Centers for Medicare & Medicaid Services
Hospital at Home Stakeholder Call
December 9, 2020
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OPERATOR: This is Conference #: 1235939.

(Ashley Simms): Good afternoon and thank you for joining us today for the CMS Hospital at Home Stakeholder Call. My name is (Ashley Simms). I'm with CMS and I will assist with moderating this call today.

Before we get started, I just want to let everyone know that we do have resources available to support this call. One is a slide deck and the other would be an FAQ document. Both of which you can find on the CMS Outreach page under Partner Resources. It would have been where you registered for this call.

So, to get started, first, I would like to turn over the call to Dr. Lee Fleisher, director of the Center for Clinical Standards and Quality at CMS and then on to Jean Moody-Williams, deputy director in the same center at CMS. Dr. Fleisher?

Lee Fleisher: Yes, (Ashley). Thank you and thank you for joining us today. As we saw the increasing number of hospital beds being occupied and hospital capacity diminishing as well as given the previous coronavirus surge at the beginning of the pandemic back in March, the issue of ensuring optimal capacity for our patients, both in the hospital and ensuring that they will get the needed care, which became a critical issue, and we're very fortunate that around 2014 there was a grant from CMMI, to Mount Sinai, whose representatives we have on the call today, for Hospital at Home, which has been developed by others like Johns Hopkins even earlier in the plan to come up with alternative care models.

So, we're very excited that approximately 10 days – almost two weeks ago we decided to add to our waivers around the Hospital Without Walls to extend it to Hospital at Home. You'll hear more about the issues that we relaxed, the requirement for 24/7 nursing, as well as in addition, relaxed the life safety or

use enforcement discretion with regard to life safety for the home environment.

And we're excited that a number of different hospitals have taken advantage of our waiver, which has – you can find on the web and (Doug) may describe more of it or we can do more of it through our question and answer because it's an individual waiver. But we want to thank all those on the call today for everything you do for our beneficiaries for CMS and for all Americans in both addressing their healthcare, both with and without COVID.

And with that, I'd like to turn it over to Jean Moody-Williams, my deputy, to say a few more words before we turn it over to Doug Clarke who is one of the leaders within CMS for this effort. Jean?

Jean Moody-Williams: Thanks, Lee, and thanks so much – yes. Thanks so much to everyone for joining the call. Really, since the beginning of the pandemic, I've hosted nearly weekly calls with many of the settings of care, and with each one become even more impressive. We listen to the best practices that are going on with the challenges that you face on a day-to-day basis and as we try to develop policies and waivers and various flexibilities to address those challenges.

So, this is our second call related to Hospital at Home. And initially, we invited the hospital community who has the ultimate responsibility of the care. But as we were thinking about who to invite to this call, we knew it was imperative that we also expand the list to include physicians, nurses, physician assistants, and other clinicians who are vital to ensuring that approach to this flexibility that we're providing works. It is incumbent that there's a strong clinical team working with the administrative team to ensure success and the patients that will benefit from the opportunities that are going to be provided.

So, again, we want to thank you for joining and we have the whole care team here on this call, and look forward to the question and answer period. I'll turn it back to you. Thanks.

Doug Clarke: Thank you. This is (inaudible) …

Lee Fleisher: So, with that – yes, we're going to turn to Doug Clarke who is one of our medical officers within the Centers for Medicare and Medicaid Innovations and who is leading the waiver program along with (Lisa Tripp) from CCSQ and (Danielle Adams), one of the other specialist who is a nurse within CCSQ. And Doug, why don't you introduce our guests.

Doug Clarke: Thanks, Lee, and thanks, Jean. I really appreciate your leadership during this extraordinary time and to see what CMS has been able to do here and also learn from some of our guests that I'm (ready) to introduce.

First, we're going to have Dr. Linda DeCherrie. She is the clinical director of the Mount Sinai Hospital at Home Program and also a professor in the Department of Geriatrics and Palliative Medicine there. Following her, we're going to have Dr. David Levine, who is a practicing general internist and clinician investigator at Brigham Health and Harvard Medical School. He is medical director for strategy and innovation for the Brigham Health Home Hospital.

I want to thank both these two and (Al Siu) from Mount Sinai and (Bruce Leff) from Johns Hopkins as well for being a consistent source of helpful expert advise. And with that, I'm going to turn it over to Dr. DeCherrie.

Linda DeCherrie: Thank you so much. I hope everyone has been able to download the slides or look at them. And I will try to say what slide I'm on as I do my presentation. Thank you for having us today to tell a little bit about the history of Hospitalization at Home at Mount Sinai where we are going forward of this.

I have no conflicts of interest. But we do have a joint venture partnership with Contessa Health for the operations of our Hospital at Home program. So, specifically about our history, as was mentioned earlier, we were fortunate enough to receive CMMI Innovation Award in 2014 that created our Hospitalization at Home program, which we operated for three years under that. We also receive funding from The John A. Hartford Foundation, which helped us a lot in our evaluations of that program.

