Icahn School of Medicine at Mount Sinai

COMMITTEE ON FINANCE
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STATEMENT FOR THE RECORD

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Chairman Wyden, Ranking Member Crapo and Members of the Senate Finance Committee, it is my distinct pleasure on behalf of the Icahn School of Medicine at Mount Sinai and Hospital at Home Users Group to submit this testimony in support of Hospital at Home, specifically extending the current Hospital Without Walls and Acute Hospital Care at Home flexibilities currently being offered under the public health emergency (PHE).

The Mount Sinai Health System is New York City's largest academic medical system, encompassing eight hospitals, a leading medical school, and a vast network of ambulatory practices throughout the greater New York region. Mount Sinai is a national and international source of unrivaled education, translational research and discovery, and collaborative clinical leadership ensuring that we deliver the highest quality care—from prevention to treatment of the most serious and complex human diseases. The Health System includes more than 7,200 physicians and features a robust and continually expanding network of multispecialty services, including more than 400 ambulatory practice locations throughout the five boroughs of New York City, Westchester, and Long Island. The Mount Sinai Hospital is ranked No. 14 on *U.S. News & World Report's* "Honor Roll" of the Top 20 Best Hospitals in the country and the Icahn School of Medicine as one of the Top 20 Best Medical Schools in country. Mount Sinai Health System hospitals are consistently ranked regionally by specialty and our physicians in the top 1% of all physicians nationally by *U.S. News & World Report*.

The Hospital at Home Users Group is a dynamic collaborative of Hospital at Home programs around the United States and Canada. We are sharing resources and best practices, working together to expand the reach of our programs, and developing the program and policy standards to inform regulatory and reimbursement policies necessary to spread this hopeful model broadly throughout North America.

Hospital at Home (HaH) is a patient centric model of care which provides hospital-level care at home for patients with select acute illnesses and acuity level who would otherwise be hospitalized. The traditional hospital can be dangerous for older adults with resultant functional decline, iatrogenic illnesses, and other adverse events. Multiple HaH studies have demonstrated improved patient safety, reduced mortality, enhanced quality, and reduced cost. This was a model that many Medicare Advantage, commercial, and Medicaid managed care plans already covered before the pandemic. Adding the rest of Medicare beneficiaries allows equitable care and has been extremely helpful since November 2020, when the Acute Hospital Care at Home waiver was approved. I believe the coverage of Hospital at Home or Acute Hospital Care at Home should be covered beyond the pandemic as a 30-day bundle of care.

Typically, HaH starts in the emergency departments where a patient is evaluated by the emergency physicians and staff and if they are determined to need inpatient care they are screened for HaH. This screening first starts with a clinical screen to see if the conditions and treatment plan can be effectively delivered in the home, then the patients home environment is screened through a bedside survey. Common diagnoses are Pneumonia, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Cellulitis. The patient then is

offered the opportunity to participate in the program and consents. Other physicians see the patient and write admission orders. Patients go home with an IV in place, in an ambulance, with a telehealth kit and potentially with oxygen. The ambulance staff sets them up in the home and within a couple of hours, a nurse arrives at the home and further assesses the home for safety and starts the treatment plan. Multiple deliveries typically occur such as IV and oral medications, equipment, and supplies. In the subsequent days, nurses come twice a day (some programs use mobile integrated health paramedics), and a physician or nurse practitioner sees the patient daily (in person or via video visit). They have access to other services such as physical therapy, occupational therapy, speech therapy, social work, and nutrition-- all as needed based on the patient's individualized care plan. Patients usually require frequent blood draws, IV fluids, antibiotics, x-rays, or oxygen, all of which can be done in the home. Teams will round a couple times a day to review the care plan. There is 24/7 immediate availability of the team, including in person within 30 minutes if needed. This care is inclusive, patient centric, and equitable, as 41% of our patients have some form of Medicaid. Once a clinician is in the home many additional barriers to improved health care, including health literacy, food insecurity, nutritional misinformation, and medical equipment needs are all readily identifiable, allowing our social worker to get involved, and referrals to be made to help improve the patient's health longer term.

There are other pathways into Hospital at Home such as from a patient's outpatient doctors' offices, urgent care, or from the inpatient floors as long as the patient requires inpatient level care and would otherwise have been admitted to the hospital.

The model of Hospital at Home has existed for several decades internationally with Australia, France, Spain, and Israel being some of the early adopters. In the mid-1990s the first trials of Hospital at Home were performed in the US at Johns Hopkins. It was shown to be safe, efficacious and the patients desired this type of care. Never the less, no payment was available and existing payment structures did not adequately cover the costs of the program. Between the mid-1990s and 2014, a number of Veteran's hospitals developed similar programs as they had payment flexibilities. One integrated health system in New Mexico with their own Medicare Advantage plan has offered a HaH program since 2008. In 2014, we at Icahn School of Medicine at Mount Sinai in New York City applied and received a Center for Medicare and Medicaid Innovation (CMMI) award to develop and test Hospital at Home for a Fee-For-Service Medicare population. We did one thing differently than previous iterations of Hospital at Home, we cared for the patients for 30 days. It was split into two phases – the acute phase where the patient would have been in the hospital and a transitional phase for monitoring and ensuring the patient was stable and back under the care of their primary care provider and outpatient specialists.

