Hospital AT Home
USERS GROUP

AMBULATORY MODELS
OF HOSPITAL AT HOME CARE: A PRIMER

Ambulatory models of Hospital at Home (HaH) care can be a valuable addition to a hospital system's home-based care continuum. Like conventional waiver-based approaches that operate under a hospital's license, ambulatory models of HaH care aim to expand hospital capacity while providing high-value, patient-centered acute care in the home environment. They may function as a standalone care delivery model or as a strategic extension of a waiver-based HaH program, leveraging existing logistics, staffing resources, and virtual care infrastructure.

Notably, ambulatory HaH programs operate outside the regulatory framework of the Centers for Medicare & Medicaid Services' Acute Hospital Care at Home (AHCAH) waiver, creating substantial operational flexibility while introducing distinct financial and reimbursement challenges and opportunities. While many hospital systems nationwide have established permanent ambulatory models, the long-term uncertainty surrounding the AHCAH waiver, as well as the operational impact of periodic instability related to federal budget negotiations and government shutdowns, has prompted more programs to explore how they can develop, or rapidly pivot to, an ambulatory model when needed. Health systems exploring an ambulatory HaH program should also consider state and local regulations, including whether it can operate as a physician practice, hospital outpatient, and/or if a home health license is needed.

Many programs similar to Hospital at Home operate under the ambulatory model, which makes distinguishing them from one another difficult. This primer offers an overview of ambulatory models of Hospital at Home, key operational considerations, and insights as to how these models may fit into a health system. All of the patients we are describing would meet inpatient criteria during these programs. As an additional resource, please also see *Another Way: Opportunities and Challenges of Ambulatory Models of Hospital at Home*, a 2025 webinar from the HaH Users Group.

Ambulatory vs. CMS AHCAH Waiver-based programs

The primary difference between the two models is that ambulatory HaH patients retain outpatient status, whereas waiver-based patients are considered inpatients even while receiving care at home. As a result, ambulatory models are not bound by the waiver's requirements, such as two daily clinician visits, 24/7 in-person response capabilities, and other inpatient-level standards. This allows programs to tailor the resources to the needs of the patients. Fewer mandated in-person touchpoints and infrastructure requirements may lead to lower operating costs than waiver-based HaH. While the CMS waiver allows for DRG-based reimbursement, ambulatory models can follow outpatient billing pathways (see "Billing" section). The operational flexibility afforded to ambulatory models results in considerable variability among programs.

The table below illustrates the differences between the waiver-based and ambulatory Hospital at Home services:

Differences between Waiver-Based and Ambulatory HaH Programs

Component	Waiver-Based	Ambulatory
MD/APP oversight	At least daily telehealth	Many choose to do at least daily telehealth
In home RN/MIH visits	At least 2x daily	Many choose to do at least daily and per plan of care of patient
Point of patient admission	ED or IP unit	Can be community/urgent care in addition to ED/IP unit
Medications	IP pharmacy	OP or IP pharmacy
PT/OT/ST	As needed	As needed

Different types of ambulatory models

All ambulatory HaH models share a common foundation: delivering acute-level care on an outpatient basis in the comfort of a patient's home. As noted above, ambulatory programs can have more flexible service structures, visit cadences, and care pathways. Given this operational leeway, programs vary considerably in how they are structured.

Generally, ambulatory HaH programs enroll patients under one of the following pathways:

- ***Early/Immediate Transfer*** - Patients evaluated in the Emergency Department are discharged home to receive acute-level care through a HaH team. Alternatively, patients at home under the care of outpatient providers or home health agencies who are identified as potentially needing a higher level of care are admitted into an ambulatory HaH model directly from home if clinically appropriate, without presenting to the ED. These approaches help provide necessary acute-level care while avoiding the use of ED or inpatient resources and support overall de-crowding efforts.

- ***Late Transfer*** - Patients receive the initial portion of their care as a brick-and-mortar inpatient, typically after meeting requirements for inpatient DRG-based reimbursement. They are then discharged home to complete their care under HaH care. This model supports a safe transition home while saving a portion of inpatient bed days.

