OneCareVermont

Vermont Medicare Accountable Care Organization Initiative

Post-Discharge Home Visits Benefit Enhancement Waiver

Guidance Document
Version 3
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CARES Act Waiver Update

The Coronavirus Aid, Relief, and Economic Security (CARES) Act is the emergency funding passed in response to the outbreak of COVID-19 in March 2020. The stimulus package addresses topics such as healthcare delivery, state funding, small business and non-profit relief and overall economic stimulus. Due to the CARES Act and its impact on healthcare delivery systems, Medicare waiver participants should shift billing practices to those in alignment with the codes outlined in the CARES Act.

How to Use this Guidance Document

This guidance document was developed by OneCare Vermont (One Care) to inform, educate, and offer tools to successfully implement the Post-Discharge Home Visits Benefit Enhancement Waiver (PDHV Waiver) in Health Service Areas (HSA) participating in the Vermont Medicare Accountable Care Organization (ACO) Initiative program. This manual will be updated as new information is made available from the Centers for Medicare & Medicaid Services (CMS). This manual, along with other PDHV Waiver materials and OneCare patient attribution lists, are available in the OneCare Secure Portal.

What is the Post-Discharge Home Visits Waiver?

In traditional fee-for-service (FFS) Medicare, beneficiaries are eligible to receive post-discharge home visit services (home health visits) after they are discharged home from an inpatient facility. These home visits are an evaluation and management (E/M) service physicians can provide to their patients themselves or through a licensed provider under the *direct supervision* of the physician.

The PDHV Waiver increases the availability of in-home care following discharge from an inpatient facility by altering the supervision level for "incident to" services to allow licensed providers under a physician's general supervision (instead of direct supervision) to make home visits under certain conditions. By eliminating the direct

supervision requirement, the **PDHV waiver allows for flexibility in billing for E/M home visits** provided to patients in the period following discharge from an inpatient facility **by allowing a physician to contract with licensed clinicians to provide home visits to a patient at the patient's home under the general supervision of a physician**. The patient may **receive up to nine (9) home visits within 90 days following the initial discharge** under the PDHV Waiver.

Provider and Participant Eligibility

Annually, Participants and Preferred Providers are enrolled into the OneCare Vermont Network (Network). OneCare will provide CMS with a list of Participants with whom OneCare intends to contract to utilize the PDHV Waiver. CMS will then notify OneCare if the providers submitted are approved to bill under the PDHV Waiver; OneCare will then inform intended Waiver Participants of their eligibility.

In addition, a **written participation agreement needs to be executed** among the Participants, OneCare and any contracted staff to authorize implementation of the PDHV Waiver. For more information about provider and participant eligibility to use the PDHV Waiver, please contact the Medicare Waiver Administrator.

In Vermont, the following provider types are qualified to be a **supervising physician** or other practitioner to provide general supervision under the PDHV waiver:

- Physicians – MD, DO
- Nurse Practitioners – RNP and APRN
- Physician Assistant – PA

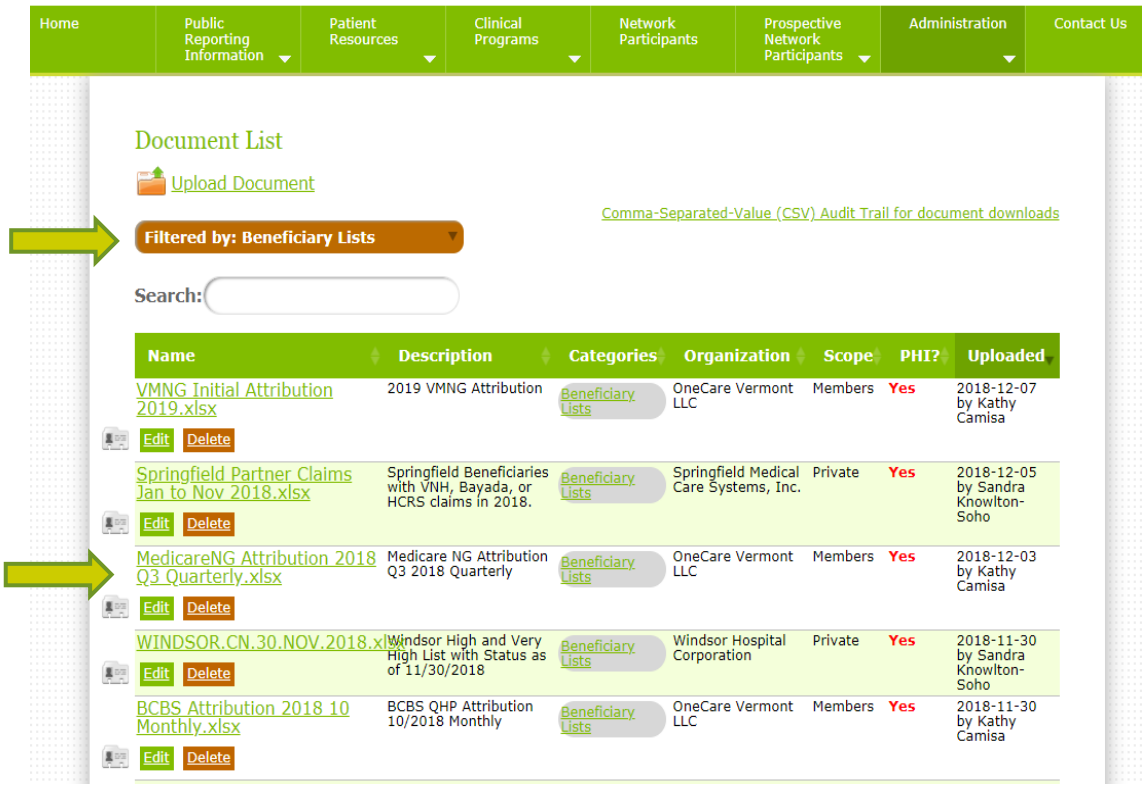
In Vermont, the following licensed clinical provider types are qualified as **auxiliary personnel to perform the services ordered by the supervising physician** or other practitioner:

