

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the PRC Home Hospitalization Alternative Payment Model

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In accordance with the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) proposal review process, proposals for Physician-Focused Payment Models (PFPMs) that contain the information requested by PTAC's Proposal Submission Instructions will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on the PTAC. This report is provided by the PRT to the full Committee for the proposal identified below.

A. Proposal Information

- 1. Proposal Name:** Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home
- 2. Submitting Organization or Individual:** Personalized Recovery Care, LLC
- 3. Submitter's Abstract:** "Descriptions of patient centered care and achieving the Triple Aim are often referenced, yet few programs create increased value and quality outcomes while also truly focusing on the preferences and experience of the patient. We believe that the following proposal for home hospitalization can achieve each of these goals and allow a broad cross section of physicians to participate in providing this type of care. Through testing of this proposed payment model of home hospitalization, Medicare fee-for-service patients would have the opportunity to receive patient-centered, acute care in their homes, whereas currently, the only option is an inpatient hospital stay with fragmented care following the discharge and recovery.

Submitted by Personalized Recovery Care, LLC ("PRC"), a joint venture between Marshfield Clinic and Contessa Health, the proposal closely tracks a program currently operational in Marshfield, Wisconsin. In this program, commercial and Medicare Advantage patients experiencing certain medical conditions normally requiring admission to an inpatient hospital instead consent to receive acute care treatment in

their homes or a skilled nursing facility. Driven by Marshfield Clinic's experience in innovation and clinical excellence, this program allows superior clinical care in a patient's home or an alternative setting from an inpatient hospital, achieved through physician telehealth, health care service delivery, and focused, high-touch care coordination. The physicians responsible for the care take financial risk on the episode period, such that Medicare would be guaranteed savings from its historical spending on these conditions, while physicians would be rewarded for improved outcomes.

The PRC operators believe that this model has the potential to become a standard of care for treatment, enabling many different types of physicians to participate in the program. In general, any Medicare patient who is medically eligible for inpatient hospitalization admission for treatment of pre-selected conditions could be treated at home through the program, except if the patient needs a higher level of care such as ICU or telemetry, or if such patient has an unsafe home environment.

The PRC operators' goals are to: 1) improve health care quality by providing hospital level care in the comfort of the patient's home, while 2) changing the reimbursement for participating physicians by making them accountable for the quality and spend throughout a 30-day episode of care. Clinical data from previous operators of this type of care model demonstrate the superiority with respect to quality, including 33% reduction in mean length of stay, 24% reduction in readmissions, and 20% reduction in mortality. While results from the PRC program are in early stages and not statistically significant, the program is seeing similar outcomes and high patient satisfaction. Building on its previous track record with innovation, Marshfield Clinic committed to and has demonstrated high quality of care focused on superior outcomes, excellence in patient experience, and lower health care costs through its partnership with Contessa Health. Through this proposal, Medicare fee-for-service patients would have the opportunity to receive patient-centered, acute care in their homes, whereas currently, the only option is an inpatient stay with fragmented care following the discharge and recovery."

B. Summary of the PRT Review

The Home Hospitalization: An Alternative Model for Delivering Acute Care in the Home proposal (available on the ASPE PTAC [website](#)) was received by PTAC on October 27, 2017. The PRT conducted its work between December 11, 2017 and February 23, 2017. A summary of the PRT's findings are provided in the table below.

PRT Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR\$414.1465)	PRT Conclusion	Unanimous or Majority Conclusion
1. Scope (High Priority)	Meets	Unanimous
2. Quality and Cost (High Priority)	Meets	Unanimous
3. Payment Methodology (High Priority)	Meets	Unanimous
4. Value over Volume	Meets	Unanimous
5. Flexibility	Meets	Unanimous
6. Ability to be Evaluated	Meets	Unanimous
7. Integration and Care Coordination	Meets	Unanimous
8. Patient Choice	Meets	Unanimous
9. Patient Safety	Does not meet	Unanimous
10. Health Information Technology	Meets	Unanimous

C. PRT Process

The PRT reviewed the PRC Home Hospitalization Alternative Payment Model (PRC HH-APM) proposal as well as additional, relevant information from other sources on key aspects of the proposed model.

The PRT's summary of the proposal and description of the additional, relevant information on key aspects of the proposed model reviewed by the PRT are described below and on the ASPE PTAC website.

1. Proposal Summary

The proposed PRC HH-APM would provide new payments designed to allow Medicare beneficiaries with acute illness or exacerbated chronic disease, who would otherwise require inpatient hospitalization, to receive hospital-level acute care services in the home plus transition services (akin to post-acute care) for a total of 30 days.

