Centers for Medicare & Medicaid Services
Acute Hospital Care at Home Question-and-Answer Session
December 22, 2020
10:30 a.m. ET

Operator: Good morning and welcome to the Acute Hospital at Home Q&A Session.

My name is (Justin) and I will be facilitating the audio portion of today's interactive broadcast. All lines have been placed on mute to prevent any background noise. For those of you on the stream, please take note of the options available in your event console. If you wish to ask a question via phone, please press "star," "1." If you would like to withdraw your question, press the "pound" key.

I would like to turn the call over to (Mr. Doug Clarke). Thank you. Please go ahead, sir.

(Doug Clarke): Thank you, operator, and thanks to all of you for joining us for this Acute Hospital Care at Home Question-and-Answer Session. We appreciate your time. We know it's close to the end-of-year holidays and just wanted to make sure we were available as a team. I've got several members on from various skill sets throughout CMS and we'd love to answer any questions that would be helpful as you think about either requesting this waiver or if you just wanted more information and we can go from there.

Female: Operator, I believe we can start taking questions.

Operator: At this time, if you would like to ask a question, press "star," then the number "1" on your telephone keypad. Again, it's "star," "1" and your telephone keypad. We'll pause for just a moment to compile the Q&A roster. Again, to ask a question, press "star," then the number "1" on your telephone keypad.

You have a question coming from an anonymous line. Please state your first and last name, then ask your question. Your line is open.

Allison Gnilka: This is Allison Gnilka with Atrium Health. Curious if the 1135 blanket waivers also would be applicable to this waiver as well.

CMS - Danielle Adams: Hello. This is Danielle Adams and I'm part of the Acute Care Hospital at Home team. Any of the 1135 waivers that have already been granted would be applicable to the hospital and this program is an extension of the hospital, so they would be applicable to those patients at home.

Allison Gnilka: Thank you.

Operator: Again, to ask a question, press "star," then the number "1" on your telephone keypad. You have another question coming from an anonymous line. Please state your first and last name, then ask your question. Your line is open.

Sondra DePalma: Hello. This is Sondra DePalma with the American Academy of PAs. I saw on the FAQ and the submission for the waiver that it has language related to APPs. Can you confirm APP visits that can be with physician assistants?

CMS - Danielle Adams: Hi. This is Danielle Adams again and the APPs would be those practitioners that the hospital would identify as part of their medical staff, so that really would depend on whatever classification each hospital uses for their practitioners on their medical staff. *(Update after call: The APP does not have to be part of the medical staff, as long as the medical staff has determined that the practitioners in question (NP, PA) are eligible for credential sand privileges.)*

Sondra DePalma: So they would have to be part of the medical staff, so even if it was an APP, but they were considered Allied Health, that would not include them?

CMS - Danielle Adams: They would have to be a member of the hospital medical staff. *(Update after call: The APP does not have to be part of the medical staff, as long as the medical staff has determined that the practitioners in question (NP, PA) are eligible for credentials and privileges and that it does not conflict with any other hospital policy or state law.)*

Sondra DePalma: OK. Thank you.

CMS - Female: Operator, as we transition to more calls, may I ask if there are any – have there been any issues with the phone line? I'm getting – I've gotten some

inquiries around the passcode not working, but I know we have folks on. So I just – I just want to double check and see.

Operator: The participants have been placed now in the conference, ma'am.

CMS - Female: OK.

Operator: There are 233 participants now.

CMS - Female: Thank you.

Operator: Are you ready to take the next question, ma'am?

CMS - Female: Yes, please.

CMS - (Doug Clarke): Yes.

Operator: Your next question comes from the line of Christopher Crowley. Your line is open. Please ask your question.

Christopher Crowley: Hi. Christopher Crowley from West Health. My question is an extension of the last question. I'm curious about the degree to which some of these services can be contracted by the hospital because some of the programs are actually available now, but are done on an outpatient basis and not necessarily by hospital staff. Thank you.

CMS - Danielle Adams: This is Danielle Adams and under this waiver, what is – what would happen with a contracted service, the hospital could contract for services or provide them directly as long as the oversight was performed by the hospital.

So if a hospital chose to contract with a home health agency, that the home health agency nurses would be acting on the behalf of the hospital to provide the nursing care and not under the supervision of the home health agency during the course of those services, then that would be permitted. So all of those services would have to be provided through the inpatient hospital.

Operator: Your next ...

CMS - Danielle Adams: Does that answer your question? We can move to the next question.

Operator: Your next question comes from the line of (Ina Bender). Your line is open. Please ask your question. Your line is open.

(Ina Bender): Yes. Hi. Do you know until when the waiver is in effect or is there expectation that this service will be allowed past the waiver?

