.

ACOs and participating providers may choose to increase their use of telehealth and other innovative non-face-to-face services in response to opportunities arising from new CMS policies and/or environmental changes. In making such a decision, ACOs would be well advised to take the opportunity to evaluate their current technology infrastructure and workflows in order to determine how these modalities can better engage patients, manage care, engage specialty care services efficiently, and support those beneficiaries in their residences who have multiple, complex, chronic health conditions. Specifically, ACOs may want to consider the role these non-face-to-face services may play in achieving the objectives of the ACO to improve the quality and reduce the cost of care for ACO-assigned beneficiaries.

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