- Registered Nurses – RN
- Licensed Clinical Social Workers – LICSW
- Licensed Clinical Psychologists – MA or PhD
- Licensed Clinical Mental Health Counselors – LCMHC
- Licensed Physical Therapists – PT
- Licensed Occupational Therapists – OT
- Licensed Practical Nurses – LPN

Confirming Patient Attribution

A Medicare beneficiary must be attributed to OneCare to be eligible to use the PDHV Waiver. Therefore, steps must be taken to verify the patient's attribution status *prior to* PDHV Waiver initiation. To verify attribution, the patient must be included in the Medicare beneficiary attribution list. Beneficiary attribution lists are available in the OneCare Secure Portal. The lists are updated quarterly (i.e. approx. 90-days), and released after the quarter of attribution. Help navigating the Secure Portal is available by contacting the OneCare Helpdesk.

OneCare Secure Portal Attribution Lists



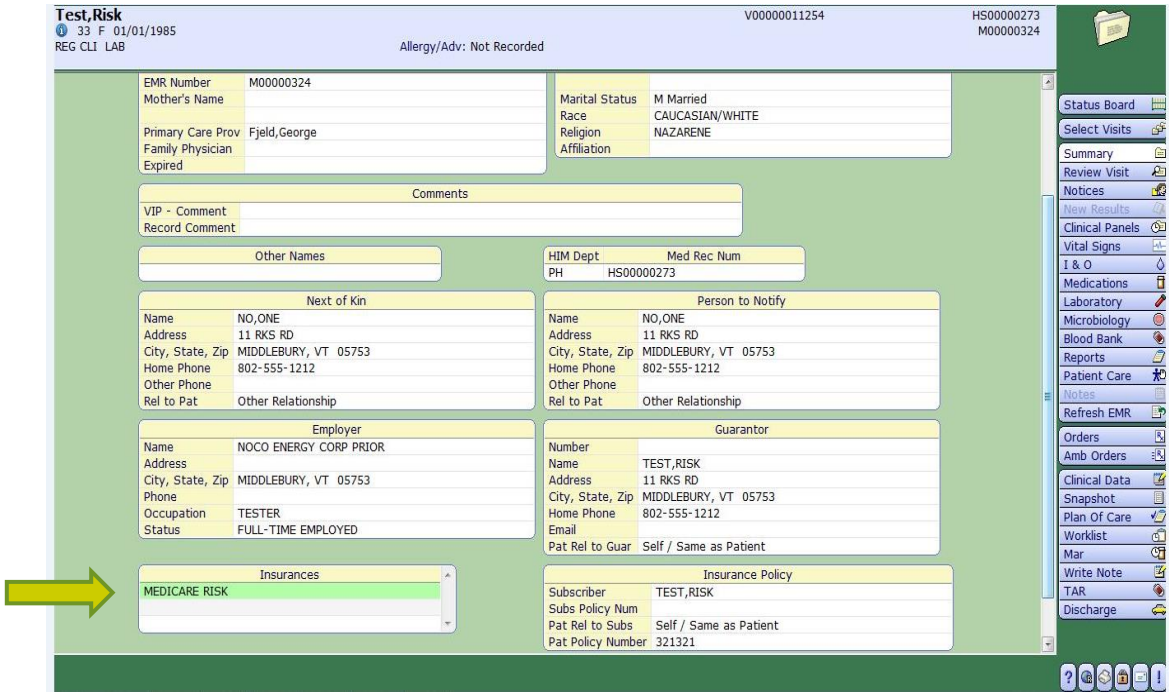
Within the Secure Portal, navigate to the "Administration/Documents" tab. Select "Beneficiary Lists" as the filter. Search for **Medicare Attribution**.