Patients with over 40 different health conditions that would be classified into one of more than 150 MS-DRGs would be eligible for home hospitalization services supported by the PRC HH-APM if (a) they met clinical criteria for an inpatient admission, (b) an assessment of their specific clinical conditions and home environment prior to admission indicated that they could safely receive care at home instead of in the hospital, and (c) the patient agreed to accept care in the home instead of in the hospital. (The original proposal included more than 160 MS-DRGs, but the submitter indicates it now would remove 13 of those MS-DRGs based on experience.) The submitter's experience to date shows that the percentage of beneficiaries who qualify for home hospitalization varies significantly by MS-DRG.

During the acute care phase, the APM Entity (the organization receiving the PRC HH-APM payments) would be expected to have the admitting physician hold telehealth visits with the patient at least daily, to have a registered nurse make visits to the patient's home at least twice daily, to provide for 24/7 phone response by a Recovery Care Coordinator (who would be a registered nurse), and to have 24/7 on-call physician access. In addition, the patient could initially receive acute care in a hospital or skilled nursing facility before being transferred home for the remainder of the acute phase of care. All of these services would be supported by the Home Hospitalization Payment component of the PRC HH-APM. As needed during the acute care phase, the patient would also receive in-home infusion services; speech, physical, and occupational therapy; visits with specialists; transportation services; durable medical equipment; and radiology studies, laboratory tests, and medications. If these ancillary services or specialist visits are delivered, or if the patient had an unplanned service such as an Emergency Department visit, those services would be billed directly to Medicare and paid according to standard Medicare payment rules.

During the post-acute care phase, the APM Entity would be expected to have the Recovery Care Coordinator monitoring and coordinating the patient's care. This service would be supported by the Home Hospitalization Payment. If the patient needed home health services or other types of post-acute care services, these would be billed directly to Medicare and paid according to standard Medicare payment rules, as would the patient's visits with their primary care physician, specialist visits, ED visits, etc.

There would be two parts to the PRC HH-APM payments to the APM Entity:

- A bundled Home Hospitalization Payment equal to 70% of the MS-DRG payment for which a hospital would have been eligible under the Medicare Inpatient Prospective Payment System (IPPS) had the patient been admitted for inpatient care. The MS-DRG would be determined based on the patient's diagnoses and procedures using the standard Medicare MS-DRG grouper. The APM Entity would use this payment for any types of service needed by the patient that are not eligible for payment under existing Medicare payment systems.
- A performance-based payment (shared savings/shared losses) based on (a) total spending during the 30 day period beginning with the patient's admission to acute (hospital-level) care at home and (b) the APM Entity's performance on five quality measures. A "Target Bundled Rate" would be established for each MS-DRG equal to 97% of the "Benchmark Rate," which is the average 30-day Medicare spending for the subset of patients who had been discharged from hospitals under the same MS-DRG and would have been eligible for home hospitalization. Medicare spending on all services the patient received during the acute phase (including the Home Hospitalization Payment equal to 70% of the MS-DRG amount and all services received by the patient that were billed directly to Medicare) and Medicare spending on related services the patient received during the 30-day period (including post-acute care services related to the acute

diagnosis, but excluding ED visits or hospitalizations for new, unrelated conditions) would be totaled. If that total exceeds the Target Bundled Rate, the APM Entity will be responsible for paying Medicare for the difference or 10% of the Benchmark Rate, whichever is less. If the total Medicare spending is below the Target Bundled Rate, the APM Entity would be eligible to receive a performance-based payment of up to 100% of the difference or 10% of the Benchmark Rate, whichever is less. The performance-based payment would be reduced by 20% for each of the five quality measures where the performance standard for that measure was not met.

The PRC HH-APM has many similarities to the HaH-Plus APM that PTAC recommended for implementation at its September 2017 meeting. The table below shows key differences between the PRC HH-APM and the HaH-Plus APM:

Dimension	PRC HH-APM	HaH-Plus APM
Patient Eligibility	Patients in over 150 MS-DRGs	Patients in approximately 50 MS-DRGs
Episode Length	30 days from the date of admission to home hospitalization	Length of acute care plus 30 days following the date of discharge from acute care
Amount of Bundled Payment	70% of the MS-DRG payment under the IPPS	95% of the MS-DRG payment under the IPPS plus average professional fees billed during an inpatient admission
Payment for Ancillary Services During Acute Phase	Would be billed directly to Medicare for payment under existing payment systems	Would be supported through the bundled payment, not billed directly to Medicare

