

Next Generation ACO Home Visits Benefit Enhancements: Frequently Asked Questions

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This document highlights frequently asked questions related to the Next Generation ACO (NGACO) Model home visits benefits enhancements and includes the following:

- Section I addresses [policy and requirements](#) of the Post-Discharge Home Visits Benefit Enhancement
- Section II considers [policy and requirements](#) of the Care Management Home Visits Benefit Enhancement
- Section III includes [general questions](#) that pertain to both benefit enhancements.

Section I. Post-Discharge Home Visits Benefit Enhancement

Currently, in traditional fee-for-service (FFS) Medicare, beneficiaries can receive a post-discharge evaluation and management (E/M) visits when they return home after discharge from an inpatient facility. A physician or non-physician practitioner can furnish this E/M service in the beneficiary's home. (This service would **not** be a home health service for the home-bound.)

Q1: What is the post-discharge home visits benefit enhancement?

A1: The NGACO Model post-discharge home visits benefit enhancement provides flexibility to furnish home visits to beneficiaries in the period following discharge from an inpatient facility by eliminating the requirement that, since these services are furnished as an incident to the professional services of a physician or other practitioner, they must be furnished under direct supervision. The waiver allows for a physician to contract, for example, with licensed clinicians (that is, auxiliary personnel) to provide a visit to an aligned beneficiary at the beneficiary's home under the *general supervision* of a Next Generation Participant or Preferred Provider following discharge from an inpatient facility. This benefit enhancement provides flexibility during the critical time when a Medicare beneficiary is discharged from an inpatient facility.

Q2: Who is eligible to furnish services under the benefit enhancement?

A2: The benefit enhancement may be furnished by Next Generation Participants and Preferred providers to ACO-aligned beneficiaries to use under the following circumstances:

- The beneficiary does not qualify for Medicare coverage of home health services (or qualifies for Medicare coverage of home health services on the sole basis of living in a medically underserved area).
- The Beneficiary is an aligned beneficiary at the time the services are furnished or within the grace period.
- The services are furnished by auxiliary personnel under the general supervision of a Next Generation Participant or Preferred Provider who is identified by the ACO as participating in the post-discharge home visits benefit enhancement and who is a physician or other practitioner.

- The services are furnished in the beneficiary's home after the beneficiary has been discharged from an inpatient facility.
- The services are furnished not more than nine times within 90 days following discharge from an inpatient facility (for example, an acute inpatient hospital, inpatient psychiatric facility, skilled nursing facility, long-term care hospital, or an inpatient rehabilitation facility).

Q3: If a beneficiary is not eligible for home health services, can he or she receive physical or occupational therapy from a home health provider under the post-discharge home visits benefit enhancement?

A3: The post-discharge home visits benefit enhancement can be used in this scenario if the beneficiary is not eligible for home health services, the physical or occupational therapist (or other health care provider) is billing for the services using the HCPCS codes required under the terms of the post-discharge home visits benefit enhancement, and all other requirements are met.

Q4: How do you bill for this service?

A4: The physician or other practitioner billing for the service must be a Next Generation Participant or Preferred Provider with the post-discharge home visits benefit enhancement indicator. The Next Generation Participant or Preferred Provider must use the following G-codes codes to bill for these services:

G2001	Post-Discharge Home Visit new patient 20 minutes
G2002	Post-Discharge Home Visit new patient 30 minutes
G2003	Post-Discharge Home Visit new patient 45 minutes
G2004	Post-Discharge Home Visit new patient 60 minutes
G2005	Post-Discharge Home Visit new patient 75 minutes
G2006	Post-Discharge Home Visit existing patient 20 minutes
G2007	Post-Discharge Home Visit existing patient 30 minutes
G2008	Post-Discharge Home Visit existing patient 45 minutes
G2009	Post-Discharge Home Visit existing patient 60 minutes
G2013	Post-Discharge Home Visit existing patient 75 minutes
G2014	Post-Discharge care plan over 30 minutes
G2015	Post-Discharge care plan over 60 minutes

Q5: What qualifies as an inpatient facility for the post-discharge home visits benefit enhancement?

