HEALTHCARE REGULATORY ROUND-UP

Hospital at Home:

Past, Present, and Future

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Introductions

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Video Place Holder

- https://www.cbsnews.com/news/new-program-lets-hospital-patients-heal-at-home/

Defining “Hospital at Home”

- Catch-all term referring to delivery of acute level hospital care furnished to individuals in their home
  - Higher acuity, intensity of services than home health care
- More appropriate term is **Acute Care at Home – AC@H**
  - ‘Hospital at Home®’ is a registered trademark of Johns Hopkins HealthCare Solutions
- Generally not recognized by payers as reimbursable services
  - Specific components may qualify for payment, but not as distinct benefit
    - E.g., home visits, remote physiologic monitoring

The Past: Before COVID-19

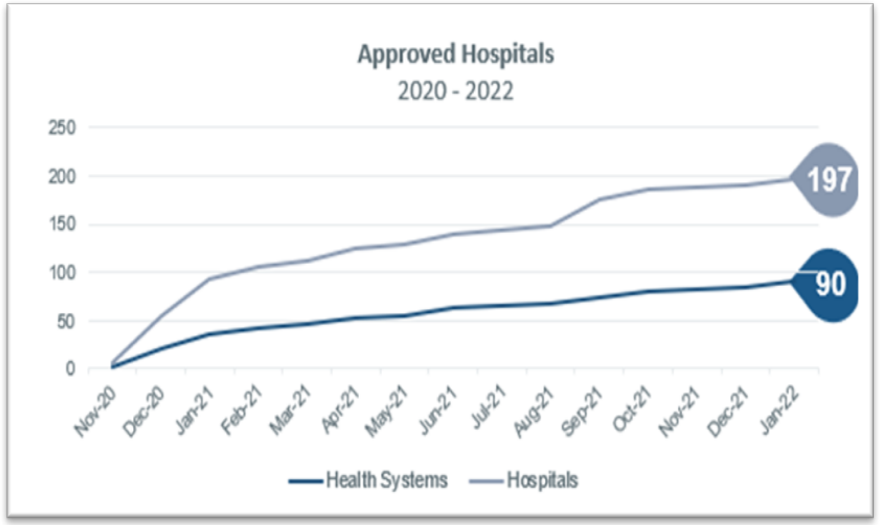
- 2000-2002: National Demonstration and Evaluation Study tested substitutive acute care at home model for pneumonia, CHF, COPD, cellulitis
- 2014-2017: CMMI HCIA-funded Icahn School of Medicine at Mount Sinai Mobile Acute Care Team care delivery and payment model
- 2017: Physician-Focused Payment Model Technical Advisory Committee recommended alternative payment model for acute care at home bundled with a 30-day post-acute period of home-based transitional care

Outcomes


Lower SNF Admission Rates
Lower Readmission Rates
Lower Mortality Rates
Reduced Length of Stay
Higher Patient Satisfaction
Pain Control?
AC@H
Lower Rates of Adverse Events
Less Use of Ancillary Services
Health Equity Impact?

The Present: CMS Acute Hospital Care at Home Waiver

- Launched in November 2020 as part of COVID-19 Hospitals Without Walls initiative
  - Traditional Medicare + Medicaid (only if state alignment)
- Hospital receives standard DRG payment for delivering inpatient-level care in beneficiary's home
  - Expedited Waivers (Tier 1) – Previously furnished in-home acute care to ≥ 25 patients who met inpatient criteria
  - Detailed Waivers (Tier 2) – Detailed explanation of how each service and safeguard would be provided
- Terminates with the end of the COVID-19 PHE (Section 1135 waiver authority)



AHCaH Waiver Requirements - Safeguards

- Only ED patients and inpatients who meet hospital-developed eligibility criteria
  - No direct admits (concerns about overutilization)
  - CMS does not restrict to specific diagnoses or other criteria
- Use approved patient leveling process to ensure patients require acute level of care
- Report volume, escalation rate, and unanticipated mortality to CMS (Tier 1 monthly; Tier 2 weekly)
- Establish local safety committee to review reported metrics
- Arrange for home delivery of services required during inpatient hospitalization
  - Monitoring (≥ 2 sets of patient vitals/day) pharmacy, infusion, respiratory, diagnostics, transportation, dietary, DME, therapies, social work and care coordination

AHCaH Waiver Requirements - Services

- Initial in-person evaluation by medical staff member
- At least once/daily visit by medical staff member (remote or in person)
- At least two in-person daily visits by RN or Mobile Integrated Healthcare/ Community Paramedic
  - If both in-person visits by MIH/CP, additional daily remote RN visit to develop nursing plan
- Immediate, on-demand remote audio connection with AHCaH team member who can immediately connect appropriate RN or medical staff member
- In-home appropriate emergency personnel response to patient's home within 30 minutes, if needed
- All documentation completed in EHR accessible to all clinicians/contracted services, including those who would treat patient in event of escalation