On that end, in 2017, we formed a joint venture with Contessa and have continued operating together since then by getting contracts with MA plans

and commercial insurances, managed Medicaid. And today, we operate out of four of the Mount Sinai hospitals in one program.

So, going to slide five, I'm going to talk a little bit about how we've operated prior to this waiver and then I'll move on to our plans under the waiver. So, prior to the waiver, we considered the care in a 30-day cycle, a 30-day bundle, which included the acute phase, and then the post-acute phase up to 30 days as follow up.

We would meet our patients mostly in the emergency room and do our admissions. And then they would transition home for three to five days of care, which includes all the things that are mentioned in this waiver, such as daily physician visits, twice a day nursing visits, IVs, meds, oxygen, and of course, 24/7 support, and then a formal discharge with information back to the primary care physician.

And then we monitor – we monitor our patients for 30 days. The ideal is that they get back in touch with their primary care provider or any consultants, but we are available to them for emergencies, and we have remote nurses who do intensive disease-specific care management during that 30 days.

If you look at slide six, again, this is prior to this waiver. This is kind of all the different pathways of how we might obtain a patient for admission. So, usually, it is through the emergency room, but we were not restricted to that. We might meet someone in the clinics, specifically congestive heart failure might be a very good example where we might meet someone in the clinic or an urgent care center.

They are evaluated by a provider and our care coordinator. They have to meet inpatient criteria. We use MCG and then our specific home safety criteria and then specific clinical criteria for us to be able to take care of them at home. We had patients we go to obs at home. If you go straight to Hospital at Home or they could start in the hospital in obs and then come in to Hospitalization at Home.

And this spring, we launched the third pathway, which is the cHaH, Completing Hospitalization at Home, really as a response to COVID so that

we could help decant the hospital and open up beds. So, those will be patients who came into the hospital for any number of days and then still needed to be hospitalized, but now we would bring them home for those last one to three days under our care.

I'm going to move now to the admission process under the new waiver, where we are restricted to meeting patients in the emergency room. But otherwise, the pathway is very similar. I think Doug is going to talk a little bit more or maybe we'll take in the Q&A about the initial observation unit and if we could take them home or not for an obs stay. And so, I'll leave that a little bit TBD.

But otherwise, it's going to be the same pathways. And we particularly admit patients from 8:00 a.m. to 10:00 p.m. Monday through Friday. We have 24-hour services for all the patients once they're home, but the admissions kind of team is available during those days.

And we have clinical protocols for the admissions for each of these diagnosis and we've been mapped into many DRGs in the end because, as you know, you may not always know what the DRG will be when you admit the patient.

So, kind of general criteria for all patient, we really look at what can be done at home, what if there – what is the hospitalist in the hospital have as their admitting orders and can we use – can we translate that to something that can be done in the home.

And so, many of the things we can do are listed on slide 11, which is, of course, labs, x-rays, consultants. We try to keep people under 4 liters of oxygen. So, we have a little bit of wiggle room. We will take patients with established CPAP and BiPAP who needs respiratory treatments, those who need IV diuretics, IV antibiotics, IV fluids.

I put a little parenthesis around peritoneal and hemodialysis patients because especially hemodialysis is challenging for us, but we do take peritoneal dialysis. And hemodialysis is challenging because the number of hours they are away – wound VACs, intermittent caths, chest tubes to gravity.

And things we don't do are higher levels of oxygen requirements, cardiac drips, insulin, heparin drips, blood transfusions, continuous telemetry, continuous pulse ox, bladder irrigation, and IV push IM narcotics. That's a list of what we don't do in the home. If someone does need a blood transfusion, we bring them back into for kind of an afternoon in the oncology chemo suite and do the transfusion there, and then they go back home with us.

Slide 12 is an example and not a complete example of what might be in our clinical criteria that we use when we evaluate a patient. This one is our heart failure one, and we have this for all our conditions.

I wanted to call out on slide 13 about our COVID admissions. Most of our COVID patients have come to us under our cHaH pathway, which means that they have started in the hospital and then they still need hospital level care but they're now on an improving trajectory that we can now take care of at home. The exception really is someone who has non-respiratory symptoms but happens to have a COVID positive diagnosis that we then could consider them for our program.

Slide 14 shows how we operate our program. And every place is different of what is kind of in source to next source in our program. So, we have physicians and nurse practitioners, social workers, all from Mount Sinai. We have our care coordinators both in the emergency room and virtual. We use our pharmacy from the Mount Sinai system. We've – all the labs are processed in our inpatient labs. And we have community paramedics.

Mount Sinai doesn't operate a home health agency. And so, we use an external vendor for our nursing, PTs, OTs, speech, infusion pharmacy, external DME company, external x-ray, ultrasound, couriers for food, an external ambulance company. We have a telehealth kit that every patient goes home with. And then we have our general medical courier to pick up and drop off things like our blood samples.

When someone is home with us, I put kind of a typical daily schedule here on slide 16. And of course, every patient will be slightly different. But an

example here is that they may start the day with the phlebotomist knocking at their door to draw their blood.

