



June 22, 2021

## **Hospital at Home: Opportunity for Continuing Beyond the Pandemic**

Since there exists nascent administrative and Congressional conversations about continuing the Public Health Emergency (PHE) hospital at home (HaH) model, now formally termed Acute Hospital Care at Home (AHCAH), this memo provides a brief history of hospital at home, a description of AHCAH and rationale for continuing use of the care model.

We have learned that there is growing interest among our health system clients and others in seeking the necessary legal and regulatory changes that would allow the HaH model to continue beyond the PHE.

### **Background**

To improve geriatric care, Johns Hopkins first piloted the HaH model over 20 years ago. Beyond Hopkins, [notable models](#) also exist today at Mount Sinai, Marshfield Clinic, Tufts and elsewhere. The frequently cited [Mount Sinai](#) HaH program was launched in 2014 with a three-year, \$9.6 million CMMI grant. To date the Mount Sinai program has treated over 1,000 patients. The VA has provided HaH services for several years (for example, [here](#) and [here](#).) Overseas, HaH care is provided in Australia, Canada, Israel, the UK and elsewhere. The ACA-created PTAC (Physician-Focused Payment Model Technical Advisory Committee) approved [two HaH payment models](#) in 2017. However, like all PTAC-approved models, CMS has failed to test. HaH research findings have been on balance favorable. For example, [research published](#) in 2018 in [JAMA Internal Medicine](#) found HaH patients had comparably lower rates of readmissions, ED revisits and SNF admissions and were more likely to rate their hospital care highly. (See also the [related HaH RCT](#) findings published in January 2020 in the [Annals of Internal Medicine](#).)

### **ACHAH Described**

Because of the COVID-19 pandemic, in March 2020 CMS [announced](#), via use of its 1135 blanket waiver authority, the agency's Hospital Without Walls program that allowed hospitals to provide alternative sites of care. This past November, CMS [updated and expanded](#) the hospital and ASC program and renamed the program AHCAH. The AHCAH FAQ is [here](#), a list of approve AHCHA participants as of June 18, in sum 63 systems, 139 hospitals in 32 states, is [here](#) and testimonials by 18 HaH healthcare providers is [here](#).

Per the AHCAH's FAQ, here is a bulleted overview of program:

- There is no deadline to apply, however, the program or waiver is only in effect for duration of the PHE.
- There are two ways to apply: an expedited pathway for experienced hospitals and inexperienced hospital application.
- Patients must meet acute inpatient or overnight observation status to qualify.
- If multiple hospitals within a system desire to participate, each is required to apply independently.
- All patients must enter via an ED visit or an inpatient hospital setting.
- The in-person provider exam must be performed by a hospitalist or admitting provider prior to the patient being transferred home.
- “At home” can mean an assisted living facility, however not a SNF, but the hospital must make sure there are no duplicate state or federal payments.
- Regarding clinical care, in-person vital signs should be consistent with existing hospital policies, RPM can be continuous or intermittent. There must be at least two in-person visits daily but these can be in-person or remote, one of which may be completed by a paramedic, the other by an RN. Other ancillary care can be provided virtually. A therapist from a partnered Home Health agency can deliver services but not part of an episode of Home Health care and their care needs to be supervised. Patients can administer their own medications.
- Regarding payment, payments are the same as in patient, billing requirements and cost reporting are the same.
- Medicare Advantage beneficiaries can participate if the MA plan is in agreement.
- There is a HaH user group (<https://hahusersgroup.org>). See this related 12/20 [side deck](#).

### **Commercial Market Moves**

Two major stakeholders—Kaiser Permanente and Mayo Clinic—have invested a total of \$100 million in Medically Home, a company that provides resources for hospital-at-home care. These systems join several others that are scaling up their hospital-at-home services, including Johns Hopkins Medicine, Presbyterian Healthcare Services, and Massachusetts General Hospital, KHN reports.

The goal for programs is to eventually shift at least 10% of current hospital patients to hospital-at-home care, KHN reports. "In a lot of ways, this remains aspirational; this is the early innings," Dean Ungar, VP and senior credit officer at Moody's Investors Services, said. However, Ungar predicted "hospitals will increasingly be reserved for acute care [such as surgeries and ICUs]," with other patients treated at home.

### **Advocacy Opportunity**

CMS created the HaH initiative to help ensure hospitals have the ability to adequately manage patient surges through the duration of the PHE. Therefore, we do not expect HaH or AHCAH to continue beyond the PHE.

That said, since HaH has been tested since the mid-1990s, since the model has over the years been expanded to treat an increasing number of diagnoses or upwards of 150 different diagnoses that disproportionately affect Medicare beneficiaries, and since it has demonstrated comparatively better clinical outcomes, we believe there is an opportunity to advocate formally

for HaH policy reform. CMS could under its 1135 waiver authority continue HaH, CMMI could create a HaH demonstration and/or the Congress could pass legislation prescribing a HaH care option for certain diagnoses.

Reasons to persist with the care model include the possibility of improving care in underserved and rural communities and, considering the cost of hospital construction at about \$2 million per bed, the model potentially offers considerable Medicare program savings.

We would like to further discuss your interest in seeking the necessary government changes that would allow HaH continue as it has under the current waiver. We have been told that there may be another coalition forming led by one of the HaH national consulting firms. We strongly believe any coalition should be led by you – the health systems and your clinicians. Our role, as always, is to coordinate and manage your advocacy effort.

We are also exploring the creation of a national coalition – led by health systems – that would work collectively to obtain these policy changes.

We look forward to discussing with you soon. Thank you.

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