OPERATIONS

Scope of clinical care

The clinical services available under an ambulatory model are generally similar to those of a waiver-based program, including remote monitoring, supplemental oxygen, labs, diagnostic imaging and medication administration (including intravenous treatments). Although there are no distinct requirements for clinician visits or oversight like waiver-based programs, ambulatory programs typically have the capacity for home visits by physicians, nurses, and/or advanced-practice providers. Some ambulatory efforts use tele-medicine physician supervision with a visit cadence determined on an as-needed basis.

Like waiver-based programs, ambulatory programs should describe explicit patient inclusion and exclusion criteria that considers their operational resources, integration with inpatient services, safety protocols, risk tolerance and local regulations. Programs should also establish clear escalation pathways for patients who require a higher level of care to ensure safety and regulatory compliance.

Patient acquisition and referral pathways

As in waiver-based models of care, it is especially important to develop consistent and reliable referral pathways aligned with the structure of the program. These pathways may include the ED, observation units, clinical decision units, inpatient floors, outpatient providers, and home health agencies. High-performing programs establish clear eligibility criteria and streamlined triage workflows that readily identify appropriate patients across these settings. Strong collaboration with ED leadership, hospitalists, primary care physicians, urgent care networks and post-acute partners is essential to ensure steady and clinically appropriate referrals.

Billing considerations

Without the ability to qualify for inpatient DRG-based reimbursement under the AHCAH waiver, ambulatory models may bill for individual services provided using existing outpatient billing and home health pathways. This includes changing the place of service code from office (POS 11) to home (POS 12) and may encompass evaluation and management (E/M) professional services, laboratory testing, diagnostic imaging, home infusion and other home-based ancillary services. Some programs have developed negotiated DRG-based outpatient payments with managed Medicare, Medicaid or commercial insurances. Other programs may bill through existing ACO or shared risk contracts.

For early discharge models, it may be advantageous to defer enrollment until a patient qualifies for DRG-based inpatient billing (e.g., two midnights) before transitioning them home, depending on a hospital system's capacity and operational priorities.

Careful consideration must be given to the potential financial impact on patients, as they may be responsible for co-pays or co-insurance associated with outpatient services. Anticipated out-of-pocket costs based on a patient's insurance benefits should be clearly communicated prior to enrollment. Because ambulatory HaH programs can drive value to a health system by meaningfully reducing length of stay and improving overall throughput, some organizations may choose to suppress billing for services that would otherwise lead to additional cost to a patient, thereby absorbing those expenses instead. Billing policies should be developed in coordination with a health system's billing and compliance teams to ensure they are consistent with any local or state requirements.

The following chart demonstrates some billing practices in an ambulatory care model:

	Notes	Billing
Negotiated bundle rate with a payor +/- shared savings	This would be an all inclusive rate which could be DRG specific, sometimes physician services are included and sometimes they are still billed separately	Often this is on an outpatient 1500 form as one charge under the name of the attending physician
Bill pieces of care as possible	• Utilize patients pharmacy benefit for medications (discuss waiving prior authorization on IV medications with payor) • Bill professional services (physician and PT/OT/ST) • Laboratory OP billing • Homebound patients may qualify for a home health episode which may cover nursing – this will require a close relationship with home health agency for being able to obtain nursing services in the time frame needed • RPM	• Patient will have multiple copays as part of this model • This will never cover all the costs of a program so there needs to be additional support for program (ACO, backfill from hospital, etc.)

Essential EHR workflows and documentation practices

Ambulatory HaH programs require EHR (Electronic Health Record) workflows that clearly distinguish outpatient HaH episodes from true inpatient encounters. While some organizations may opt to create individual outpatient encounters for each touchpoint (similar to recurring clinic visits), this can be cumbersome to navigate for clinicians accustomed to inpatient use of an EHR, including how data, medication administration records, and orders are displayed. Although this approach requires significant upfront resources, an alternative is to build a unit that mimics a standard brick-and-mortar hospitalization, but is configured to suppress all inpatient/DRG-based billing. Once enrolled in an ambulatory HaH program, patients would be admitted to this unit, allowing teams to use familiar workflows, order sets and note templates while the encounter is still treated as an outpatient episode from a billing perspective.

