

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the Hospital at Home Plus Provider-Focused Payment Model

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In accordance with the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) *Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary of the Department of Health and Human Services*, proposals for Physician-Focused Payment Models (PFPMs) that contain the information requested by PTAC's Request for Proposals 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:** "HaH-Plus" (Hospital at Home Plus) Provider-Focused Payment Model
2. **Submitting Organization or Individual:** Icahn School of Medicine at Mount Sinai
3. **Submitter's Abstract:**

"Hospital at Home Plus (HaH-Plus) is a physician-focused payment model designed to engage physicians and other professionals in ordering, providing, and managing hospital-level services at home for beneficiaries with selected acute illnesses and acuity levels who would otherwise be hospitalized. Traditional fee-for-service (FFS) Medicare does not currently provide adequate payment for such care. Unfortunately, lack of a payment model in FFS Medicare has limited dissemination of HaH, under which providers furnish acute hospital-level services that are beyond the scope and intensity of Medicare skilled home health care services and physician home visits.

"Enabling HaH-Plus care in Medicare will be a transformative change in U.S. health care delivery. Although the hospital is the standard venue for providing acute medical care

for serious illness, it is expensive and hazardous for vulnerable older persons who commonly experience functional decline, iatrogenic illness, and other adverse events during care. Providing acute hospital-level care in a patient’s home for carefully selected patients is patient-centered and demonstrated in scores of randomized trials to improve patient safety, reduce mortality, enhance quality, and reduce the costs of providing acute care for medical illness.”

B. Summary of the PRT Review

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. Information Reviewed by the PRT

- 1. Proposal** (Proposal available on the PTAC [website](#))

Proposal Overview:

The proposed HaH-Plus model allows 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 30 days of transition services (akin to post-acute care) following “discharge” from the acute care phase. The proposal also describes two variants of the model called Observation at Home and Palliative Care at Home. The goal of HaH-Plus is to increase quality of care and reduce costs by reducing complications and readmissions.

The submitter indicates that patients presenting with conditions that will generally fall into one of 44 MS-DRGs could potentially be admitted to HaH-Plus. Medicare beneficiaries would be carefully screened to ensure they could safely receive care at home prior to admission to the program. The submitter estimates approximately 21% of patients classified into the 44 MS-DRGs would be eligible for HaH-Plus. The acute care phase of HaH-Plus involves daily (or more frequent) visits by a physician or advanced practice nurse, daily (or more frequent) visits by a registered nurse, and in-home

radiology, labs, and pharmacy as needed. The 30 days of transition services include post-discharge visits and care coordination with the patient's regular care providers.

Since the Medicare fee-for-service (FFS) program does not currently pay for hospital-level acute care in the home, this proposed model fills a gap in current payment systems. HaH-Plus is a bundled payment encompassing the acute (hospital-level) phase of care plus 30 days of post-acute services. The HaH-Plus bundled payment is composed of two parts: (1) a bundled payment set equal to 95% of the sum of (a) the DRG payment that would have been paid to a hospital and (b) the average professional fees that would have been paid to physicians had the patient been admitted to a hospital and (2) a performance-based payment (shared savings/shared losses) based on (a) total spending during both the acute care phase and 30 days afterward relative to a target price and (b) performance on quality measures. Some services will still be billed FFS (including professional fees for consultations; post-acute labs/diagnostics; post-acute skilled nursing, outpatient, and home health services; post-acute ED services and hospital readmissions), but these services will be included in the measure of spending used for calculating shared savings/losses. The target price will be based on average spending during the episode (the acute care phase plus 30 days post-discharge) for hospitalized patients in the same geographic region who had matching DRGs. The APM Entity will only be responsible for savings and losses up to 10% of the target price, with CMS entitled to the first 3% of any savings and the remainder paid to the APM Entity. In the case of losses, the APM Entity pays CMS.

PRT Review: The HaH-Plus proposal was received on May 4, 2017. The PRT held several conference calls between May 30, 2017 and August 2, 2017. The PRT sent two rounds of questions to the submitter, received written responses from the submitter, and had a telephone discussion with the submitter to clarify aspects of the proposal. The PRT received 22 public letters of support and two additional comment letters raising substantive questions regarding the proposal. The PRT's questions, the submitter's written responses, the transcript of the PRT's telephone discussion with the submitter, and the public comment letters are available on the PTAC [website](#).