2. Additional Information Reviewed by the PRT

a) Environmental Scan and Literature Review

ASPE, through its contractor, conducted an environmental scan related to this proposal. Documents comprising the environmental scan were primarily identified using Google and PubMed search engines. Key words guiding the environmental scan and literature review were directly identified from the Letter of Intent (LOI). The key word and combination of key words were utilized to identify documents and material regarding the submitting organization, the proposed model in the LOI, features of the proposed model in the LOI or subject matter identified in the LOI. Key terms used included: AIM Program; Comprehensive Health Care; Contessa Health; COPD Hospital at Home; Cost; Cost Of Health Care; Economic Benefit; In-Patient Hospital Care; Johns Hopkins Hospital at Home; HF Hospital at Home; Home-

Based Healthcare; Home Health; Home Hospitalization; Hospital at Home Acute Care; Hospital at Home; Hospital-at-home care; Hospital at Home Model; Hospital at Home Programs; Hospital at Home Trial Home-Based Healthcare Marshfield Clinic Health System; Managed Care; Medical Home; Medicare; Medicare-managed care; Mobile Acute Care Team; Mount Sinai Health System; New Care Delivery Models; and Organization And Delivery Of Care.

b) Data Analyses

In light of the similarities between the PRC HH-APM and the HaH-Plus APM that PTAC reviewed in 2017, the PRT determined that the materials that had been prepared to assist in the review of the HaH-Plus APM were sufficient for its review of the PRC HH-APM. Those materials are available on the ASPE PTAC [website](#).

c) Additional Information reviewed

The PRT submitted a list of detailed questions to the submitter in December 2017, and the submitter provided detailed written responses in January 2018. The PRT held a one hour teleconference with the submitter on February 14, 2018 in which the submitter provided responses to additional PRT questions. The PRT submitted a second round of written questions to the submitters on February 15, 2018 and received written responses on February 21, 2018.

d) Public Comments

The PRT received 2 public comments in support of PRC’s Home Hospitalization proposal. Gunderson Health System, an integrated care delivery network similar in size and geographic nature to Marshfield Clinic, indicated that it supports this approach and stated it would follow the pilot and implement a similar program if the evidence supports it. University of Wisconsin Health (UW Health) also supports the proposal as being based upon evidence based protocols and practices.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope (High Priority Criterion). Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

PRT Qualitative Rating: Meets the Criterion

Strengths:

- No other CMS APMs are specifically designed to provide a home-based alternative for patients requiring inpatient-level care at the point when they are facing a hospital admission or observation stay.

- The CMMI Independence at Home program provides intensive home based services to chronic disease patients at risk of hospitalization, but the PRC HH-APM would also serve patients with acute conditions.
- The CMMI Bundled Payments for Care Improvement (BPCI) initiative and the new BPCI Advanced program include patients who would be eligible for the PRC HH-APM, but BPCI and BPCI Advanced require an inpatient admission for all of the conditions eligible for the PRC HH-APM conditions, so the PRC HH-APM would provide an additional opportunity for savings and quality improvement.
- The ability to deliver ancillary services in the home using existing providers and payment systems could facilitate the ability of small providers to participate compared to the HaH-Plus APM recommended by PTAC in 2017.

Weaknesses:

- A minimum volume of patients is needed for financial viability, which could make it difficult to implement in small and rural communities. Although the wide range of patients who would be eligible would help to increase the volume of patients served, it could be difficult for small primary care or multi-specialty practices to safely deliver home hospitalization services to such a wide range of patients.
- The PRC HH-APM may be attractive to ACOs seeking methods of paying for community-based alternatives to hospital care.

Summary of Rating:

The proposed PFPM meets the criterion because the proposed services and eligible patients are significantly different from what is currently supported under standard Medicare payments and other Alternative Payment Models. Although the need to have a minimum number of patients for financial viability could limit the number of communities where the services could be implemented, the broad and flexible eligibility criteria could reduce the likelihood that the model would only be implemented in large communities. However, it could also be more difficult for smaller practices to serve patients with such a wide range of clinical needs, particularly initially.

Criterion 2. Quality and Cost (High Priority Criterion). Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

PRT Qualitative Rating: Meets the Criterion

Strengths:

- Multiple studies of similar programs in other countries and at several sites in the U.S. have found that home hospitalization programs achieve better outcomes for eligible patients and have lower costs than traditional hospitalization.
- The PRC HH-APM is specifically designed to deliver care for inpatient-eligible patients at a cost below normal Medicare payment amounts for inpatient care.