And then we have twice a day – what I call flip card rounds, which is not with the patient. It's a Zoom call with the team. So, the physician, the NP, the social worker, the nurses, care coordinators are all on that call to review what happened the day before and new admissions, and then the potential plan for the day for the patient.

Then they have a nursing visit and they may have an NP visit in the home or virtual. Then there's probably some delivery that needs to happen that day, some DME or infusion or food. Then they're likely to have a call from the social worker, could be in person, could be their one-time PT eval that comes. And then there's another flip card rounds for and then they would have their evening nursing visits.

And then I wanted to draw attention to one of our challenges that we had, some of our EMR challenges. At Mount Sinai, we use EPIC. And I'll tell you that in 2014 we were on outpatient EPIC and that was tremendously challenging. There's no ongoing order set in outpatient EPIC. There's no medication administration record.

And so, in 2018, we moved to outpatient EPIC with therapy plans. For those of you who know EPIC, that's with the chemotherapy and actual set of orders that are open for a number of days. That was helpful, still didn't solve all our problems. But this summer, we did transition to fully inpatient EPIC with some functionality turned off. And that has been a big win for us and we find that much better. However, because we do have an outside agency for nurses, we've had to develop a workaround for them to document so they're not documenting in both records.

So, I just wanted to share that because that was one of our challenges in starting our program. I'm cognizant of the time. So, I'm going to shift over and allow David to present about his program.

David Levine: Wonderful. Thanks so much, Linda. Really, a pleasure to be with you all today and we're on slide 20 here. Really excited to talk to you all about

Brigham's experience in Boston with Home Hospital and look forward again to a lively Q&A with everyone.

Just quickly on slide 21, I do have two disclosures. One, I have PI-initiated study as well as I've co-developed software with a company called Biofourmis making kind of end-to-end hospital at home solution, and then have a PI-initiated COVID-19 study outside of the present work.

I think a lot of the folks on the call right now, on slide 22, get the need for home hospital, right? It creates bed capacity in a really big way and does so we think in a very safe and high quality manner. And this is really all bout getting the right care to the right patient.

And I think if you're – if you're on the right mindset, it's all about taking patients who normally need care on the medical floor instead we're providing them that care at home. That's really our perspective. And this is not ICU care, but it's also not home health and not rehab. It's home hospital. So, I think it's important to differentiate that and kind of try to change this paradigm of, I'm sick and in the emergency room, and instead of getting hospitalized, getting home hospitalized.

And on slide 23, there's really kind of several models to consider for home hospital and there's a big X on one of the models here. I just wanted to point that out. And Linda pointed that out also that the transfer to home model where the patient has been in the hospital for something like 24 hours or more still needs more acute care but can get the rest of that acute care at home, right? Maybe they are diuresing for the another 10 days from a heart failure exacerbation.

And then there's the substitute with the ED model where the patient comes from their home, hits the emergency department and gets their triage, diagnosis, and first round of treatments, and then ends up getting the rest of their care at home instead of in the hospital. And then there's that big X around substituted without the ED because is not part of the CMS waiver. So, we're going to be skipping over that. In that scenario, frankly, we have much less experience at Brigham.

Just quickly on slide 24, our timeline and experience kind of started back 2016, just a couple of years after Sinai. We did the first randomized controlled trial of home hospital care then repeated that with a larger randomized controlled trial. First one in the United States, I should say. And we're able to kind of show that care was very high quality. Patients like their care, lower readmission rates, and even lower costs for the system providing the care.

And since then, we've really just been expanding into additional studies, additional diagnosis, new technologies, and that really has a ton of fun providing really topnotch care to patients in their home.

Our flow in page 25 is very similar with what you would expect. Patient hits the emergency departments and the decisions made to admit them. If they meet our criteria and they agree to enroll, than they get home hospitalized, and our team then deployed in their home. And that team, again, is a combination of nurses, paramedics, physicians, PT, OT, home health aids, and then all the treatments that you would expect of a regular inpatient stay, oxygen, nebulizers, (vast) IV infusion, would care, all sorts of things that we deliver in hospitals.

And then you can see there other options where they're already in the hospital and they meet home hospital criteria and agreed to enroll, then they can also go home for their continued acute care.

A lot of the conditions we treat are very much evidenced back from folks who work over the last two decades. On this care model really includes, on slide 26, any infectious process like cellulitis, complicated UTI, pneumonia, heart failure exacerbations, asthma and COPD exacerbations, and then a whole slew of other kind of smaller buckets such as cardiac diagnosis like Afib with RVR, diabetes and its complications, DVT and PE, and a whole other set of diagnosis.

And definitely I want to point you all towards our publication. In January, the (inaudible) of Internal Medicine where our inclusion/exclusion protocols are completely published and open source and the very, very nitty-gritty clinical

details of the different conditions we take are in the appendix in that publication, and those are the ones that we, in general, use to this day. And so, we definitely has had good luck with those. And they're built on the expertise of two decades of work in this area from others as well.