2. Data Analyses

The PRT sought additional information regarding the volume of Medicare discharges annually for the proposed MS-DRGs and illnesses across Hospital Service Areas (HSAs), Core-Based Statistical Areas (CBSAs), and rural/urban hospitals, nationally and within each state. The Office of the Assistant Secretary for Planning and Evaluation (ASPE), through its contractor, produced data tables that are available on the PTAC [website](#).

3. Literature Review and Environmental Scan

The submitter cites relevant literature in the proposal. ASPE, through its contractor, conducted an abbreviated environmental scan that included a review of peer-reviewed literature as well as a search for relevant grey literature, such as research reports, white

papers, conference proceedings, and government documents. The abbreviated environmental scan is available on the PTAC [website](#).

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 submitter's letter of intent (LOI). The key words and combinations 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 "Mount Sinai Health System," "Mobile Acute Care Team," "CMS Mobile Acute Care Team," "Hospital at Home Trial," "Johns Hopkins Hospital at Home," "Hospital at Home Programs," "Hospital at Home Trial," "Hospital at Home Acute Care," "COPD Hospital at Home," and "HF Hospital at Home." These searches produced 5 documents from the grey literature and 9 peer-reviewed articles. The search included the first year evaluation of the Mount Sinai Health System's Mobile Acute Care Team (MACT) Round Two Health Care Innovation Award (HCIA2). These documents are not intended to be comprehensive and are limited to documents that meet predetermined search parameters including a five-year look back period, a primary focus on U.S. based literature and documents, and relevancy to the LOI.

The PRT also requested an additional environmental scan on care guidelines that may be used to determine the appropriateness of hospital admission, particularly focusing on the Milliman Care Guidelines (MCG) and McKesson InterQual Criteria. A summary document of the environmental scan was created and is available on the PTAC [website](#). Documents identified as part of the environmental scan included both peer-reviewed and grey literature. Key search terms included "Milliman guidelines," "Milliman Care Guidelines," "Milliman & Robertson guidelines," "M&R," "MCG," "InterQual," "McKesson InterQual," "Clinical practice guidelines," "Medical appropriateness," "Validity," "Appropriateness," and "Criteria." Much of the information describing the systems was gathered from vendor marketing and sales materials (i.e. system websites), as a review of the literature yielded few relevant peer-review articles, with only a small number referencing either the Milliman Care Guidelines or the McKesson InterQual Criteria systems as tools for assessing medical necessity or appropriateness of hospitalization. The majority of resources identified in the review focused on the use of these tools to help guide clinical decision-making.

4. Additional Information Reviewed

The PRT sought additional information from CMS' Office of the Actuary (OACT) regarding the proposed payment methodology and the ability to evaluate the proposed model. The PRT sought additional information regarding the Independence at Home (IaH) demonstration to determine the differences between IaH and HaH-Plus and assess whether an HaH-Plus program could potentially use the same staff and other

infrastructure of an existing laH program. ASPE, through its contractor, produced a document on aspects of laH relevant to HaH-Plus available on the PTAC [website](#).

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 Criterion
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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 HaH-Plus would also serve patients with acute conditions.
- The CMMI Bundled Payments for Care Improvement (BPCI) initiative includes projects focused on patients who would be eligible for the HaH-Plus program, but BPCI does not permit use of alternatives to hospitalization, so HaH-Plus would provide an additional opportunity for savings and quality improvement.

Weaknesses:

- Although it is possible that a small primary care or multi-specialty practice could deliver HaH-Plus services, it seems likely that most small practices would need to be part of a larger organization to do so because of (a) the need to organize and manage backup support and (b) the need for capital to support the significant financial risks under the proposed payment methodology.
- The HaH-Plus program may be attractive to ACOs seeking methods of paying for community-based alternatives to hospital care.
- A minimum volume of patients is needed to make the program financially viable, which could limit it to large communities.

Summary of Rating:

The proposed PFFM 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. However, the minimum number of patients needed to make the program financially viable will likely limit the model to large communities. An all-payer option for the model could increase the number of potentially eligible patients, particularly in regions with high Medicare Advantage penetration, to increase the number of geographies with sufficient patient volume. While the total savings to Medicare may be limited for the DRGs the submitter has currently identified, the model could potentially be expanded to include other DRGs or other types of services, such as the

proposed Observation at Home and Palliative Care at Home variants, which could increase the potential savings.