- Post-acute care costs are included in the target spending amount for which the APM Entity is accountable, which discourages cost-shifting from the acute phase of home hospitalization care to the post-discharge period.
- The same providers are involved during both the acute and post-acute phases, which may reduce complications and readmissions during the critical post-discharge period.

Weaknesses:

- While providing care to patients in the home should reduce hospital-associated morbidity (and associated costs), this care model may have risks for patients if they are not carefully selected for participation. Under the proposed payment model, revenues will depend on the number of patients participating, so financial pressures could result in (a) enrolling patients who would be better served in an inpatient unit or not admitted at all or (b) providing less intensive home services than patients need, which could lead to poorer outcomes.
- The proposed eligibility criteria could include many types of patients who have not been served through other home hospitalization programs, so the impacts on quality and cost for those patients are less certain.
- The need for providers to have an adequate volume of patients to generate adequate revenue to cover the costs of home services, the higher Home Hospitalization Payments that would be received for patients with more serious conditions or comorbidities, and the lack of precise home assessment criteria could encourage admission of patients who cannot be cared for safely in the home.
- The review process for adverse events currently described in the proposal provides only limited assurances regarding the quality of care.
- A significant component of the proposed payment would reward the APM Entity for low post-acute care spending. It is likely that the types of patients eligible for and willing to participate in home hospitalization would have had lower average post-acute care spending than other patients even if they had been admitted to the hospital. This could result in payments to the APM Entity based on “savings” in post-acute care that did not actually occur.
- It seems likely that care of the patients deemed eligible for the PRC HH-APM would have involved lower costs to the hospital than for patients deemed ineligible. Although Medicare would have paid the same amount for an admission of both sets of patients, the hospital’s margin will decrease if it has fewer total inpatients and if the remaining inpatients have higher average costs, which could discourage hospital participation or lead to higher charges on services for other patients. Moreover, if the model were broadly used, the higher average costs for inpatient care could require increases in Medicare payments for inpatient care, offsetting some of the savings from the program.

Summary of Rating:

The proposed PFPM meets the criterion. Multiple studies have demonstrated that the Hospital at Home care model improves quality and reduces costs, and the proposed PFPM seeks to improve quality of care for patients while reducing costs to Medicare. The PRT

believes the model would benefit from modifications to ensure patient selection is based on clinical rather than financial considerations and to adjust the proposed payment for the likely lower spending on patients in the PRC HH-APM relative to patients admitted to inpatient units. Also, although the performance-based payments are tied to quality measures, there is no quality-based adjustment to the payment for the acute (inpatient) phase. The PRT believes the payment model would be strengthened by also tying the amount of payment for the acute phase to quality measures. The PRT believes the payment model would be stronger if measures of all adverse events and escalations to the inpatient unit were reported and monitored through a standardized plan for review. Given the expected low rate of these events, the measures would not need to be used for payment adjustments but could be used to ensure appropriateness of admissions and quality of care. An option could be to adjust an individual payment to an APM Entity if an adverse event occurred and a review showed that inadequate steps were taken to prevent or respond to that event. The payment model could also be strengthened if there were an auditing mechanism (e.g., through a Quality Improvement Organization or Medicare Administrative Contractor) in place to further assure appropriateness for hospital admission, as is already done with inpatient admissions. Finally, the PRT believes that the target price could likely be discounted further to account for the fact that patients in the PRC HH-APM are less likely to have expensive post-acute care (e.g., less likely to require skilled nursing) than their comparison group, but the data necessary to do this would not be available until after the PFPM had been in place for some years.

Criterion 3. Payment Methodology (High Priority Criterion). Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.

PRT Qualitative Rating: Meets the Criterion

Strengths:

- The proposed payment methodology is described in detail and examples were provided in response to PRT questions showing how it would function in different scenarios.
- The payment methodology would provide payments for several types of home-based services that are not currently paid for, or not paid adequately for, under the Medicare Physician Fee Schedule or other Medicare payment systems. Paying for in-home alternatives to hospital care could also assist ACOs in reducing spending by filling a gap in the current FFS payment structure.
- The payment methodology is based on spending during a 30-day episode starting with the admission date, which protects against cost-shifting from the acute (inpatient) phase to the post-acute care phase, encourages avoiding readmissions, and encourages reducing unnecessary and unnecessarily expensive post-acute care.

- By allowing continued billing for ancillary services under current payment systems, the PRC HH-APM could be simpler for both CMS and small providers to implement.

