Hospital at Home USERS GROUP™

Straight Talk: CMS Discusses the Acute Hospital Care at Home Initiative

Linda DeCherrie, MD | DispatchHealth

Ashby Wolfe, MD, MPP, MPH | Centers for Medicare and Medicaid Services

AAHCM AMERICAN ACADEMY OF HOME CARE MEDICINE

The John A. Hartford Foundation

Webinar
September 17th, 2026

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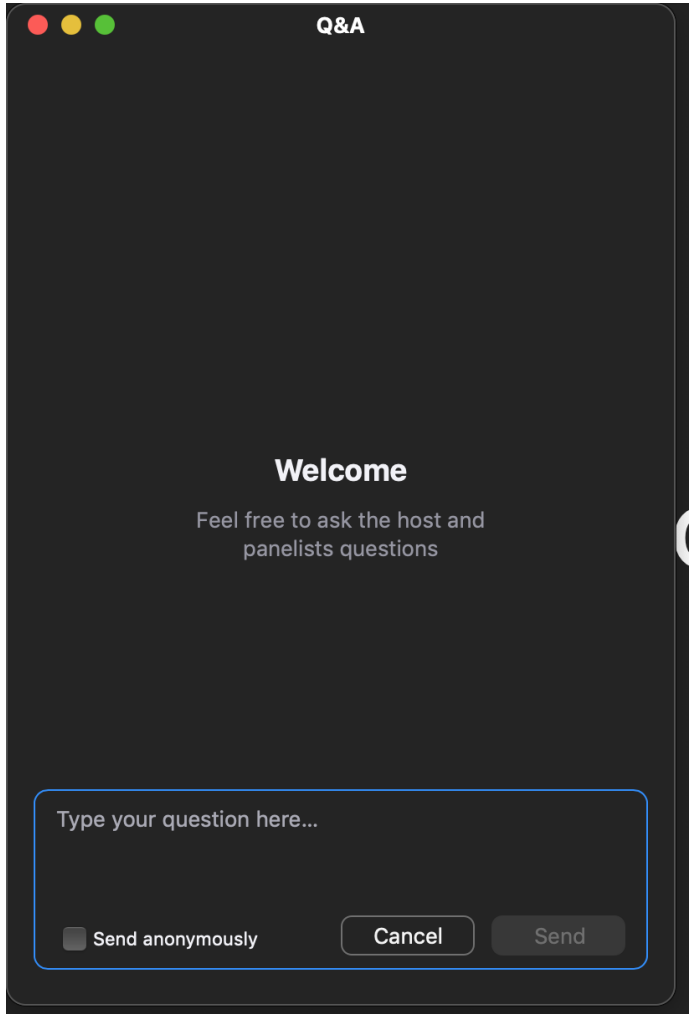
Hospital AT Home USERS GROUP

ZOOM Webinar Housekeeping

- Due to the large audience for today's webinar, everyone has been placed on mute.
- If you have any technical issues, please contact Jane Donahue (jdonahue@aboutscp.com).
- Slides and webinar recording will be available afterwards on our website



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The HaH Users Group Webinar Series

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Scan to learn

Learn more at: HaHUsersGroup.org

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Linda DeCherrie, MD

Vice President of Clinical Strategy and
Care Delivery,
DispatchHealth

Hospital at Home
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Today's Webinar

Straight Talk: CMS Discusses the Acute Hospital Care at Home Initiative

Hospital at Home USERS GROUP

Today's Speaker

Ashby Wolfe, MD, MPP, MPH

Regional Chief Medical Officer,
Physician Lead, Acute Hospital Care at Home Initiative
Centers for Medicare and Medicaid Services (CMS)

Panelist Disclosures

- **Ashby Wolfe, MD, MPP, MPH**
  - None

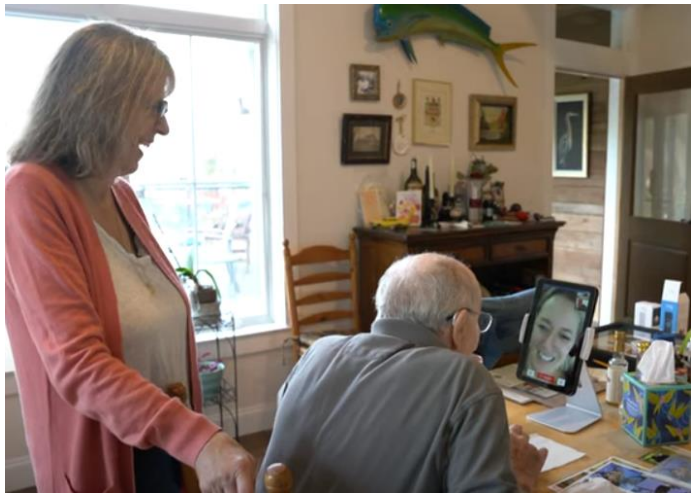
The CMS Acute Hospital Care @ Home Initiative

