VIEWPOINT

COVID-19: BEYOND TOMORROW

Outpatient Treatment at Home for Medicare Beneficiaries During and After the COVID-19 Pandemic

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Viewpoint

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On April 30, 2020, the Centers for Medicare & Medicaid Services (CMS) released an unprecedented emergency policy waiver to increase capacity in response to coronavirus disease 2019 (COVID-19): Hospital outpatient departments can now relocate health care services to off-campus sites or even into Medicare beneficiaries' homes. For the duration of the public health emergency, these relocated services will be reimbursed at the higher outpatient prospective payment system rates rather than the typical physician fee schedule rates for new off-campus sites, an increase of approximately 40% for similar outpatient services.[1] Both the relocation and payment waivers will terminate when the Department of Health and Human Services withdraws the emergency declaration at the end of the COVID-19 pandemic, although how that will be decided is unclear.

Even though most of the new waivers offer the potential for innovations in home-based health care delivery, care in the home is not new. Patients prefer to receive medical treatments at home, if available, rather than in health care facilities. For many clinical conditions, care at home is as safe and effective as at other sites and is less costly. For instance, home infusion of intravenous therapies is common and growing, although traditional Medicare is more restrictive in its coverage of home infusion than are Medicare Advantage and commercial plans. Postacute care, which can include nursing and rehabilitation therapy, is also provided in home-based settings, a lower-cost alternative to skilled nursing facilities, but is restricted to patients who are homebound, only about 5% of Medicare beneficiaries.[2] Still, in 2018, these services were delivered to an estimated 3.4 million Medicare beneficiaries at an estimated cost of $17.7 billion.[3]

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However, the newly announced Medicare waivers have the potential to catalyze new innovations that could fundamentally shift care delivery, well beyond the scope of what patients currently can receive in their homes, for 2 reasons. First, the waivers set site-neutral payments for care at home at the higher outpatient payment rates. This is atypical for site-neutral payments, which are usually used to lower spending for equivalent care by paying, for example, the lower physician office amount whether the care is given in a physician office or hospital outpatient facility. Second, the waivers effect a major change to Medicare beneficiary benefit design for infused or injected drugs. Before the COVID-19 pandemic, traditional Medicare beneficiaries were eligible to receive a limited set of infused or injected drugs at home under the prescription Part D benefit, with beneficiary coinsurance that could reach $6350, and receive a small number of drugs administered by infusion pump under the medical Part B benefit. Now, the waiver permits beneficiaries to receive any infused or injected drug at home covered under the Part B benefit. The waiver also includes other outpatient services, such as physical therapy or wound care.

The changes are potentially beneficial for patients and for hospital facilities. Patients with illnesses associated with immunosuppression, like inflammatory bowel disease, for example, can now receive the infused biologic infliximab at home rather than in hospital outpatient facilities, decreasing unnecessary exposure during COVID-19. Commercial payer site-of-care policies, which use utilization management strategies to drive infusion services to lower-cost sites of care, have also encouraged infliximab and other infused or injected drugs to be administered at home or in physician offices, where commercial reimbursement can be 2 or 3 times lower than in hospital outpatient facilities. For hospitals and their outpatient departments, which have sustained immense financial losses during the pandemic, the changes permit immediate reductions in crowding for infusion suites and hospital facilities while preserving revenue and margin, an important difference from the site-of-care policies in the commercial market.

Nevertheless, as currently construed, the waivers may not be as substantial a change as CMS might hope. To achieve their full potential for improving the health care for Medicare beneficiaries, CMS will need to take 4 important actions. First, to encourage the greatest possible uptake of innovation in response to the waivers, CMS should publicly signal that the waivers will be extended for 12 months following the end of the pandemic. Hospitals may be reticent to invest in personnel and equipment needed to push outpatient care to home if the financial justification could abruptly disappear. CMS could preserve the waivers beyond the emergency declaration under the authority of the

Center for Medicare & Medicaid Innovation (CMMI) to test alternative payment models through demonstration projects.

Second, CMS should provide technical assistance to accelerate implementation. Providing outpatient care at home is not simple. Success will be dependent on many factors, including existing infrastructure, readiness to change, existence of strong institutional champions, and the effects of the pandemic on the health care facility and its region. Even for vertically integrated health care systems with home health or home infusion businesses, adapting outpatient programs to home may be challenging. For example, Penn Medicine implemented a cancer-treatment-at-home demonstration program for 13 cancer drugs typically administered in outpatient clinics that scaled from approximately 40 patients to more than 300 patients during the rise of COVID-19 between March and April 2020. The program overcame several barriers to scale, including developing new ways to assess and communicate about drug and patient safety for the home setting, extending clinical roles, and streamlining the electronic health record for ordering complex chemotherapy regimens at home. To initiate and implement learning health system approaches rapidly and to measure and maintain high-quality care at home for beneficiaries, CMS could leverage its existing practice support resources, such as those provided to innovation model participants from CMMI.

Third, CMS should create alignment between these waivers and its existing value-based payment model strategy. It is likely that early adopters of this shift toward home health will be participants in Medicare's payment innovation programs such as the Oncology Care Model or Next Generation Accountable Care Organization. This underscores the logistical and administrative complexity of developing and implementing different payment models that are at times layered atop one another (although CMS has reduced the administrative burden to comply the emergency waivers). The higher reimbursement for care delivery at home during the COVID-19 crisis could justify hospital investments without increasing Medicare spending relative to outpatient hospital care. However, Medicare should also recognize the long-term potential for home-based care to reduce costs to patients and taxpayers. If there is a substantial shift, over time Medicare will be able to capture savings for care that costs less to deliver at home. Yet in the short-term to the mid-term, hospitals will still expect strong economic rationale to invest in care delivery models that achieve safe and effective treatments at home, and there may be economies of scale that favor keeping outpatient care in facilities. Therefore, rather than simply reverting payment rates to the physician fee schedule or home health rates at the end of the pandemic, CMS should use an alternative payment model approach that allows for higher reimbursements in the short-term while driving broader cost-saving incentives in the long-term.

Fourth, to protect Medicare beneficiaries from higher out-of-pocket spending based on benefit design differences between Part D and Part B, CMS should harmonize the Part D and Part B benefits under this waiver. A simple approach would be to charge the beneficiary the lesser of the 2 cost-sharing amounts, although Medicare could also leverage its prior work in this area.[4]

By promoting site of care innovation without financial downside, CMS is opening a historic opportunity for hospitals to test new care delivery models to provide safe and effective outpatient services at home to all Medicare beneficiaries. If CMS and hospital outpatient clinics are successful with this approach, this period of flexibility in outpatient care could result in better health care at lower cost for Medicare beneficiaries. And, hopefully, in the not so distant future, Medicare beneficiaries will receive their COVID-19 vaccines—in the comfort of their homes.

ARTICLE INFORMATION

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