Weaknesses:

- The Home Hospitalization Payment component based on 70% of the MS-DRG is not adjusted based on quality. The only financial penalty for poor quality care is tied to the performance-based payment (shared savings or losses).
- Although the submitter suggested that at least twelve different quality measures be tracked, only 5 of the measures would be used to affect payment.
- The Home Hospitalization Payment component does not depend on the magnitude of the needs of the patients admitted to home hospitalization relative to patients admitted to the inpatient unit. The types of patients admitted to home hospitalization could have lower care needs than those in the same MS-DRG who are admitted to the hospital, since their characteristics are more favorable and these characteristics contributed to the admission decision.
- Since ancillary services would be billed and paid separately, it is not clear how often the costs of the nursing and other services supported by the PRC HH-APM payment would be proportional to the amount of the MS-DRG payment. (The submitter provided data indicating that home hospitalization patients in higher-weighted MS-DRG categories had a longer average length of stay in the acute phase of care, but the relative cost of services would also depend on the intensity of services needed per day.)
- Since payment amounts would differ significantly across the 150+ MS-DRGs that would be included in the model, and since only a small percentage of patients in many of the MS-DRGs would likely be eligible for home hospitalization, this could create a perverse financial incentive for the provider to focus on patients in the MS-DRGs that would result in higher payments, even though the higher severity and complexity of these patients might make them more challenging to manage in the home.
- Since a patient could potentially receive ancillary services or specialist visits that were not ordered by the home hospitalization provider, separate billing of these services would increase the financial risks for small providers during the reconciliation process.
- Small providers could face financial challenges if the cost of home nursing services is higher than the Home Hospitalization Payment (based on 70% of the MS-DRG payment) for the patients they serve, even though the cost is lower than what the full MS-DRG payment to a hospital would have been had the patient been admitted to the hospital.
- The proposal does not include any method for adjusting the amount of risk the APM Entity bears over time to reflect the APM Entity's startup costs or its increased experience in managing patient care over time.
- The calculation of spending during the 30-day episode used in the PRC HH-APM excludes certain types of services based on rules in the BPCI program. However, the exclusion rules in the BPCI program were defined for a narrower range of MS-DRGs, and the new BPCI Advanced program will include an even smaller range of MS-DRGs and a different set of exclusion rules.

Summary of Rating:

The proposed PFPM meets this criterion. The proposed payment methodology would fill the gaps in current Medicare payment systems that preclude delivering Hospital at Home services, and it is designed to achieve the goals of the PFPM criteria. However, the PRT believes the payment methodology would benefit from some modifications. It would be preferable if the payment based on the MS-DRG were adjusted based on performance on quality measures, and if program included additional quality measures. Additionally, the benchmarking methodology requires refinement to account for differences between the PRC HH-APM patients and inpatient admissions.

Criterion 4. Value over Volume. Provide incentives to practitioners to deliver high-quality health care.

PRT Qualitative Rating: Meets the Criterion

Strengths:

- Since patient participation is voluntary, and since patients generally require a referral from a physician, the program would likely have difficulty attracting sufficient participation to remain operational if it did not deliver high-quality care.
- Shared savings payments are reduced if quality performance is low.

Weaknesses:

- There is no direct financial penalty for poor performance on quality measures; poor performance would only reduce the amount of shared savings payments.
- The APM Entity would experience a financial penalty if a patient had to be escalated to the inpatient unit, because the payment to the hospital for the inpatient stay would be counted towards the episode spending.

Summary of Rating:

The proposed PFPM meets the criterion. The proposed PFPM includes incentives to providers to deliver high value care to patients participating in the model. However, because this model depends upon sufficient patient volume to make the program financially viable, there are still risks that physicians would be incentivized to admit patients inappropriately. The PRT believes that one way to mitigate this concern would be to make the MS-DRG-based Home Hospitalization Payment contingent on quality. Additionally, monitoring for admission appropriateness and escalation and patient safety in general will be critical.

Criterion 5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.

PRT Qualitative Rating: Meets the Criterion

Strengths:

- The bundled payment based on 70% of the MS-DRG payment would give the APM Entity significant flexibility to deliver different types of services to patients.
- The APM Entity would also have the flexibility to order ancillary services and specialist visits to be paid through existing payment systems, as long as the overall spending on the patients served was less than the target prices established for those patients.