CMS – Doug Clarke: I can take that one.

CMS - Danielle Adams: At this – go ahead.

CMS – Doug Clarke: Thanks, Danielle. So at this point and as is noted on the waiver landing page, there's the expectation that this will end at the end of the public health emergency. The flexibilities which allow this to exist are only possible within the extraordinary powers granted earlier this year by the secretary. There may be further investigation of this down the road with CMS, but this program, as it stands, will end at the end of the PHE.

(Ina Bender): And do we know what that date is as of today? Because it keeps changing. Do you know what that date is?

CMS – Doug Clarke: We will continue to extend this as long as the PHE and that will be extended at the discretion of CMS and HHS leadership.

CMS - Danielle Adams: (At this time – at this) ...

(Ina Bender): OK. And then in terms of billing, the only expectation is that we, the hospitals, use condition code? There's no other special coding or anything else that's required for this program?

CMS – Don Thompson: That's correct. At the moment, the only billing requirement – you treat it as if it was a service being provided at any other alternative inpatient care location being utilized by the hospital and so at the moment, it's just that condition code.

(Ina Bender): OK. Thank you.

Operator: Again, to ask a question, press "star," then the number "1" on your telephone keypad. Again, to ask a question press "star," then the number "1" on your telephone keypad.

Your next question comes from another anonymous line. Please state your first and last name, then ask your question. Your line's open. Your line is open. Please ask your question.

Female: Defer.

CMS - Female: Are there other questions ...

CMS - Male: Sounds like we can probably move on to the next question.

CMS - Female: Yes.

Operator: Your next question comes from the line of Nancy Foster. Your line is open. Please ask your question.

Nancy Foster: Hi. It's Nancy Foster from the American Hospital Association and perhaps not a question, but just a comment with regard to the public health emergency, just further information. Our understanding is that the current declaration of the public health emergency will end on – end on January 20th if it's not extended, but given what's happening across the country, we have every belief that it, in fact, will be extended for another 90 days, but by law, it can only be done for 90 days at a time.

So to the questioner who asked about what's the end date, I think we don't know yet, but as long as we continue to see surges in COVID patients, it's reasonable to assume that there will be a lot of interest in extending the public health emergency in order to accommodate the needs of healthcare delivery to meet the needs of its community. I know, working for the federal agencies, you probably can't say that, but I just want hospitals to have some sense that it is not going to end in January.

Operator: Your next question ...

CMS - Female: Can we have our next question?

Operator: Your next question comes from the line of (Margaret O'Brian). Your line is open. Please ask your question.

(Margaret O'Brian): I'll defer that. Thank you.

Operator: Your next question comes from the line of (Jerry Bird). Your line is open. Please ask your question.

(Jerry Bird): Yes. My question is about the Regeneron cocktail and the coding for the Regeneron cocktail. Right now, there's the one code, but it's actually two individual medications with two individual NDCs and while it's free right now with the single code, I don't think we have a problem with it because we're reporting that it's free, but as soon as we go to a non-free situation, the expectation would be that we would have to report those two individual drugs separately with the NDCs in order to get reimbursed, at least from a commercial payer.

Has there – have you heard anything about potentially the code being changed to actually give those two drugs together one NDC or is there going to be some instruction later on that we should report the two individual drugs with an unlisted (hit pick) and the two individual NDCs? Thank you.

CMS – Don Thompson: So I'm not sure we have the right folks on the call on the billing side for that question, but if you did want to send that in to CMS, we can connect you with the right – the right individuals.

Operator: Again, to ask a question, press "star," then the number "1" on your telephone keypad. To ask a question, press "star," then the number "1" on your telephone keypad. Your next question comes from the line of (Becky Claudefob). Your line is open. Please ask your question.

(Becky Claudefob): Hi. Looking at the FAQs that you all had sent, when it's talking about a patient going home, about an in-person provider exam being performed by the inpatient hospitals or ED, (is the) Hospital at Home program, can we send a patient home directly from the ED if a patient needs to have inpatient care or

would they need to have an inpatient in the acute facility before we can send them home?

CMS - Danielle Adams: Hello. This is Danielle and the patient can be sent directly home from the ED to start their admission as long as they have an admission order. It's really up to the program to decide if they want to send patients directly from the ED or if they've already started the course of their inpatient stay and want to finish their inpatient stay at their home.

(Becky Claudefob): Thank you.

Operator: Again, to ask a question press "star," then the number "1" on your telephone keypad. Again, it's "star," "1" on your telephone keypad. Your next question comes from the line of (Angela Simmons). Your line is open. Please ask your question.