The 90-day delay in patient attribution list updates does not impact the process of confirming patient attribution as the PDHV Waiver has a built in **90-Day Grace Period for Excluded Beneficiaries**. This grace period allows a former Medicare attributed patient who was aligned to the ACO at the start of the *performance year*, but who is later excluded from attribution during the *performance year*, to be eligible for the PDHV Waiver provided that admission occurs within 90 days following the date of the alignment exclusion and all other eligibility requirements of the PDHV Waiver are met. **This grace period applies only within a performance year.** Therefore, at the beginning of a new performance year, you will need to use the new year's attribution list. If you have questions about the 90-Day Grace Period, please contact the Medicare Waiver Administrator.

One suggestion to assist facilities in confirming patient attribution is to build an icon or data field into your Electronic Health Record (EHR). Below is a screen shot of

patient demographic page in a Meditech EHR. Notice in the bottom left hand corner, in the Insurances box, "Medicare Risk" is highlighted indicating that the patient is attributed to the Vermont ACO Medicare Initiative.

Patient Attribution Identification in EHR Example



Patient Eligibility Criteria

1. The patient must be a Medicare beneficiary attributed to OneCare.

2. The patient has been discharged from an inpatient facility within the past **90-days**. For purposes of the PDHV Waiver, the following facilities qualify as an inpatient facility:

    a. Acute care hospital
    b. Emergency department
    c. Observation
    d. Critical access hospital (CAH)
    e. Skilled nursing facility (SNF)
    f. Inpatient rehabilitation facility (IRF)

g. Inpatient psychiatric facility
h. Long-term care hospital

3. The patient is **not eligible** for traditional Medicare home health services;

4. The patient meets at least one of the following clinical criteria:

   A. Diagnosed with a condition such as: CAD, CHF, COPD, Diabetes, Sepsis, Dementia, Frailty, Major Depression, Falls, Delirium During Hospitalization and/or Pneumonia;

   B. Polypharmacy (≥4 medications) or a high-risk medication, such as an anti-coagulant;

   C. Primary language other than English;

   D. Concern regarding low health literacy;

   E. Cognitive impairment;

   F. Inadequate support at home;

   G. Patient or caregiver anxiety; and/or

   H. Clinical judgment by a medical professional that indicates the need for a home health visit.

5. The services are furnished in the beneficiary's home or residence.

6. The visits do not exceed 9 visits within 90-days following inpatient discharge.

Below is a **list of examples when the PDHV Waiver MAY be appropriate** for a patient. *This list is not comprehensive and should not be used as a substitute for medical decision-making and clinical judgment.*

One or Two Visits

- Patient with minimal home health needs post-discharge.
- New medication regimen.

Three to Five Visits

- New medication regimen and need for teaching/training of patient and/or family with low health literacy.
- Patient cognitive impairment limits self-management of disease.

- Homebound with no full skilled nursing need under Medicare, but need for going home health monitoring due to medical condition or condition.

Six to Nine Visits

- Continued home health needs determined for patient challenges to understanding new health condition(s) and self-management.
- Patient with continued wound care, supportive partner works full-time and is unable to assist in care.

Standing Orders for Primary Care Patients Discharged from UVMMC

A medical provider must order the home visits for a patient and standing orders may be used under the Waiver. The established standing orders for home visits from the University of Vermont Medical Center (UVMMC) is as follows:

Assessment:

- Vital signs
- Medication reconciliation
- Assess as clinically indicated: Cardio-pulmonary, GI, GU, neurological, musculoskeletal systems
- Home safety evaluation

Interventions:

- Provide and instruct patient and family in treatments as ordered by discharging hospital provider or medical practice provider, ex. Colchester Family Practice
- Follow up on unmet needs related to social determinants of health

Education:

- Facility discharge instructions, medications, wound care, disease process, adherence with follow-up provider appointment(s), transportation to visits

Patient Medical Documentation

Please note, medical record documentation should substantiate the level of care provided and the medical reasonableness for the services rendered. Such documentation not only supports proper care of the patient, but also serves as a legal document to verify that care was provided. At every home visit, assess the patient to determine if ongoing home health visits are appropriate and necessary.