On slide 27, this an example, something we show on our patients when they come home, right, like what can you expect when you're at home. It's two daily nurses or paramedic visits or the daily doctor visits, IV medication if you need them, remote vital sign monitoring. We do continuously monitor our vitals – our patients with a wearable patch – diagnostic testing as well as 24/7 availability of our team booked in your home by video or by telephone.

I think I wanted to also highlight a couple of the key questions when you need to think about really starting one of these and we hope that a lot of folks on this call are here because they want to do this or already doing this. And really, I think there is a big build versus buy question here, right?

So, here are some of the core areas that you need to make that decision around. And so, we saw – Linda had that great table on things that Sinai has built versus bought. And there's lots of different considerations and every system is going to have to make a different decision because maybe you already have an infusion company that you own or work closely with, maybe your pharmacy is extremely able to deliver care to patients in their home, and so on.

And so, just to run through a couple of these decisions. For us, we in source our infusion entirely. Our team does all of our own advanced infusion. Our pharmacy is just incredible and Brigham's inpatient pharmacy is our home hospital pharmacy and is able to provide us all of the formulary drugs that we need for our patients.

We also do a lot of our own monitoring. And so, we have entire – continuous monitoring system that we've essentially in source. We don't kind of send that to a central command center or something like that, but we do that in our own team pretty evenly.

And then there's software, right? So, software can either bring you to your knees in the healthcare world or can actually make logistics work quite well. And so, again, there's a whole slew of different opportunities for folks out there to essentially run the logistics of a program via software, make sure communication easy, make sure it's all HIPAA compliant, et cetera.

And then durable medical equipment, our team has chosen to in source some of the DME that we need on a regular basis and then outsource a couple of the other pieces. But we're able to very sassily get the different pieces of equipment that we need for our patients.

And the same thing with personnel, there are some programs who have chosen to outsource nursing or outsource paramedicine versus other programs that have that inside. And we have probably a hybrid model of that for our program.

Diagnostics, we try to, again, do absolutely as much point of care work as we're able to, use point of care blood diagnostics, point of case imaging diagnostics as much as possible, and then you are able to outsource formal echoes and things like that in the home as needed. But again really depends on your builds and your system.

And then food, for example, are you going to take food from your hospital food service and bring to patients' homes? Maybe. Or perhaps there's a community nonprofit that does health supported food that they're able to deliver. That's the case for us. We partner with a nonprofit in our community to provide food for patients.

So, on slide 29, thinking about kind of the stuff you might need really for the minimum viable product here, the MVP. And again, I think the mantra here is you really want to build for what you need and need what you built. And this is really crucial because you could build a home hospital program that can deliver ICU-level care at home. You really could. But most likely nobody is going to do that right now.

Just like Linda said in the Sinai program, you really think about what does your patient need and you – and depending what you're able to build and what

you want to build, you can then design sorts of patients that you can take into your program.

And so, some of the really just key stuff off the top is your program is going to need oxygen concentrator. So, that's almost certainly something you don't own right now in your hospital. And so, oxygen concentrators are key items here.

You going to need some sort of an infusion gadget, right? So, whether that's a pump or an elastomeric ball, your hospitals already have IV pumps but likely they're not ambulatory infusion pumps. And so, chances are you don't want folks attached to a pole in the homes. And so, you are going to want a different kind of pump or an elastomeric ball. And really simple (VM) sources or depending on your market can outsource this to an infusion vendor as well.

You're going to want some sort of monitoring gadgets, whether that's a continuous patch faced system that's wearable of sorts, whether this is intermittent monitoring for vital signs, you need to think about what's the best for your system.

You're going to need a commode and that's something you can usually get from your hospital most likely. You're going to need a scale. You may not have the kinds of scale since you're on patient's home, but heart failure exacerbations and home hospitals always need a scale.

And then you're going to need some sort of an encrypted video, audio and text systems. Maybe you already have that platform or maybe that platform is going to be part of your home hospital platform but also crucial for getting the right communication in the home.

And then on slide 30, the people you need, kind of the minimum viable products. And in here, the mantra is, in my view, to really use your hospital wherever you can, right? You have an amazing infrastructure and a really innovative, ingenious team, how can you get that team out into the community in a really efficient way.

And so, the barebones home hospital team and the place that we're going to start with actually in 2016 was a physician, a nurse, and what we call program associate and really kind of an administrative aid to the program that helps with patient enrolment, patients' package – getting all the stuff packaged for the patient, and really you can – you can pull off an amazing, amazing care system just with those three people.

And then you can start to layer on all the other pieces, that we know many kinds of patients need, right? Physical therapy, occupational therapy, advanced practice providers, mobile integrated health paramedics, home health aide, and so on. But again, those are what you need. And if your patient – if you select patients who don't need physical therapy, we don't need a physical therapist on your team. But again, you may want to select patients who need physical therapy. And so, you need to be very conscientious of the exact kind of personnel that you need on your team.