A5: For the post-discharge home visits benefit enhancement to apply, the beneficiary must have been discharged from one of the following types of inpatient facilities:

- 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

Q7: How many post-discharge home visits services is a beneficiary eligible to receive after being discharged from an inpatient facility?

A7: Under the benefit enhancement, a beneficiary is eligible to receive up to nine post-discharge home visits within 90 days following discharge. The nine services cannot be accumulated across multiple discharges; if the beneficiary is readmitted within 90 days of the initial discharge, following the subsequent discharge, the beneficiary may receive only the nine visits in connection with the most recent discharge.

Section II. Care Management Home Visits Benefit Enhancement

The Care Management Home Visits Benefit Enhancement equips NGACOs with a new tool to provide home visits proactively and in advance of a potential hospitalization. Aligned beneficiaries, at risk of hospitalization or other factors identified by a NGACO, and for whom a Next Generation Participant or Preferred Provider has initiated a care treatment plan is eligible to receive up to two care management home visits within 90 days of seeing a Next Generation Participant or Preferred Provider who has initiated a care treatment plan for the beneficiary. Beneficiaries may become eligible to receive a third care management home visit within the 90-day period if the beneficiary first has an in-office visit with a Next Generation Participant or Preferred Provider in which an E/M service is provided.

This is not part of the home health benefit, and beneficiaries eligible to receive home health services generally are not eligible for this Benefit Enhancement. The items and services provided as part of these care management home visits are intended to supplement, rather than substitute for, visits to a primary care provider or specialist in a traditional health care setting.

Q1: What is the care management home visits benefit enhancement?

A1: The NGACO Model care management home visits benefit enhancement provides flexibility in billing for home visits, provided to beneficiaries to prevent possible hospitalization, by eliminating the requirement that these services must be furnished under direct supervision. The benefit enhancement allows licensed clinicians (that is, auxiliary personnel) to provide a visit to a patient at the patient's home under the *general supervision* of a Next Generation Participant or Preferred Provider. These services must be furnished within 90 days of the patient seeing a Next Generation Participant or Preferred Provider who has initiated a care treatment plan.

Q2: Who is eligible to furnish services under the care management home visits benefit enhancement?

A2: The care management home visits benefit enhancement is available to ACO-aligned beneficiaries to use under the following circumstances:

- The beneficiary is determined to be at risk of hospitalization;
- The beneficiary does not qualify for Medicare coverage of home health services (unless the sole basis for qualification is living in a medically underserved area);
- The services are furnished in the beneficiary's home after a Next Generation Participant or Preferred Provider has initiated a care treatment plan;
- The beneficiary is not receiving services under the post-discharge home visits benefit enhancement.
- The services are furnished not more than two times within ninety (90) days of the beneficiary seeing a Next Generation Participant or Preferred Provider who has initiated a care treatment plan, except that a beneficiary may receive one

additional care management home visit within this 90-day period if the beneficiary first has another in-office visit with a Next Generation Participant or Preferred Provider where a service identified by an E/M code is furnished.

For a complete list of criteria, please consult Appendix Q of the Participant Agreement.

Q3: How do you bill for this service?