Criterion 2. Quality and Cost (High Priority Criterion). 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 Criterion
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Strengths:

- Multiple studies of similar programs in other countries and at several sites in the U.S. have found that Hospital at Home programs achieve better outcomes for eligible patients and have lower costs than traditional hospitalization.
- HaH-Plus 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 benchmark for shared savings or losses, which discourages cost-shifting from the inpatient stay to the post-discharge period.
- Care during the acute and post-acute phases is provided by the same team of providers, 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 (b) providing less intensive home services than patients need, which could lead to poorer outcomes.
- There may also be a financial incentive to enroll patients into HaH-Plus who would not have been admitted to an inpatient unit at all in the absence of the HaH-Plus program. This would cause Medicare to spend more than it otherwise would have thereby offsetting savings achieved from appropriately enrolled patients.
- The review process for adverse events currently described in the proposal provides only limited assurances regarding the quality of care. Although the applicant notes that rates of adverse events would likely be very low and measures of those events would not be appropriate for use in standard performance-based payment adjustments, adverse event and escalation rates could still be tracked and a well-defined mechanism put into place to trigger an external review for any sites falling outside of pre-specified 'guardrails' for these measures. The applicant has suggested revisions which would strengthen this aspect of the payment model.
- A significant component of the proposed payment would reward the HaH-Plus program for reducing post-acute care spending. It is likely that the types of patients eligible for and willing to participate in the HaH-Plus program 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 HaH-Plus program based on “savings” in post-acute care that did not actually occur.

- It seems likely that care of the patients deemed eligible for HaH-Plus 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.
- Because only a minority of patients with selected DRGs could participate in HaH-Plus, the total savings for Medicare may be limited.

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 HaH-Plus patients 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 HaH-Plus patients 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 Criterion

Strengths:

- The proposed payment methodology is described in detail and examples have been provided 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 includes a 30-day post-acute care episode as a mechanism for protecting against cost-shifting from the acute (inpatient) phase to post-acute care phase and also to encourage avoiding readmissions and reducing unnecessary and unnecessarily expensive post-acute care.
- The payments for the acute and post-acute phases of care are specifically tied to current Medicare IPPS (DRG) and Medicare PFS (CPT) payments, similar to the way CMS defined inpatient bundles in the Acute Care Episode demonstration, but in HaH-Plus, the payment could be made for care delivered outside of an inpatient hospitalization. The direct tie to inpatient payment amounts would provide a straightforward way of ensuring that Medicare spends less for the acute care phase than it would have spent had the patient been admitted to the hospital.
- The episode payment structure uses components similar to those in the Bundled Payments for Care Improvement (BPCI) initiative, including the standard CMS DRG grouper, the exclusions and post-acute care definitions, and the shared savings methodology.

Weaknesses:

- The payment for the acute (inpatient) phase 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).
- The size of the discount to the DRG applied to the payment for the acute (inpatient) phase does not depend on the magnitude of the needs of the patients admitted to HaH-Plus relative to patients admitted to the inpatient unit, and the proposed amount of the discount is not based on the expected difference in costs of serving patients at home instead of in the hospital.
- The methodology for calculating the spending benchmark for post-acute care services would be biased in favor of the HaH-Plus APM Entity and biased against Medicare if the patients who are determined to be eligible and appropriate for home-based care are less likely to require skilled nursing facility care than patients admitted to the hospital, who form the comparison group for setting the target price.

- 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.
- If the hospital is participating in the BPCI program, the payment methodology would only be partially aligned with BPCI, since different sets of patients would be eligible and the lengths of the post-acute care episodes could be different (30 days in HaH-Plus versus 30, 60, or 90 days in BPCI).
- Although the proposal recommends inclusion of two additional components – an “Observation at Home” program and a “Palliative Care at Home” program – it does not describe payment models for these programs in sufficient detail to allow PTAC to evaluate them.

Summary of Rating:

The proposed PFPM meets this criterion for the Hospital at Home component. 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. The DRG-like HaH-Plus payment should be adjusted based on performance on quality measures, and the magnitude of the discount should be set based on the costs of serving patients in the HaH-Plus program relative to the inpatient unit. Additionally, the benchmarking methodology requires refinement to account for differences between the HaH-Plus and inpatient populations. The PRT also believes that the amount of risk the APM Entity bears should start at a lower level and be increased over time to reflect the APM Entity’s startup costs and its increased experience in managing patient care over time.