And I can tell you when we started out it was really – it was just an M.D., an R.N., and a program associate, and that was our team and we slowly kind of gotten more complex but it is – you don't need to start with that enormous, enormous team from the very, very get go.

And we also wanted to make a few comments about COVID-19. Obviously, that's why we're here. It's this terrible, terrible calamity going on right now and everyone is working so hard. There are probably two ways to think about COVID-19 adaptations for home hospital care, right?

There's the system that have actually said, you know what? We are – we are going to not treat COVID-19 in our home hospital programs. And actually, that's Brigham. Brigham has not treated patients with COVID-19. And then there's system that say, you know what? That's all we're going to do. We're just going to focus on COVID-19.

Some of the considerations here, right, if you have a sufficient volume of non-COVID diagnosis in your hospital, you may – you may be able to do a whole lot of good by tackling everything but COVID and that's essentially what we did at Brigham. We were able to free up a lot of bed days at Brigham during

our March and April surge just by taking patients with heart failure, infections, and so on.

And so, if there's pretty insufficient PPE in your hospital system, which was the case for us in March and April, we had to stay away from patients with COVID. That was another kind of consideration. If you have a very small specialized bench as part of your team, which is the case for Brigham, then you also may want to stay away from COVID because one infection in your team could end up hurting your program, forcing it to even close.

And then finally, if you have continuous pulse oximetry, continuous oxygen, which we happen to have those capabilities in our program, but if you don't, you also will probably need to stay away from COVID-19.

I think the reason I put this slide together is because I really want to make sure that hospitals understand that a home hospital operation can do a whole lot of good even if it doesn't care for patients with COVID because those patients still are there and they still need care. They may be taking up beds rightfully so in our hospital and deserve really great care, but we can provide that care at home, and then the patient with COVID can take that bed instead.

Finally, to close up, we wanted to make sure that our folks knew that home hospital care, you're part of the community and we're really excited if you do start to care for patients in this way. There's actually a hospital at home users group. Now, we're about a year old now. Linda and I are co-chairs of the group along with (Bruce Left) and (Elle Sue).

And we're about 25 plus programs strong. And really, the only bar to be in our group is that you take care of acutely ill patients at home. And we have a set of practice standards and quality measures as well as regulatory framework to look at. And we're looking at research and advocacy as well. So, we really encourage you all to kind of reach out and kind of join that community if you start taking care of patients in this way.

And then finally, there's a worldwide community for hospital at home as well. And on slide 33, the Second World Congress actually would be in April, unfortunately, not in Vienna but virtual, and will be, again, a great place to

exchange best practices even for new programs who may have only started in the last couple of months.

And then the last piece I just wanted to put out there is on slide 34. If you happen to be a rural home hospital site, do not – do not be sad. This can be for you too. We've actually (inaudible) at Hartford that I am at, we've actually built an entire rural home hospital prototype and figured out how to make this work in a rural setting as well. So, if that is of interest to – in a rural hospital, we'd be happy to help with that too. There are a bunch of special considerations but certainly can work.

And just I wanted to quickly end kind of with this quote from one of my mentors, Atul Gawande, who says, we focus on breakthrough innovations without a matching investment in follow-through innovations. And home hospital is absolutely a follow-through innovation, right? We're not – we're not rocket scientist here. We're not inventing any new kind of medicine or a new drug. We're really just putting together care pathways that make a lot of sense and that we know have great outcomes with patients.

And so, on slide 36 is – if Phase 1 is the paper airplane, and people thing, it might work, there's a little bit of interest in something like this home hospital. And Phase 2 is a turbo (crop) plane, it works. It gets you from point A to point B and there's really measurable outcomes. And then Phase 3 is how we work. It's the jet lines. It's how you get from San Francisco to New York City. There's real impact.

I think all of those in home hospital is definitely in Phase 2 and we want to work with you and see it even grow to Phase 3 such that this is the way that we do take care of patients when they're acutely ill in our country.

With that close, really welcome your questions and super excited to be with you all today. Thanks.

Lee Fleischer: Thanks so much. I really appreciate the – both presentations. David and Linda are very good in those great insights. And so that those on the webinar understands we really focused this during the pandemic but we are collecting a lot of data both to ensure safety but also to help CMS make decisions for

post pandemic. And one of the things to – that becomes clear of the original grant to Sinai was the thought of this being developed within the innovation center.

So, the second thing is we did limit this to really coming from the emergency department and from the inpatient area, and that was really because of the way we're structuring this in our waivers. It was critical that the patient be seen by members of the medical staff, be evaluated, and this falls under the care of the medical staff.

So, with that, (Ashley), I'll turn it over so we can start getting questions from the audience.

(Ashley Simms): Sure. Thank you. Operator, can we open for questions now?

Operator: To ask a question via the telephone, please press "star," "1". If you would like to withdraw your question, please press the "pound" key. And we'll pause for a moment to compile the Q&A roster.

OK. First question comes from the line of (Liz Clark) of UC Davis Health. (Liz), your line is now open.