From our CMMI period, we examined more than 500 Fee-For-Service Medicare beneficiaries who received HaH care. We received additional funding from The John A. Hartford Foundation, and were able to compare care to a group of patients who received traditional inpatient care. For both groups of patients, the full 30 days of care were examined, and more than 65 Diagnosis-Related Groups (DRGs) were included in this analysis. Length of stay was reduced

from 5.5 days to 3.2 days, 30-day readmissions were reduced from 15.6% to 8.6 %, and Skilled Nursing Facility transfers on discharge were reduced from 10.4% to 1.7 % with a resultant higher use of Certified Home Health for this HaH cohort. With regards to patient satisfaction, 45.3% of traditionally hospitalized patients were highly satisfied with care, while with HaH it increased to 68.8%.

While some programs may start with a limited number of DRGs for which they can provide HaH care, we currently believe there are more than 150 DRGs that HaH can serve, and believe this is probably a conservative estimate. As many programs expand into oncology and surgical cases, the number will increase.

From this work, we submitted a proposal to the Physician Focused Payment Model Technical Advisory Committee (PTAC) - "HaH Plus" (Hospital at Home Plus) -Provider Focused Payment Model. Moreover, after evaluation, PTAC recommended two separate HaH proposals in 2018: 1) our proposal, the Hospital at Home Plus Model (HaH-Plus); and 2) the Home Hospitalization: An Alternative Payment Model for Delivering Care in the Home (HH-APM), to the Secretary of the Department of Health and Human Services for implementation. The Secretary expressed interest in testing home-based, hospital-level of care models and agreed with the PTAC that these models hold promise for testing. The Agency has the authority to further refine the recommended PTAC models; however, to-date, they have not utilized this authority. While we recognize the broader need for a refined HaH model, and we look forward to working with the Agency to advance such a model to ensure greater availability of hospital care in the home to all patients, we believe congressional action to extend the current waivers and flexibilities is necessary and particularly valuable for patient care in the immediate and near term.

We believe these regulatory flexibilities should be made permanent beyond the PHE and will be an effective foundation for establishing Medicare reimbursement that is specific to Hospital at Home services. We applaud The United States Department of Health and Human Services (HHS) for providing these flexibilities to ensure hospital services in the home during the PHE, and we encourage Congress and HHS to consider extending these flexibilities as a new model of care that prioritizes the patient's safety and care needs.

In 2017 when the CMMI award was finished, our Hospital at Home program no longer provided care for Fee-For-Service patients as there was no Fee-For-Service reimbursement and the program shifted to focus on Medicare Advantage, commercial and Medicaid managed care plans. We created a joint venture with Contessa Health and together have negotiated contracts with most of the major insurance providers in our area.

During the initial surge of COVID-19 in March 2020 we were an important part of helping the Mount Sinai Health system admit both COVID negative and positive patients to open up more capacity for patients needing higher levels of care like ICUs, but were still unable to admit a Fee-For-Service Medicare patient from the emergency room. The PHE has demonstrated the need to have Hospital at Home accessible to Fee-For-Service Medicare patients.

We were very excited to be part of the original group of hospitals approved for the Acute Hospital Care at Home waiver in November 2020. Despite having operated since 2014, we still needed some time to set up and meet the new requirements. We are appreciative that CMS made this available to Fee-For-Service Medicare patients. My colleagues and I have been happy to engage with CMS as stakeholders in this process. In addition, we formed the Hospital at Home Users group with funding from The John A. Hartford Foundation, which provides technical assistance, office hours and a member community which has engaged in multiple work groups. To date, there have been 129 hospitals approved for the Acute Hospital Care at Home waiver, with 56 health systems in 30 states since November. This shows that there is great interest. It does take significant start up resources and time and many are not planning to launch until this summer. I believe even more hospitals would apply if they knew this program would be made permanent. This waiver allowed many hospitals to jump start a program in the pandemic, which has been helpful in many communities for the provision of high quality and safe patient hospital inpatient care.

Having a payment model for Hospital at Home/Acute Hospital Care at Home is needed to serve Medicare beneficiaries beyond the pandemic and especially if an emergency of this type ever happens again. These programs are complex to start, and many places could not start instantaneously; therefore, if the flexibilities continue beyond the PHE, I believe many additional hospitals will join. There is a strong interest in the community of Hospital at Home programs to continue this.

Due to the regulatory barriers outlined above, hospitals have been wary about and disincentivized from implementing the innovations of providing acute level care in the home. Therefore, we request Congress and HHS to consider a permanent extension of the Hospital Without Walls and Acute Hospital Care at Home waivers beyond the PHE to mitigate the residual impacts of COVID-19 on public health and encourage broader adoption of providing patient centered health care services in the home. Thank you for the opportunity to provide this testimony to the committee. My colleagues and I look forward to continuing to work with Congress and HHS on this important issue.