AHCaH Waiver Experience

Escalation and Unexpected Mortality Associated with the Acute Hospital Care at Home Initiative

Total Patients	1,878
# Escalations	134
% Escalations	7.14%
# Unexpected Mortalities	8
% Unexpected Mortalities	0.43%

This data is based on participation among hospitals that received waivers to participate in the Acute Hospital Care at Home program between November 25, 2020, and October 27, 2021. Source: The authors

D. Clark, et al, *Acute Hospital Care at Home: The CMS Waiver Experience,* NEJM Catalyst (Dec. 7, 2021).

Even with reimbursement and need to expand capacity, less than 4% of community hospitals participate in AHCaH waiver with average of 10 admissions per program

Future AC@H Programs?

- Traditional Medicare
  - Incorporate into existing Conditions of Participation through notice-and-comment rulemaking (e.g., 2023 IPPS Proposed Rule)?
    - Statutory authority? (“inpatient” not defined in Social Security Act)
  - Incorporate into soon-to-be-released Rural Emergency Hospital program?
  - Center for Medicare & Medicaid Innovation demonstration program?
- Medicaid
  - Approval of state plan amendments?
- Medicare Advantage
  - 2023 MA Advance Notice proposes changes to Star Ratings to evaluate engagement in value-based payment models
- Commercial Plans
  - Beyond individual provider pilot projects?

Hospital at Home Users Group™

"a dynamic collaborative of Hospital at Home programs across the United States and Canada"

MEMBERSHIP

Members of the Users Group build community by sharing resources and best practices.

TECHNICAL ASSISTANCE CENTER

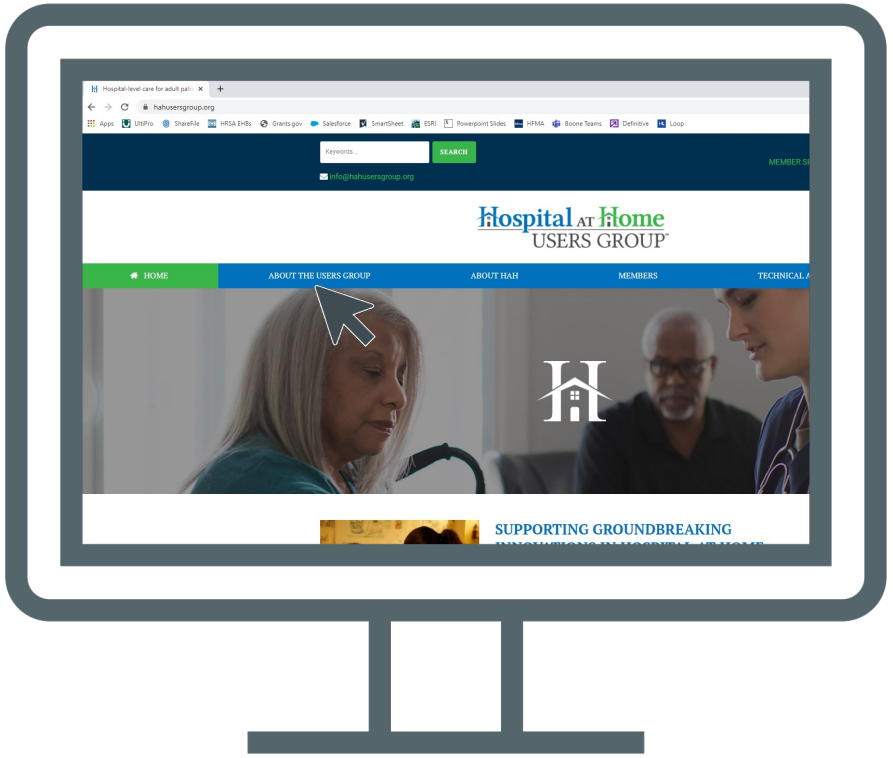
Serves as hub of materials, resources, and information to help members build high quality programs.

RESOURCES & EVENTS

Knowledge is shared via frequent webinars, events, and workgroups.

DEVELOPING STANDARDS

Working to develop program and policy standards to inform regulatory and reimbursement policies.



OTHER RESOURCES

Third-party vendors (Contessa Health, Medically Home, Johns Hopkins Health Care Solutions) offer direct implementation solutions for hospitals ready to stand up acute care at home programs.