(Liz Clark): Thank you. Thank you very much for taking my question. I was wondering as far as any billing or payment for this Hospital at Home program that have already been instituted and have you build commercial payers and received any payment?

CMS Lee Fleisher: So, we'll start with – on (Dan), are you on for CMS? Because that's really what this program is about.

CMS (Dan): Sure. The Medicare inpatient payment policy is the billing requirements, your cost reporting requirements. They have not changed at all because of this waiver. So, you should bill appropriately for the services that you provide consistent with the existing Medicare policies and requirements. There's no – this waiver did not change anything on the inpatient side with respect to payment policies or rates.

(Liz Clark): I am curious though if just the established programs have been billing commercial payers and receiving any payments.

CMS Lee Fleisher: Sure. We can quickly – David or Linda?

CMS David Levine: Yes. I can just …

CMS Linda DeCherrie: Yes. I can take …

CMS David Levine: Go ahead, Linda.

CMS Linda DeCherrie: Yes. So, we have – we have contracts through our joint venture with a number of MA plans and commercial insurance and managed Medicaid for bundled 30-day payments.

CMS David Levine: Yes. On the Brigham side, we do have commercial contracts with a payer in Massachusetts for a DRG-based payment and had been successful on that contract over the last year and a half or so.

(Liz Clark): Thank you so much.

CMS Lee Fleisher: OK. Thank you. Next question.

Operator: Next question comes from the line of (Miriam Blankenbiller) of (Marshall) Home Health. (Miriam), your line is now open.

(Miriam Blankenbiller): Thank you. I have two questions actually. One is, are any of these programs using home health agencies as acute care providers? And then the second one is, we were unable to locate the slides. How can we find them?

CMS Lee Fleisher: (Ashley), do you want to comment on the slides and then …

CMS (Ashley Simms): Yes. And apologies that it's not as easy as we thought. So, the slides are on the CMS website. There is a partners page or partners toolkit where all of the stakeholder calls are listed for COVID-19, and it is listed on that page under this call. You'll see this call listed with registration information or call in information and then the slide a link to the slide is directly under that information.

(Miriam Blankenbiller): Thank you.

CMS Lee Fleisher: And with regard to home healthcare and also – David and Linda, and also how you would have to structure it. If you want to comment, Doug, (Lisa), or (Danielle). David and Linda, you want to go first?

CMS Linda DeCherrie: Sure. This is Linda. So, yes, we do use a home health agency for our nursing partner and they do not bill a home health episode for this. They – we have an arrangement for paying them. But they are – I guess I will call it up trained home health nurses, like they're specifically trained for our protocols and things that we would require, like the pumps and visits and the documentation requirements for our program. And they do – the same nurses will do regular home health work if we're not occupying all their time because we do have a large geography that we cover. But we have a specific group of nurses that are trained.

CMS Lee Fleisher: So, just to be clear, the way this works as was mentioned by (Dan), the payment is a DRG rate. And therefore, if you need to send the patient home in the hospital or you need to bring them back to the hospital for any reasons, if there's a subcontract for some of your care with other providers, that is the responsibility of the hospital. Just double checking, (Dan), that is a correct statement?

CMS (Dan): Correct. The normal Medicare inpatient payment policies, everything that's normally bundled into the DRG stays bundled into the DRG. So, just because the care is being provided as hospital in the home doesn't change the Medicare inpatient bundling policies.

CMS Lee Fleisher: And Doug, anything at how you evaluate the waivers as far as if you see the subcontracting.

Doug Clarke: Yes. I think Linda hit the nail on the head here. It depends on how they're being used. It's fine if they're internal or external and contracted arrangement. The important thing is that we need and we expect, just like any other inpatient stay, an appropriate nursing plan and for the home health nurse while they're in this role to be playing in the role of a nurse for the inpatient care.

CMS Lee Fleisher: Operator, next question.

Operator: Next question comes from the line of (Genovia Brown) of (Northwest Health).

(Genovia Brown): OK. Hi. Thank you. Thank you for this great presentation, just very exciting programs. So, congratulations definitely Sinai and Brigham. Some sort of in the weeds question and I'm hoping you make some clarifications .

As part of the condition to participation, in a hospital, patients don't self administer. So, my question I guess goes to CMS team and two groups who have been doing in, how are – how does that fit into this in terms of like a p.r.n. Tylenol order, for example? I did – also was going to ask if you all could comment on how you are using sort of home health aides can be the health workers because these are other considerations in our minds. I have a thousand questions (out there).

CMS Lee Fleisher: OK. So, running on the COPs, (Lisa), do you want to comment?

CMS (Lisa Tripp): Actually, I was seeing if (Danielle) wanted to comment or …

CMS Lee Fleisher: (Danielle), that would be great, yes.

CMS (Danielle Adams): Sure. For the COPs, whatever the hospital policy is for delivering that care or that service would be applicable to these patients. For example, if the hospital allowed patients to self administer under the supervision of the nurse and that policy would applicable to the patients in the home. So, whatever the policy for the COP in the hospital would be that would extend to the home for those patients.