Weaknesses:

- Since ancillary services would be paid for through standard payment systems, the provider's flexibility to deliver different services in different ways would be more limited than with a single bundled payment for all services.
- The challenges in gaining an adequate number of patients to generate the revenues needed to cover the financial costs of the program could make APM Entities less willing or able to deliver or order all of the services that patients need.
- The APM Entity would be accountable for coordinating post-acute care and would have the flexibility to deliver different services than are available today, but it would not be able to control all aspects of post-acute care services (e.g., what skilled nursing facility a patient chooses if a patient needs a SNF or how effectively the SNF provides care).

Summary of Rating:

The proposed PFPM meets the criterion. The proposed payments offer flexibility to redesign the delivery of care to achieve reduced spending and maintain or improve quality.

Criterion 6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

PRT Qualitative Rating: Meets the Criterion

Strengths:

- The proposal specifies goals for quality of care and costs that can be evaluated.
- Because a number of other similar Hospital at Home programs have previously been evaluated, the results of those evaluations could be combined with the evaluation of this PFPM to allow more robust conclusions about the impact of the care model.
- The Mount Sinai Health Care Innovation Award (HCIA) program is currently being evaluated, and the methods for drawing valid comparison groups in that evaluation should be helpful in designing an evaluation of the PRC HH-APM.

Weaknesses:

- Because of the diversity of patients eligible for the PRC HH-APM (especially in relation to the Mount Sinai HCIA program), it may be difficult to accurately compare costs and quality other than for the most common types of participating patients.
- Because the patient's home environment will be a major factor in determining the patient's eligibility for home hospitalization, and information about the home environment is not available in claims data or standard clinical data, it will be difficult to establish a comparison group of patients who have similar characteristics.

Summary of Rating:

The proposed PFPM meets the criterion, but special efforts will be needed to develop a comparison group of patients that are similar on the characteristics affecting eligibility for home hospitalization.

Criterion 7. Integration and Care Coordination. Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

PRT Qualitative Rating: Meets the Criterion

Strengths:

- Under the PRC HH-APM, the APM Entity would be financially responsible for the cost of inpatient care for patients who need to be taken to the ED or admitted to the hospital during a home hospitalization episode, and it would be responsible for the cost of post-acute care for patients following discharge. This will require the Entity to develop relationships with hospitals and post-acute care providers if those relationships do not already exist.
- A patient's primary care provider would be involved in the patient's admission to home hospitalization under the PRC HH-APM, either through a direct referral from the PCP to the program or as a consultation during the admission to the program from the ED.
- Upon discharge from the acute phase of home hospitalization, the patient's PCP would be sent a discharge summary within 48 hours and an appointment with the patient's PCP would be scheduled within 5-7 days.
- There is a quality measure and explicit financial incentive for connecting patients with their PCPs after the acute phase.
- The same team would provide care during the acute and post-acute phases, which ensures continuity of care during the critical post-discharge period.
- During the post-acute phase, providers under the PRC HH-APM would begin transitioning care to the patient's primary care provider, providing critical information about the patient's home situation to inform the care plan.

Weaknesses:

- The proposal assumes PCP participation but does not directly require that collaboration.
- The quality measure for PCP follow-up is based on scheduling of an appointment with the PCP, rather than an actual visit with the PCP and communication with the PCP about the patient's care during the home hospitalization.
- Although the program would provide a new care option for patients, it creates three new situations in which coordination, communication, and transition would be needed – the initial transfer from the ED to the home, a transfer to the hospital from home (if escalation is required), and a possible transfer back to home following an escalation.

Summary of Rating:

The proposed PFFM meets the criterion. The proposal has several mechanisms in place to ensure that the patient's usual providers are aware of the patient's participation in the PRC HH-AM and are involved in care planning as appropriate. By providing care in the home, providers can provide insights into the patient's home situation, which may be particularly useful for care planning.

Criterion 8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

PRT Qualitative Rating: Meets the Criterion

Strengths:

- The program would provide a significant new home care option for eligible patients, which evaluations have shown is preferred by many patients and their families.
- Admission to the program would be voluntary on the part of the patient.
- The payment model would provide flexibility to the care team to deliver non-traditional services to patients.

Weaknesses:

- The discretion involved in determining patient appropriateness could result in providers encouraging participation of patients who would be better served in an inpatient setting, in order to meet financial goals.
- The higher payments for more complex patients could cause APM Entities to admit patients in higher-weight DRGs inappropriately. For example, the payment for patients with renal failure and major comorbidities (MS-DRG 682, \$12,000) is twice the payment for a patient with simple pneumonia (MS-DRG 195, \$5,300).

Summary of Rating:

The proposed PFFM meets the criterion. Eligible patients may decide to participate in PRC or to receive traditional inpatient admission. Serving patients in their home affords patients and their families more control over the environment in which care is delivered.