(Angela Simmons): Good morning. Thank you for taking my question. Regarding the Hospital at Home program, I am unclear on how to count the patient days while the patient is at home. Do those go into the total count of patient days as if they were in the facility? That's one question. If so, and do the beds count towards your overall bed count in terms of how many licensed beds you have if that caused you to go over your total?

Do these patients that are admitted into your program, do those beds that they're in are, quote, what you called a virtual bed or whatever, do those count? And if so, how do we make sure that we don't lose some of our indirect medical education payment? Because that calculation is based on – the denominator's based on the number of beds available and so if you added these beds in, it would cost the IME payment to go down and I'm just trying to understand how all that would work from a accounting for the number of patient days and accounting for the beds perspective. Thank you.

CMS - Female: So for the patients that are at their home, those days would count as if they were in the hospital. So there wouldn't be a differentiation between actual in-hospital days and at-home days. (John), do you want to speak on the GME payment for those beds? Because I know from a state perspective as far as your licensed beds, that the hospital would really need to work with their

states because in some states, there are certificate of need issues and licensing issues.

CMS - (Don Thompson): Right. That was – that was my understanding on the – on the question as well with respect to the counting of the beds. On the – yes, agree on the first part. For payment purposes, you treat the length of stay exactly the same as if the patient was in the hospital. On the IME part, I would like to get the payment expert so that – I know enough to be dangerous on this question and I don't want to mislead the person in the inquiry. If you could send that one in as well, we'll connect you up with the right folks on the GME side.

(Angela Simmons): Is there a specific mailbox that I need to send it to? I missed the first part of the call, so I might have missed that.

CMS - (John): Is there a Hospital Without Walls mailbox?

CMS – Doug Clarke: There is. You can send it to AcuteHospitalCareatHome@CMS.HHS.gov

(Angela Simmons): Thank you.

CMS – Doug Clarke: ... and we'll get it to the right people.

Operator: Your next question comes from the line of (Patricia Schakowsky). Your line is open. Please ask your question.

(Patricia Schakowsky): Hello. Can Remdesivir be is administered in the home under this waiver?

CMS – Doug Clarke: Don, do you know anything about that from a payment side? We've been pretty careful on the clinical side not to limit anything that the hospital feels it can do safely and is consistent with its policies.

(Patricia Schakowsky): Thank you.

CMS - (Don Thompson): There's no – yes. There's no restriction on the payment side because it's considered as if it was part of the inpatient four-walled hospital. So any restrictions would come really on the – on the coverage side, if there were any.

Operator: You have a follow up question coming from the line of (Ina Bender). Your line is open. Please ask your question.

(Ina Bender): Yes. Hi. Just a quick question in terms of room and board. On one of the earlier calls, it mentioned that the room and board charge for these at-home patients should reflect the cost of providing the service. Does that also apply – how would you classify the room and board charges for these patients? Typically hospitals have semi-private grade or private grade and they go with the revenue codes. How would you classify or how are we supposed to classify these patients? As semi-private or private, considering they're like home in their own beds?

CMS – Don Thompson: So CMS isn't dictating the hospital charging practices here, but you are correct that the charges that the hospital provides should reflect the services that the hospital provides. So the hospital should, per the individual circumstance it's in, determine an appropriate charge for the services that it provides and then bill accordingly.

(Ina Bender): Right, but how do you classify patient's home? Typically semi-private, you're in bed with another patient. If the hospital classifies them as a private for medical reasons? I don't know how do you classify these category of beds?

CMS – Don Thompson: That would be up to the individual hospital to determine the most appropriate way to bill for the service for the circumstances.

(Ina Bender): OK. All right. Thank you.

Operator: Your next question comes from the line of (Kim Yalton). Your line is open. Please ask your question.

(Kim Yalton): Yes. I just want to piggyback off that last question. So we've been doing a lot of research for Hospital at Home and charging. We had thought about did we need to have a lower room and board charge for these patients at Hospital at Home? With all the research that we've been doing and talking to folks who have kind of gone before us, it was that CMS was trying to make this as easy as possible.

So the room and board that we would charge for the patient in the facility is the room and board that we would continue to charge at Hospital at Home. We would treat these patients just like they were in the hospital. So any further clarity about that? I mean, I don't want to over complicate things. Of course we want to be compliant and doing what we should, but is your stance that we treat these patients as if they're in our hospitals?

CMS - (Don): Yes, (you treat the patients just like in the) hospital, but that means, because we haven't changed (or waived) any payment policies, that your billing and charging practices should reflect the services provided. So there's like two parts to your question. Do you treat – do you treat them, from a payment policy perspective, as if they were inside the hospital? And the answer to that question is yes, but what that means is that you need to be charging and billing appropriately for the services provided.