All patients seen under the PDHV Waiver require the same medical documentation as would be normally documented during home visits not provided under the PDHV Waiver. Documentation of patient visits should follow the established criteria:

- E&M, Place of Service and Diagnosis: Diagnosis has to be established as these visits are incident-to. Place of service needs to be home/wherever the patient resides.
- Appropriate documentation in Epic (or other EHR) of plan of care including an order for the service.
- Service performed and documented by the Home Health nurse during the home visit.
- Documentation for services complied by the Home Health sent to medical provider in a secure manner.
- Clinical review of the documentation performed as required based on accepted protocol.
- Clinic staff would scan documentation to patient record in Epic.
- Clinic staff would determine appropriate code(s) and either drop code electronically in Epic via a documentation visit or complete a paper record of the charge to be provided to PRD for charge processing and billing.
- Charge entry staff would enter charges to the system to initiate the billing process.

Coding and Billing for the Post Discharge Home Visit *CARES Act Update

*Due to the COVID-19 pandemic, participants should use the CARES act post discharge home visit blanket waiver coding guidelines instead of those associated with the ACO Medicare waiver. CARES act waiver codes can be found here.

The following HCPS G codes must be used for billing under the PDHV Waiver as of April 1, 2019, and are reimbursable by Medicare as long as they are delivered by a PDHV Waiver approved provider (CPT codes are listed for reference only):

1. HCPS **G2006** (CPT 99347) - Established patient w/problem focused history, problem focused exam and straightforward medical decision making, the time based guideline is *20 minutes*

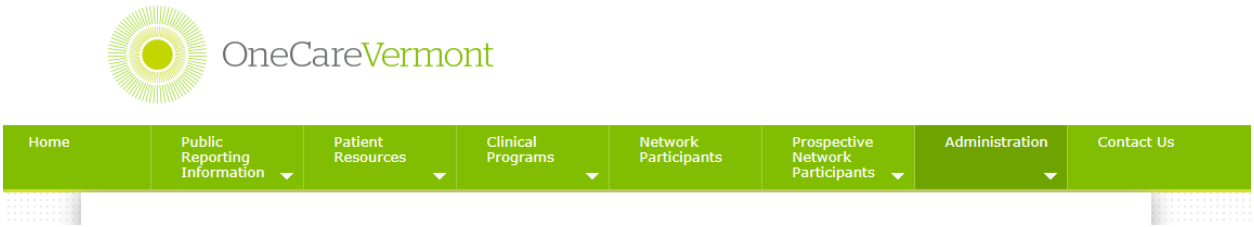
2. HCPS **G2007** (CPT 99348) - Established patient w/problem focused history, expanded problem focused examination, low medical decision making, the time based guideline is *30 minutes*

3. HCPS **G2008** (CPT 99349) - Established patient w/detailed history, detailed examination, moderate medical decision making, the time based guideline is *45 minutes*

4. HCPS **G2009** (CPT 99350) - Established patient w/comprehensive history, comprehensive examination, moderate to high medical decision making, the time based guideline is *60 minutes*

Important Note: While additional HCPS G codes are available for billing under the PDHV Waiver, for purposes of the Pilot program the above listed codes have been agreed upon for billing and reimbursement of E/M Services in the participation. As the PDHV Waiver is established and sustained across the OneCare Network, additional HCPS codes for E/M services *may* be added. For questions about coding under the PDHV Waiver, please contact the Medicare Waiver Administrator.

OneCare Data Resources



OneCare Secure Portal

A secure OneCare participant only internal website with financial, patient attribution lists, and network information.

CARE NAVIGATOR

A secure care management software system that supports greater alignment and integration in the work of complex care coordination in our network. CareNavigator is designed to support quality care management, population health, and improved outcomes by utilizing a single and secure platform that supports communication, shared care planning and collaboration among care team members.

Workbench One™

An innovative population health data platform powered by up-to-date clinical and claims data. Workbench One utilizes Advanced Analytics Applications ("Apps") that allows it's users to generate timely utilization and financial queries and reports across provider, practice, patient(s) and clinical service.

To request access to or training on OneCare Data Resources, please email: helpdesk@onecarevt.org

OneCare Vermont Contact Information

OneCare Vermont
Accountable Care Organization, LLC
356 Mountain View Drive, Suite 301
Colchester, VT 05446
Phone: (802) 847-7220
Toll-free: (877) 644-7176
Email: Helpdesk@onecarevt.org Website: www.onecarevt.org

Norman Ward, MD
Chief Medical Officer
Phone: (802) 847-1261
Email: norman.ward@onecarevt.org

Jodi Frei, PT, MSMIIT
Manager, Clinical Programs
Email: Jodi.frey@onecarevt.org

Emily Martin, RN, CCM, CPHQ
Clinical Education Coordinator
Email: Emily.martin@onecarevt.org

Appendix A: Proposed Workflow for PDHV Waiver Pilot