Criterion 9. Patient Safety. Aim to maintain or improve standards of patient safety.

PRT Qualitative Rating: Does Not Meet the Criterion

Strengths:

- Participation in the program is intended to be limited to patients with diagnoses and other characteristics that can be cared for safely in the home. However, the proposal does include a large and diverse number of health conditions and patients who would otherwise require inpatient acute care.
- Patients can be escalated to an inpatient unit at any time, either at the patient's request or the clinician's judgment.
- In response to questions, the submitter indicated that the APM entity would have the flexibility to initially admit a patient to the hospital or to a skilled nursing facility before transferring the patient home. (The cost of this initial inpatient stay would be covered by the Home Hospitalization Payment.)
- The submitter recommended that a minimum number of daily telehealth visits by the admitting physician and a minimum number of in-home visits by the registered nurse be required during the acute phase to ensure proactive monitoring of patients, and that 24/7 response capability should also be required.
- The submitter described special training that could be provided for home nursing staff.
- The same team provides care during the acute and post-acute phases, which may help to reduce complications during the post-discharge period.

Weaknesses:

- Although the submitter has recommended a minimum number of home visits, 24/7 response capability, and special training for staff, the PRC HH-APM does not include a method for measuring, reporting, and monitoring to ensure these visits are completed, that timely responses are made to calls, or that training has been provided.
- The payment model is not intended to support any in-person home visits by a physician or other clinician. Although daily physician contacts with the patient would be required, these would only be through a telehealth system.
- The discretion involved in determining patient appropriateness could result in providers encouraging participation by patients who would be better served in an inpatient setting in order to meet financial goals.
- There is a financial disincentive to escalate care to the inpatient unit or to provide initial care in a hospital or skilled nursing facility if needed for patient safety.
- Although measures of hospital admissions and mortality would be tracked, performance on these measures would not affect payment. The proposal does not define the actions that would be taken by CMS or the APM Entity if performance on the measures is poor.
- The model lacks both a clear mechanism for patients and their families to report adverse events and an independent entity designated to review adverse events and the response to them.
- The large numbers of MS-DRGs proposed for inclusion in the program reflect a wide range of patient diagnoses, ranging from traditional home hospitalization diagnoses

such as uncomplicated cellulitis and heart failure to non-traditional conditions such as hip fracture and inflammatory bowel disease, and they would also permit inclusion of patients with major complications and comorbidities. It would likely be more difficult for home hospitalization providers, particularly small providers, to provide appropriate care for all of these different patients, which would increase the risks to patient safety.

- Because the Home Hospitalization Payment component that supports the home nursing services is proportional to the MS-DRG payment amount, and because the MS-DRG payment amount is much higher for patients with more severe conditions and with comorbidities, there could be a problematic financial incentive to focus service on the more complex and higher-risk patients.

Summary of Rating:

The proposed PFPM does not meet the criterion. Although the PRC HH-APM would likely improve patient safety by reducing complications associated with hospitalization, the PRT believes that the proposed PFPM does not have adequate safeguards to assure patient safety in the home. The submitter has recommended a minimum number of daily nursing visits during the acute phase, training for staff, and measurement of specific kinds of adverse events. In addition, a patient can be escalated to an inpatient unit at any time. However, the PRT believes that further safeguards are necessary, such as (a) formal monitoring and review of the frequency of home visits, (b) monitoring and review of the rate of escalation to the inpatient unit, (c) monitoring and review of response to adverse events, and (d) formal mechanisms for patients and families to report safety concerns and adverse events. Additionally, better tying payments to quality measures and expanding the number of quality measures would provide greater assurances about patient safety.

Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.

PRT Qualitative Rating: Meets the Criterion

Strengths:

- Participants in the PRC HH-APM will be required to use Electronic Health Record systems.
- The use of multiple types of personnel and potentially multiple organizations to deliver care would serve as an incentive to record and share information electronically.
- APM Entities would be expected to use telehealth capabilities for remote patient visits and monitoring of vital signs.

Weaknesses:

- Current EHR systems are not designed to support inpatient-level services in an ambulatory care environment.
- The lack of effective interoperability of current EHR systems will make it difficult to share information if separate organizations are providing services to patients.

- The costs of the modifications to EHRs required for optimal functioning of the proposed PFPM may limit its attractiveness to potential APM Entities.
- There is no mechanism for ensuring that APM Entities implement telehealth services in a way that successfully identifies and addresses patient problems.