Customized order panels, documentation templates, and automated eligibility or referral tools can streamline overall operations. These elements are best developed in partnership with a health system's clinical informatics and EHR teams to ensure usability, compliance and consistency across a system. From a regulatory standpoint, customized documentation templates can help accurately reflect outpatient status to avoid confusion during transitions of care, utilization reviews and billing audits.

Photo credit: UW Health

Tracking key metrics

Tracked metrics should reflect clinical outcomes, patient safety, operational performance, and patient experience. If you are operating both types of programs, the waiver-based portion must be reported through the hospital like any inpatient unit, while the ambulatory unit does not have the same requirement. Operationally you will still want to collect that same data. These metrics are essential to showcase the high-value, patient-driven care any HaH program provides while also demonstrating its value to the health system.

The HaH Users Group has a number of resources to help ambulatory (and waiver-based) programs choose the most important metrics for their needs, including the latest practice standards and the ***How Are We Doing? Evaluating Hospital at Home Quality and Safety*** webinar recording and slides.

Value creation for health systems

Ambulatory HaH programs may deliver high-value, patient-centered care that directly supports several core health system priorities, including improved throughput, reduced length of stay, ED de-crowding and overall capacity expansion. In addition to offering a pathway for early discharge by supporting continued patient care at home, ambulatory models allow systems to provide home-based acute care to patients who may not qualify under the CMS AHCAH waiver. This includes those who are commercially insured, those under observation status that do not meet inpatient criteria, or patients in areas where the waiver cannot be used due to state regulations. Because these models are independent of CMS regulations, they also serve as a critical hedge against regulatory uncertainty and can, in many cases, expand capacity even more effectively than waiver-based programs.

Simultaneous operation of ambulatory and Waiver-based models

It can be highly operationally and strategically advantageous for a hospital system to simultaneously operate both an ambulatory and Waiver-based HaH model. As the clinical services provided under either model can be virtually identical, hybrid programs can share core infrastructure such as staffing, pharmacy, supply chain, remote monitoring, vendor relationships, scheduling, dispatch/call intake and escalating pathways.

However, certain key operational elements related to regulatory compliance, billing and clinical outcomes must be kept clearly distinct between the two tracks to ensure proper reimbursement and adherence to CMS regulations. In practice, a hybrid model could admit patients into two separate EHR units with one similar to inpatient for waiver-based patients (allowing for DRG-based billing following inpatient pathways) and the other unit built similarly with back-end billing suppressed for ambulatory model patients.

When enrolling patients, clear criteria should be established to determine whether a patient enters the waiver-based or ambulatory track. While patients with Medicare must be admitted to a brick-and-mortar hospital before admission under the AHCAH waiver, those with commercial insurance might only be eligible for home-based acute care through an ambulatory model (or via other agreements within the health system or directly with the payor). Otherwise, there could be little difference in the eligibility requirements for the two models.

Careful consideration should be given to each patient to select the service that is most clinically appropriate and operationally advantageous, taking into account the key differences between the models and the program's overall priorities.

Importantly, operating both models affords hospital systems substantial flexibility. This allows systems to seamlessly shift patient volume and operational resources between them as needed. For example, during periods of Waiver instability, such as lapses in CMS approval, government shutdowns, or policy changes, systems can rely on its already functional ambulatory model to ensure uninterrupted HaH throughput. A dual-model structure may allow for more rapid scaling during hospital census surges, as overall HaH capacity can be increased more readily when both pathways are available due to variability among staffing and in-person touchpoint requirements. Additionally, maintaining a hybrid approach could help stabilize HaH census to support staffing and other operational commitments during periods of growth, lower than expected volume, or unexpected capacity constraints.