CMS Lee Fleisher: And David or Linda, you want to answer the other question, the use of other providers:

CMS David Levine: (Inaudible). Yes. Thanks, Lee. Question of home health aides, for example, we do have the ability to push a home health aide into the homes of some of our more frail patients who may need that extra hands like at night getting to the bathroom. So, again, that's a subcontract that we have with the home health aide agency to provide us that service. And we found that it does

help quite a bit in taking even – patients who are even more frail and were down for the count when they're acutely ill, and it works out quite nicely.

CMS Lee Fleisher: Thank you so much. Operator, next question.

Operator: Next question comes from the line of (Tina Fender) of Mount Sinai Hospital. (Tina), your line is now open.

(Tina Fender): Yes. Hi. Thank you. Great presentation. I just want to clarify from the billing side because I was on the CMS COVID-19 call yesterday and they kept mentioning this acute home program is built almost like a regular inpatient claim by the hospital on a (UB921). Is that correct?

CMS Lee Fleisher: (Dan)?

(Tina Fender): It's almost like this program was an attempt during COVID days and we were told to bill them as regular inpatient claims?

CMS (Dan): Correct. You should bill them – well, a regular inpatient claim that will be provided at alternative site. So, for example, the DR condition code. But the payment is exactly the same and the payment policy surrounding it are exactly the same as if you provided care at any other alternative site, and it should be billed that way.

(Tina Fender): And is there any special codes we have to – because when this was affecting providing care in tents in Central Park, are we supposed to indicate any kind of code or something to indicate this is an alternative site program or you just bill as a regular inpatient claim as we would bill for the acute hospital claim?

CMS (Dan): Correct. With the understanding as if you were providing in an alternative care site. So, the same way you would have billed it if it was provided in a tent, for example, if it was an inpatient service is how you would bill for it here. And so, for example, again, that would include the DR condition code to indicate that this care is being provided under a waiver.

(Tina Fender): And the same rules in terms of submitted to our rules, all the typical CMS rules for billing would apply to these services as well.

CMS (Dan): That is correct. The way we did not alter any inpatient – existing inpatient payment policies, billing requirements or cost reporting requirements.

(Tina Fender): OK. Thank you.

CMS Lee Fleisher: So, in fact, we will be looking at (Intercall). This will be evaluated. One of the key reasons, as you heard, is we will not – while we're asking for some of the data, we will actually not know which of the patients got their care at hospital at home. We will know that it was an alterative site. That's some of the oversight for this individual waiver program.

Operator, next question?

Operator: Next question comes from the line of (Jo Sanders) from Southern Illinois Healthcare. (Jo), your line is now open.

(Jo Sanders): Thank you. My question really was how to find the slides and that was such good direction that you gave just in that. I found them. Thank you. I guess we're just looking at what we might be doing in our rural Illinois area to address taking specific care of some of our patients who are discharged with – who have had care for COVID. So – because we have not done this program. We're just trying to gain some information about that specific use.

So, if anybody could talk more about – a little bit more about how you're addressing the needs of COVID patients at home because we really probably are not – we're going to do a lot of follow up with tele – telehealth type of thing, not actually visiting them.

CMS Lee Fleisher: So, just to be specific, this is not home healthcare.

(Jo Sanders): Right.

CMS Lee Fleisher: This would be that if the patient will require to be in the hospital but you chose to send them home but still get the same level of care at home then that's what we were talking about. So, it's an inability to discharge patients maybe a few days earlier and do the final days at home. I don't know if that –

Linda or David, you want to quickly go because I'd like to get one more question in.

(Jo Sanders): Sure.

CMS Linda DeCherrie: Yes. I can take that. So, we've been taking care of COVID patients. Yes, I think that's very important to understand that these are patients who would – if we didn't (exist be) in the hospital. This is not a post discharge program. These are patients who still need hospital level care. They still need the two nursing visits a day, et cetera. And so, we take them – as I said, usually one to three days that we are completing their hospitalization at home.

(Jo Sanders): Great. Thank you.

CMS Lee Fleisher: Thank you. Doug, did you want to make a comment?

CMS Doug Clarke: No. I think that – I was just going to say that even if you're not treating it kind of going on the COVID question. David brought this up earlier. Even if you're not treating COVID in this program, it's still freeing up beds potentially in your hospital for COVID patient. I'll stop there.

CMS Lee Fleisher: Great. Operator, we're going to take one more question.

Operator: Next question comes from the line of (Michael Spiritos) of Duke University. Michael, your line is now open.

(Michael Spiritos): Thank you. I think I'm duck tailing on the back of another question regarding the conditions of participation and administration of home medications. Our policy typically makes certain that nurses provide that and obviously with two or three nurses visits per day that is not feasible. How had David or Linda done that at home for Medicare populations?

CMS Lee Fleisher: David or Linda?

CMS Linda DeCherrie: I can speak to some of that. So, I can tell you that prior to the waiver we were not regulated as a hospital. So, I can tell you our experience up until now we didn't have to meet all those conditions of participations.