Summary of Rating:

The proposed PFPM meets the criterion. While current EHR capabilities pose challenges to implementation of home hospitalization services, the proposed model encourages use of HIT. Implementation of home hospitalization programs supported by the PRC HH-APM could encourage EHR vendors to develop better cross-setting and interoperability capabilities.

E. PRT Comments

The PRT found that the Home Hospitalization Alternative Payment Model (HH-APM) submitted by Personalized Recovery Care, LLC (PRC) has many similarities to the Hospital at Home Plus (HaH-Plus) Provider-Focused Payment Model that PTAC recommended for implementation in 2017. The PRT believes that most of the same strengths and weaknesses that PTAC identified with respect to HaH-Plus also apply to the PRC HH-APM. However, the PRC HH-APM also has several important differences from the HaH-Plus model:

- **Patient Eligibility.** In the PRC HH-APM, patients in over 150 different MS-DRG categories would be eligible to participate, whereas the HaH-Plus model is designed for patients in fewer than 50 MS-DRGs. Since PTAC had concerns about whether there would be a sufficient number of patients in the HaH-Plus model to make it financially viable in small and rural communities, the broader eligibility criteria in the PRC HH-APM could help to increase patient volume. However, the PRT is concerned that the greater diversity of patients in the larger number of MS-DRGs could also make it more challenging for a small home hospitalization program to deliver appropriate care safely to every patient.
- **Services Included in Bundled Payment.** In the HaH-Plus model, the home hospitalization provider would receive a single bundled payment to cover virtually all of the services the patient would receive, similar to the way a hospital DRG payment covers all of the services the patient receives during an inpatient admission. In contrast, in the PRC HH-APM, the provider would receive a smaller payment designed to only cover home nursing, social work, and physician telehealth services; the provider or other providers would continue to bill Medicare for infusion services, DME, laboratory tests, therapy services, and other ancillary services under standard Medicare payment systems. In both models, the home hospitalization provider would be accountable for the total amount spent during the episode through a financial reconciliation process. By allowing continued billing for ancillary services under current payment systems, the PRC HH-APM could be simpler for both CMS and small providers to implement, but the PRT is concerned that this could also potentially increase the financial risks for small providers during the reconciliation process.

- **Relationship of Payments to Costs.** In the PRC HH-APM, the home hospitalization provider would receive a payment equal to 70% of the MS-DRG payment that would have been paid to a hospital if the patient had been admitted. Since ancillaries would be billed separately, it is not clear how often the costs of the nursing and other services would be proportional to the amount of the MS-DRG payment. Since payment amounts would differ significantly across the MS-DRGs that would be included in the model, and since only a small percentage of patients in many of the MS-DRGs would likely be eligible for home hospitalization, the PRT is concerned that this could create a perverse financial incentive for the provider to focus on patients in the MS-DRGs that would result in higher payments, even though the higher severity and complexity of these patients might make them more challenging to manage in the home. Small providers could also face financial challenges if the cost of home nursing services is higher than 70% of the MS-DRG payments for the patients they serve, even though the cost is lower than what the full MS-DRG payment to a hospital would have been if the patient had been admitted to the hospital.

In its review of the HaH-Plus proposal, PTAC concluded that there was a need for Medicare to create a payment model to support home-based hospital-level acute care for appropriate patients. The PRT believes that some of the differences in the PRC Home Hospitalization APM proposal from the HaH-Plus model could enable a broader range of providers and communities to implement home hospitalization services, which in turn could enable a larger number of Medicare beneficiaries to benefit from home-based acute care.

However, the PRT also felt that the differences described above could increase the kinds of safety risks for patients and financial risks for providers that PTAC had identified with respect to the HaH-Plus model. The PRT believes that these issues could be addressed through enhancements and modifications to the service delivery standards, patient eligibility requirements, quality measures, and payment methodology that are described in the PRC HH-APM proposal, while preserving the basic care model and payment model that the applicants proposed. (In the PRT's discussion with the applicant, the applicant expressed a willingness to make modifications to address a number of these issues, but the PRT's comments here are based only on what was contained in the applicant's proposal and the written responses it provided to the PRT's questions.) Some of the modifications to the HaH-Plus model that were suggested by PTAC would also be applicable to the PRC HH-APM. In addition, the PRT felt that it could be desirable for providers participating in the PRC HH-APM to focus initially on patients in a narrower range of MS-DRGs and phase in services to a broader range of patients over time, and the PRT suggests that adjustments to the payment amounts and risk levels should be considered to allow this phased approach.

On balance, the PRT felt that if refinements were made to this proposal to address these issues, it would merit implementation.

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