The PRT believes that the proposed components for “Observation at Home” and “Palliative Care at Home” are desirable services but the payment models for them are not sufficiently well described for a determination as to whether they meet this criterion. The PRT does not believe the HaH-Plus program requires either “Observation at Home” or “Palliative Care at Home” to be successful, though with further development these two components could potentially be added to the HaH-Plus program.

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

PRT Qualitative Rating:	Meets Criterion
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Strengths:

- Since patient participation is voluntary, and since patients generally will 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 and repayments to CMS are increased if quality performance is low.

- The program proposes that physician compensation be tied to performance on quality measures and readmission rates, rather than to service utilization or savings.

Weaknesses:

- The payment methodology makes the program dependent on achieving a certain minimum level of volume, which could result in physicians enrolling and encouraging participation by patients who would be better treated in an inpatient setting, or enrolling patients who would otherwise not have been admitted to the hospital at all.
- There is no direct financial penalty for poor performance on quality measures; poor performance would only reduce the amount of shared savings or increase the payment on losses.
- 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. Although the proposal recommends that this penalty not be reflected in physician compensation, if the penalty creates losses for the APM Entity, it could indirectly affect the physicians’ compensation, and that could lead to keeping patients at home when they should be admitted to the hospital.

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 DRG-like payment contingent on quality. Additionally, monitoring for admission appropriateness and escalation will be critical, and adding an all-payer option may help to relieve some of the concerns around achieving a minimum volume.

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

PRT Qualitative Rating:	Meets Criterion
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Strengths:

- A single bundled payment would cover the acute phase of services, and the APM Entity would have complete flexibility to determine the number and types of services patients would need and to determine the best individuals or organizations to deliver those services.
- The APM Entity would also have the flexibility to deliver more services to some patients than others, as long as the overall costs for all of the patients served was less than the revenue generated by the payments.

Weaknesses:

- The challenges in gaining adequate patient participation to cover the financial costs of the program could make the program less willing or able to deliver all of the services that patients need.

- The APM Entity would be accountable for post-acute care spending 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 single bundled payment for acute and post-acute care offers 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 Criterion
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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), which forms the basis for the proposed PFPM, is currently being evaluated, and a method for drawing a valid comparison group will be developed as part of that evaluation.

Weaknesses:

- Because of the diversity of patients participating, it may be difficult to accurately compare costs and quality other than for the most common types of participating patients.
- The limited number of potential participants may make it difficult to have enough participants to precisely measure the effects, and it may be challenging to implement a randomized test of the model.

Summary of Rating:

The proposed PFPM meets the criterion. The model describes evaluable goals for quality of care and cost. The Mount Sinai HCIA, which forms the basis for this proposed PFPM, is currently being evaluated, and lessons learned from that experience can inform the evaluation of this proposed PFPM.

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 Criterion
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Strengths:

- The HaH-Plus program 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 an HaH-Plus

episode, and it would be responsible for the cost of post-acute care for patients following discharge, which will force the HaH-Plus program to develop relationships with hospitals and post-acute care providers, if those relationships do not already exist.

- The patient’s primary care doctors are involved upon a patient’s admission to the HaH-Plus program, either through a direct referral from the PCP to HaH-Plus or as a consultation during the patient’s admission to HaH-Plus from the ED.
- Upon discharge, the patient’s PCP is sent a discharge summary within 48 hours and an appointment with the patient’s PCP (and specialists, if applicable) is scheduled.
- The same team provides care during the acute and post-acute phases, which ensures continuity of care during the critical post-discharge period.
- During the post-acute phase, HaH-Plus providers 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:

- Although the program would provide a new care option for patients, it would also create three new situations in which coordination, communication, and transition would be needed – the initial transfer from the ED to the HaH-Plus program (at home), a transfer to the hospital from home (if escalation is required), and a possible transfer back to HaH-Plus care (at home) following an escalation.

Summary of Rating:

The proposed PFFM meets the criterion. The HaH-Plus has several mechanisms in place to ensure that the patient’s usual providers are aware of the patient’s participation in HaH-Plus and are involved in care planning as appropriate. By providing care in the home, HaH-Plus 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 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:

- Because of the nature of the model, some patients who would like to participate in HaH-Plus may not be eligible.
- 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 participation goals.