A3: The physician or other practitioner billing for the service must be a Next Generation Participant or Preferred Provider with the Care Management Home Visit Benefit Enhancement indicator. The Next Generation Participant or Preferred Provider must use the following HCPCS codes to bill for these services:

G0076	Care Management Home Visits new patient 20 minutes
G0077	Care Management Home Visits new patient 30 minutes
G0078	Care Management Home Visits new patient 45 minutes
G0079	Care Management Home Visits new patient 60 minutes
G0080	Care Management Home Visits new patient 75 minutes
G0081	Care Management Home Visits exist patient 20 minutes
G0082	Care Management Home Visits exist patient 30 minutes
G0083	Care Management Home Visits exist patient 45 minutes
G0084	Care Management Home Visits exist patient 60 minutes
G0085	Care Management Home Visits existing patient 75 minutes
G0086	Care Management Home Visits care plan overs 30 minutes
G0087	Care Management Home Visits care plan overs 60 minutes

Q4: For beneficiaries receiving care management home visit services, what information must be included in the care treatment plan?

A4: There are no specific model requirements that define the care treatment plan. Care management home visits can be incorporated into a broader care treatment plan for the beneficiary, and need not be a standalone document.

Q5: Eligible beneficiaries may receive up to two care management home visits within 90 days of seeing the Next Generation Participant or Preferred Provider who initiated the beneficiary's care treatment plan. What qualifies as "seeing" a Next Generation Participant or Preferred Provider?

A5: Beneficiaries must be present for an in-person office visit with a Next Generation Participant or Preferred Provider in which an E/M service is provided to qualify as seeing the Next Generation Participant or Preferred Provider.

Q6: If a beneficiary received two care management home visits within 45 days, when can they receive an additional series of care management home visits?

A6: Care management home visits may be furnished not more than two times within ninety (90) days of the Beneficiary seeing a Next Generation Participant or Preferred Provider who has initiated a care treatment plan. A beneficiary may receive one additional care management home visit within this 90-day period if the Beneficiary first has an in-office visit with a Next Generation Participant or Preferred Provider where a service identified by an E/M code is furnished.

A beneficiary can receive an additional series of care management home visits only after the conclusion of this 90-day period. A beneficiary cannot receive two concurrent series of care management home visits during the same 90-day period, even if initiated by a different Next Generation Participant or Preferred Provider. Also, to receive each new series of care management home visits, all eligibility criteria must be met for the new series (e.g., the beneficiary must be seen by a Next Generation Participant or Preferred Provider who has initiated a care treatment plan, ineligible for the post-discharge home visit waiver or home health services, determined to be at risk of hospitalization, etc.).

Q7: A beneficiary is determined eligible to receive care management home visits during a visit with a Next Generation Participant or Preferred Provider. Within 90 days of that visit, the beneficiary is treated for an acute care need in the inpatient setting and discharged. Can the beneficiary receive the care management home visits, as planned?

A7: No; to be eligible for care management home visits services, the beneficiary must not be eligible for post-discharge home visits services.

Section III. General Questions

(for both Care Management Home Visits and Post-Discharge Home Visits Benefit Enhancements)

Q1: How does CMS define general supervision?

A1: In our regulation at 42 CFR §410.26(a)(3), general supervision means that the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service.

Q2: How does CMS define licensed clinical staff?

A2: Licensed clinical staff means auxiliary personnel, as defined in 42 C.F.R. § 410.26(a)(1), licensed or otherwise appropriately certified under applicable state law to perform the services as directed by, and under the general supervision of, the supervising physician or other practitioner.

Q3: Who is certified or qualified as a licensed clinician that can furnish services under *general supervision* for the home visits benefit enhancements?

A3: An ACO should consult with its legal advisors on how the state defines licensed *clinician* and to ensure services are furnished in accordance with all applicable laws, including Medicare coverage and payment criteria.

Q4: What services can be provided at a home visit?

A4: Care management and post-discharge benefit enhancement home visits are billed using codes that are defined in the aforementioned tables in Section I. Q5 and Section II. Q3. Additional medically necessary services can be furnished in the beneficiary's home as permitted under the generally applicable Medicare rules and requirements, including the usual supervision requirements.

Q5: What qualifies as a "home" for providing home visits under the Post-Discharge Home Visits or Care Management Home Visits benefit enhancements?

A5: Care management and post-discharge home visits can be conducted at a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.