Source: Hospital at Home Users Group

AC@H Success Factors

- **Universal buy-in**
  - Governance
  - Management
  - Medical Staff
  - Hospital patient care staff
  - Operational support (IT, finance, legal, compliance)
  - Patients and family
- **Identification of appropriate patients**
  - Medical condition (admitting diagnosis, complications)
  - Appropriate home setting
  - Financial class
- **Timing**

Pursue AC@H? Evaluate the 5 S's

1. Strategy
2. Savings
3. Staffing
4. Setting
5. Sustainability

1. Strategy

- Does an AC@H program align with and support current strategic imperatives?
- Is there organizational capacity (time, talent, and treasure) to pursue AC@H given other priorities (especially given present lack of reimbursement)?
- What assets and relationships does the organization presently have that can be deployed in support of AC@H program (e.g., SNF, home health)?
- Does the organization face capacity issues that may require capital replacement or expansion?
- Is there an opportunity to increase case mix index?
- Is there current market demand (patients and payers) for AC@H services? Is there likely to be such demand in the future?
- Would an AC@H program enhance organization's reputation/market position?
- Would an AC@H program expand traditional service area?

2. Savings

- Patient origination
  - Direct admission from community
  - Diversion from ER or inpatient admission (ACHaH waiver)
  - LOS reduction
- Savings derived from difference in variable costs associated with acute hospital services furnished in lower cost setting
  - Calculate and compare AC@H per diem costs vs. AC@F (acute care at facility) per diem costs
  - AC@H per diem costs include “new incremental” costs (e.g., telehealth, remote patient monitoring)

Methodologies for Calculating AC@F Per Diem Costs

- Aggregate financial statement average cost/day (outpatient and case mix adjusted)
- Department-level cost-to-charge ratios or operating CCRs as reported in annual Medicare cost report
  - Apply selected CCRs to billed charges to calculate encounter-level cost; further refine by segregating charges into days within LOS when charges were incurred
- DRG-level cost accounting system average cost/day (direct variable costs only)
- Medicare DRG reimbursement per diem
  - DRG payment minus capital component and add-on payments divided by average length of stay

3. Staffing

- Define staffing model based on volume projections (e.g., AHCaH waiver requirements)
- Evaluate build (employ) vs. buy (contractor) to provide necessary staffing levels
  - To what extent can existing patient care team members be trained and re-deployed to provide AC@H services?
  - Will physician service agreements need to be re-negotiated? Will new physicians/APPs need to be recruited? What training will they require?
  - What is the appropriate compensation and incentive model for AC@H providers?
- Consider necessary modifications to work rules and any union contracts to accommodate AC@H programs

4. Setting

- Plan for achieving medical staff buy-in
- Establish enrollment algorithm (admitting diagnoses + disqualifying medical conditions/complications + financial class)
- Determine appropriate enrollment criteria (health equity concerns)
- Define enrollment process (including patient recruitment)

Enrollment Criteria:

- Resides within 30 minutes from acute care facility
- Has a 24/7 caregiver at home
- 18 years of age or older
- English / Spanish Speaking
- Working Utilities in the Home
- Cellular Reception

- Example -

Wellspan Hospital at Home

https://www.wellspan.org/programs/hospital-at-home/

Enrollment Diagnoses

- COPD
- Pneumonia
- CHF
- Dehydration
- Asthma
- Covid-19
- UTI
- HTN
- DVT / PE
- Sepsis

5. Sustainability

- Develop performance measures for quality (successful outcomes) and financial results (realized incremental revenue or actual measurable cost savings)
- Consider volume of savings from reduced LOS
- Consider increase in case mix index through increased capacity
- Consider existing reimbursement (e.g., transitional care management, remote patient monitoring)
- Monitor developments with government payers (advocate for Medicaid state plan amendments)
- Evaluate opportunities with commercial payers (e.g., bundled payments for episode of care)
- Consider impact on participation in partial- and full-risk arrangements

Crawl, Walk, Run

- Transitional care management
- Remote patient monitoring
- Screening for social determinants of health
- Quantifying cost savings
- Reducing LOS

Rural AC@H

Opportunities

- Makes Rural Emergency Hospital model more appealing to communities considering transition
- Potential solution for communities losing inpatient services
- Better connect rural communities to broader care continuum
- Work to reduce acute care inequities in rural settings
- Further integrate physician and nurse care with community paramedicine, emergency department, pharmacy, and remote technologies
- Promote patient centered care and innovate decentralized care access patterns in rural communities

Challenges

- Cellular and internet access
- Resources and staffing
- Transportation
- Lack of network relationships
- Attitudes toward rural acute care at home, both from clinicians and potential patients
- New payment model required to support care delivery
- Lack of data and established protocols for delivery of acute care at home in a rural setting (nearly all existing HaH programs geared toward urban populations)

Our Next Healthcare Regulatory Round-Up

COVID-19 Relief Funds Update

February 23, 2022

How Can We HELP?

A national healthcare advisory services firm providing consulting, audit, and tax services