(Kim Yalton): OK. I mean, I think I understand what you're saying. I just think if we could be provided a little bit more clarity, maybe in a FAQ, that would be better.

CMS - (Don): Sure. We can – we can look at – we can look at the guidance that we sort of normally provide with respect to sort of hospital charging practices and the services it provides, but it's exactly the same policy. There's no – there's no change in policy in the payment policies for this waiver.

So there's nothing that's changed, there's nothing new from a payment policy perspective associated with this waiver, but sure, we can – I think we could look at maybe putting up a Frequently Asked Questions that just goes to the manual provisions on – the existing manual provisions on hospital charging and billing.

(Kim Yalton): OK. That ...

CMS - Male: (Inaudible) ...

CMS - (Don): But that's what it would be. There's no – there's no new – no new guidance. So you should be billing and charging for the service – appropriately for the services that you provided.

CMS – Doug Clarke: And just to piggyback on that, (Don), part of the reason that we feel that CMS has been very rapid in its response to this capacity issue and paying a full DRG payment and trying to keep this as simple as possible. I understand that not every question may be answered right now, but we're trying to address this problem as quickly as we can and as completely as we can. So I appreciate (Don) saying to continue to bill as appropriate.

(Kim Yalton): Yes. And I think that the thing is that with these being inpatient, they're going to fall under the DRG. Thank you.

Operator: Your next question comes from the line of (Tracy Fields). Your line is open. Please ask your question. Ms. (Tracy Fields), your line is open. Please ask your question.

(Tracy Fields): OK. I'm just ...

Operator: (Ms. Tracy Fields), your line is open. Please ask your question.

(Tracy Fields): Thank you. Sorry. I'm just a little confused about answering that last question because that's a big point to – it's not an easy charge to – change your chargemaster to add on for the bed. I mean, I understand the DRG payment, but I do think referencing back to the manual guidelines would mean that that's a much more complicated process to try to account for that. So I appreciate any clarification on that.

CMS – Don Thompson: Sure. Again, we did not change any payment policies. So to the extent the hospital believes it's providing a different, new service that's not the equivalent of the service that it provides in the hospital, then it should bill and charge appropriately. So there's no – there's no change in sort of that underlying principle that's always existed and continues to exist and was not impacted by the waiver.

Operator: Again, to ask a question, press "star," then the number "1" on your telephone keypad.

CMS – Doug Clarke: It might be a useful time as well just to remind that the waiver really only waived those sections of hospital conditions of participation as they related to the 24/7 on-premises nursing care. Just to put that out there.

Operator: Again, to ask a question press "star," then the number "1" on your telephone keypad. Your next question comes from the line of (Joanie Nebeker). Your line is open. Please ask your question.

(Joanie Nebeker): Hi. Thank you for taking my question and for providing these calls. I also was interested in getting further clarification concerning days, beds, counting of beds and IME. Is there going to be – how will – how will that information and answers to those questions be disseminated to the groups?

CMS – Doug Clarke: If you're able to e-mail the similar question as before, presuming it's the same question, to that e-mail address, the AcuteHospitalCareatHome@CMS.HHS.gov, we can make sure that we get the correct answer and we are pretty frequently iterating the Frequently Asked Questions. We used the last webinar and all the questions asked to update pretty extensively and so if there's a – the more specific you can be, the better we can help and we're happy to update the Frequently Asked Questions as they come about.

(Joanie Nebeker): OK. Great. Thank you.

Operator: Your next question comes from the line of (Dana Striker). Your line is open. Please ask your question.

(Dana Striker): Hi. My question is regarding COVID reporting to HHS. If we have a COVID-positive patient that is discharged to our Hospital at Home program, do we count that patient under our originating hospital or do we set up a separate line item for that patient – for that patient and report them that way?

CMS - Danielle Adams: Hi. This is Danielle Adams – we need to clarify that these patients aren't discharged to their home. It's the same as if they were transferring between floors, so they belong to that inpatient hospital. So any of that COVID data, these patients will be included in that – in that hospital reporting data as if they were in the brick and mortar facility.

(Dana Striker): OK. Sorry. Follow-up question then. So for our bed counts, would we add a bed count for that – to account for that patient's bed.

CMS - Danielle Adams: Yes and as I said previously, as far as your bed count would go and how these – how this fits into your licensed beds, you would need to work with your state on that, but they would count as a bed.

(Dana Striker): OK. Thank you.

(Doug Clarke): Operator, I think given the time, that was probably the last question we can take. We really appreciate everyone joining us and thank you very much for the CMS panel for giving their time here as well.

Operator: This concludes today's conference call. Thank you for participating. You may now disconnect.

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