We, ourselves, also evaluating how we're going to meet everything under the COP going forward.

What we do do is that every patient gets a pill box that is filled by our nurse and then the nurse when they come twice a day check to see the meds that would have been given are indeed give, have been taken I should say by the patient, documented as such. But our nurses administer all IV, IM subcu medications – not all the insulin. I should put asterisk with that – and then documents it. So, we are going to see how that translates to our hospital COP going forward.

CMS Lee Fleisher: And why don't we just get – because we're actually not requiring all those visits to be a nurse. So, (Danielle) or Doug – (Danielle), are you prepared to clarify what needs to be in person and who?

CMS (Danielle Adams): Yes. So, for the inpatient visits, it is at least one RN visit a day. It could be two. It could be part of – if you have a mobile integrated team which could have consisted of paramedics. So, that would be required, but there has to be at least one in person RN visit.

CMS Lee Fleisher: So, the second visit could be a paramedic?

CMS (Danielle Adams): Paramedic, yes. It could be. It doesn't require to be a nurse.

CMS Lee Fleisher: And recognize …

CMS Doug Clarke: I just want to clarify …

CMS Lee Fleisher: Go ahead.

CMS Doug Clarke: I just want to clarify that there needs to be one in person or remote RN visit per day. And based on that interaction and the appropriate nursing plan that's put in place there, the determination is made whether an in-person RN visit is needed during that day. But there always have to be at least one visit either remote or in person by an RN.

CMS Lee Fleisher: And we try – although we – our goal was to provide as much flexibility as possible since this is – not even a pilot. This is something we expanded

during the pandemic, during the public health emergency, we felt that there were certain minimum standards and conditions of participation we felt were critical to meet to ensure our beneficiaries that they were getting the same standard of care being at home or the hospital.

Before we finish, I just want to – there is one nuance and (Will), one of our colleagues from the Center for Medicare, do you want to just talk about observation space and how that's working under the (PHE)?

CMS (Will): Yes. Sure. I mean I can provide at least some sort of a high level information and then I think we're going to follow up internally to provide more sort of specific information, the context of this inpatient hospital at home specific waiver.

And it's really, I think, we just wanted to make clear that as a result of the (PHE) and to support hospital's flexibility to furnish outpatient services in the – in alternate care settings, CMS, several months ago, waived both the provider-based rules and the conditions of participation, the same COPs that we're talking about and that that makes it easier for hospitals to furnish inpatient care at home also make it easier for hospitals to furnish outpatient care in the home and in other alternate care locations.

There is a nuance with the payment policy related to outpatient services because Congress several years ago determined that there would be a different payment system applied to new provider-based departments that were created, I believe, after 2016. And so – and I'm not sure I have that date specifically right. And again, we will follow up with additional information. So, don't – the specific date may be wrong. But broadly speaking, there is some nuisance with the payment policy that we're going to follow up on.

There's actually already several FAQs on our website that relates to this relocation of a provider based department and the process that hospitals and the outpatient departments can go through to relocate the payment or a provider based department and avoid any payment reduction that would, otherwise, apply outside of the (PHE) as a result of this law that I was talking about.

But again, we will – we will follow up with more information. I just want to sort of folks to understand that hospital outpatient departments can already furnish hospital outpatient services at home. There are a variety of hospitals around the country that have already submitted these request to us to do that. And we will provide more information about that flexibility in the context of this hospital – inpatient hospital at home program.

CMS Lee Fleisher: Thanks so much. And I really want to thank David and Linda for providing all their insights, our colleagues from CM, Jean for joining, and in particular, Doug, (Danielle), and (Lisa) for leading this program and individually approving the waivers.

We're excited that this really gives the healthcare ecosystem some additional capacity. We think it's primarily will be used for non-COVID patients to make room as well as allow non-COVID patients to not forego care. We're trying. If you submit a waiver application, Doug, our goal is 72 hours trying to get some response back or three business days?

CMS Doug Clarke: Yes. That's the goal for newer programs. And if we can do it faster, we will.

CMS Lee Fleisher: Great. And we will hopefully and certainly in the new year we'll run another one of these webinars to present additional learnings and we can produce additional information and we will also – as we stated, there's a lot of information on the website and the team here at CMS are always willing and able and available to answer your questions.

So, again, thank you for what you do everyday for our beneficiaries and for all the individuals of the nation to protect them during this public health emergency. And with that, I will turn it back to (Ashley).

CMS (Ashley Simms): Thank you and thank you to all who joined and for staying on with us for a couple of extra minutes. We appreciate that. As always, if you don't get – if didn't get your questions answers during the call, you can always reach out to us via the COVID-19 mailbox and that's COVID-19@cms.hhs.gov.

So, thank you all again for joining and have a good evening.

CMS Lee Fleisher: Thanks, everyone.

Operator: Thank you so much to our presenters and to everyone who participated. This concludes today's conference call. You may now disconnect. Have a great day.

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