Summary of Rating:

The proposed PFPM meets the criterion. Eligible patients may decide to participate in HaH-Plus 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 Criterion**Strengths:**

- The program aims to reduce adverse events associated with hospitalization such as delirium, loss of functional status, and use of chemical restraints.
- 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.
- Patients can be escalated to an inpatient unit at any time, either at the patient’s request or the clinician’s judgment.
- The proposal specifies a minimum number of daily visits by the physician/nurse practitioner and the registered nurse during the acute phase to ensure proactive monitoring of patients.
- The same team provides care during the acute and post-acute phases, which may help to reduce complications during the post-discharge period.

Weaknesses:

- While there is a minimum number of provider visits specified in the HaH-Plus program, there is not a method for measuring, reporting, and monitoring in place to ensure these visits are completed.
- 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 participation goals.
- There is a financial disincentive to escalate care to the inpatient unit.
- There is not a clear mechanism for patients or their families to report adverse events nor is an independent entity designated to review adverse events and the response to them.

Summary of Rating:

The proposed PFPM does not meet the criterion. Although the HaH-Plus program 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 program specifies a minimum number of daily provider visits during the acute phase, and 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 provider visits, (b) monitoring and review of the rate of escalation to the inpatient unit, and (c) monitoring and review of adverse events. Additionally, tying payment for the acute (inpatient) phase to quality may provide further incentives to assure patient safety.

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

PRT Qualitative Rating:

Meets Criterion

Strengths:

- 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.
- The relatively small scale of the program means that essential elements of tracking and exchange of patient information could be successfully carried out using simple tools.

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.
- While the proposed PFPM encourages health data/information sharing across multiple care providers, the low patient volume and small scale of this model may not be sufficient to prompt investment in data integration systems and interoperability.
- The costs of the modifications to EHRs required for optimal functioning of the proposed PFPM may limit its attractiveness to potential APM Entities.

Summary of Rating:

The proposed PFPM meets the criterion. While current EHR capabilities pose challenges to HaH-Plus program implementation, the proposed model encourages use of HIT. Implementation of programs such as HaH-Plus could encourage EHR vendors to develop better cross-setting and interoperability capabilities. Given their relatively small scale, individual HaH-Plus programs likely could be successfully implemented even in the absence of optimal EHR functionality.

E. PRT Comments

Strengths:

- The proposed PFPM aims to increase quality and reduce costs by reducing complications associated with hospitalization. Elderly patients are particularly vulnerable to hospital-associated morbidity, and this model will offer eligible patients the option of receiving hospital-level care within the comfort of their own home.
- The proposed PFPM fills a gap in the current Medicare payment portfolio. Medicare currently has no payment mechanism to support hospital-level care in the home for these types of patients.
- The proposed PFPM includes a bundled payment for both the acute and post-acute care (30 days after discharge) phases to prevent cost-shifting from the acute to the post-acute phase. Including post-acute care in the bundle also offers providers flexibility to reduce costs and improve quality during this critical and often costly period.

- The proposed PFPM would be an attractive model for an all-payer option. Including Medicare Advantage, in particular, may mitigate concerns around patient volume in the model while ensuring integration of alternative payments across payers.

Weaknesses:

- The proposed PFPM has financial incentives that may lead to inappropriate enrollment of patients into HaH-Plus. Because the model depends on sufficient patient volume to be financially viable, providers may be incentivized to enroll patients who either would not be admitted to an inpatient unit in the absence of HaH-Plus or to enroll patients who would be better served in an inpatient unit.
- The proposed PFPM's payment methodology should be modified to more accurately reflect costs and savings both during the acute and post-acute care phases.
- The proposed PFPM's quality metrics need refinement. The current quality metrics do not comprehensively capture adverse events (even if the data are only used for monitoring due to low event rates).
- The link between quality and payment should be strengthened. Currently, only the performance-based payment is tied to quality; the DRG-like HaH-Plus payment should also be adjusted for quality performance.
- The proposed PFPM also requires additional mechanisms for ensuring patient safety. Currently, there is no formal monitoring to ensure escalations occur as appropriate or that providers are making scheduled visits during the acute phase. Sufficient monitoring of adverse events, and a standardized plan for review, also is currently lacking.

Summary:

The HaH-Plus model holds promise. While the PRT finds that stronger safeguards for patient safety and incentives for quality are needed, it believes that the shortcomings within the currently proposed model (discussed above) can be addressed with simple modifications.