Ashby Wolfe MD, MPP, MPH
Center for Medicare & Medicaid Services

An overview of the CMS AHCAH Initiative

September 17, 2026

An Overview of the AHC@H Initiative



- **AHC@H leverages innovation, collaboration, and communications technology**
  - Authority under the Consolidated Appropriations Act, 2026 to waive hospital requirements to provide 24/7 on-premises nursing and physical environment requirements, in conjunction with other telehealth flexibilities
- **Can be clinically tailored to serve the local beneficiary community**
  - Hospitals develop their own inclusion/exclusion criteria
  - CMS does not prescribe specific conditions to be treated or specific inclusion and exclusion admission criteria
- **Payment under the Inpatient Prospective Payment System (IPPS)**
  - Hospitals receive the full Medicare Severity Diagnosis Related Groups (MS-DRG) payment for AHC@H care and are required to include AHC@H patients in hospital quality reporting measures as all other inpatients

Required Elements for CMS AHC@H Waiver Approval

Provide or contract for the following services:

- Pharmacy
- Infusion
- Respiratory care including oxygen delivery
- Diagnostics (labs, radiology)
- Monitoring with at least two sets of patient vitals daily
- Transportation
- Food services including meal availability as needed by the patient
- Durable Medical Equipment
- Physical, Occupational, and Speech Therapy
- Social work and care coordination

At least one daily MD/APP visit; can be remote after initial in-person History and Physical Exam performed in the hospital or ED.

At least two in-person daily visits by RN or MIH/CP. If *both* in-person visits performed by MIH/CP, additional daily remote RN visit required to develop a nursing plan.

Immediate, on demand remote audio connection with an AHC@H team member who can immediately connect the appropriate RN or MD.

In-home appropriate emergency personnel response to a patient's home within 30 minutes, if needed.

Only patients in an ED or inpatient hospital are eligible.

Must develop or use patient selection criteria.

Agree to voluntarily provide volume, escalation, and unanticipated mortality data to CMS.

Establish a patient safety committee (like a Mortality and Morbidity team) to review reported metrics.

Use of an accepted patient leveling process to ensure patients require an acute level of care.

APP = advanced practice provider; MIH/CP = Mobile Integrated Healthcare-Community Paramedicine

Consistent Waiver Review Process

Hospitals may request a waiver through the QualityNet portal based on experience delivering inpatient-level care in the home

Tier 1 Hospitals: Experienced in having provided inpatient care to ≥ 25 patients and attest to meeting the requirements of the waiver and agree to submit outcomes data to CMS monthly

Tier 2 Hospitals: Inexperienced in having provided inpatient care to < 25 patients and are required to submit written evidence of how each element of the waiver requirements will be met and agree to submit outcomes data to CMS weekly

Each waiver request submission is systematically reviewed by the AHC@H waiver review team of clinicians

Step 1: Waiver submission received in JIRA

Step 2: Waiver evaluation: Review for Immediate Jeopardy citations over the past 2 years

Step 3: Waiver evaluation: Review details of the Hospital at Home program

Step 4: Waiver evaluation: Hospital virtual interview and discussion

Step 5: Waiver recommendation: AHC@H team recommends approval to CCSQ Senior Leadership

Step 6: Waiver decision and subsequent communication to requesting hospital

Why Details Matter

Each waiver review, interview, and discussion focuses on the details of following topics:

- Standardize and socialize the team approach to care
- Ensure the patient makes an informed decision to participate in the Hospital at Home program
- Develop a robust pharmacy workflow
- Identify clear protocols for oxygen and other DME delivery and function
- Coordinate with and supervise vendors and third-party contractors
- Ensure seamless data collection and communication
- Develop a robust workflow for triage, evaluation, and escalation

The CMS team also provides technical assistance through sharing lessons learned, best practices, and any guidance to all hospitals. The goal is to **“Get to Yes”** for any hospital submitting a waiver

How do we measure success?

Measures/Responses required to be reported by Hospitals with Approved AHCAH waiver *

- **Patient Volume** – number of patients with Medicare/Medicaid/both
- **Unanticipated Mortality during an acute episode of care** – number of patients who died during their hospitalization, including those whose care was escalated to the hospital (excluding those on hospice and those for whom death was expected)
- **Escalation** – number of patients transferred back to the traditional inpatient setting from the home
- **Safety Committee Review**– attesting that metrics have been reviewed before being reported
- **Patient List** – identifying each patient admitted and discharged by the hospital at home program

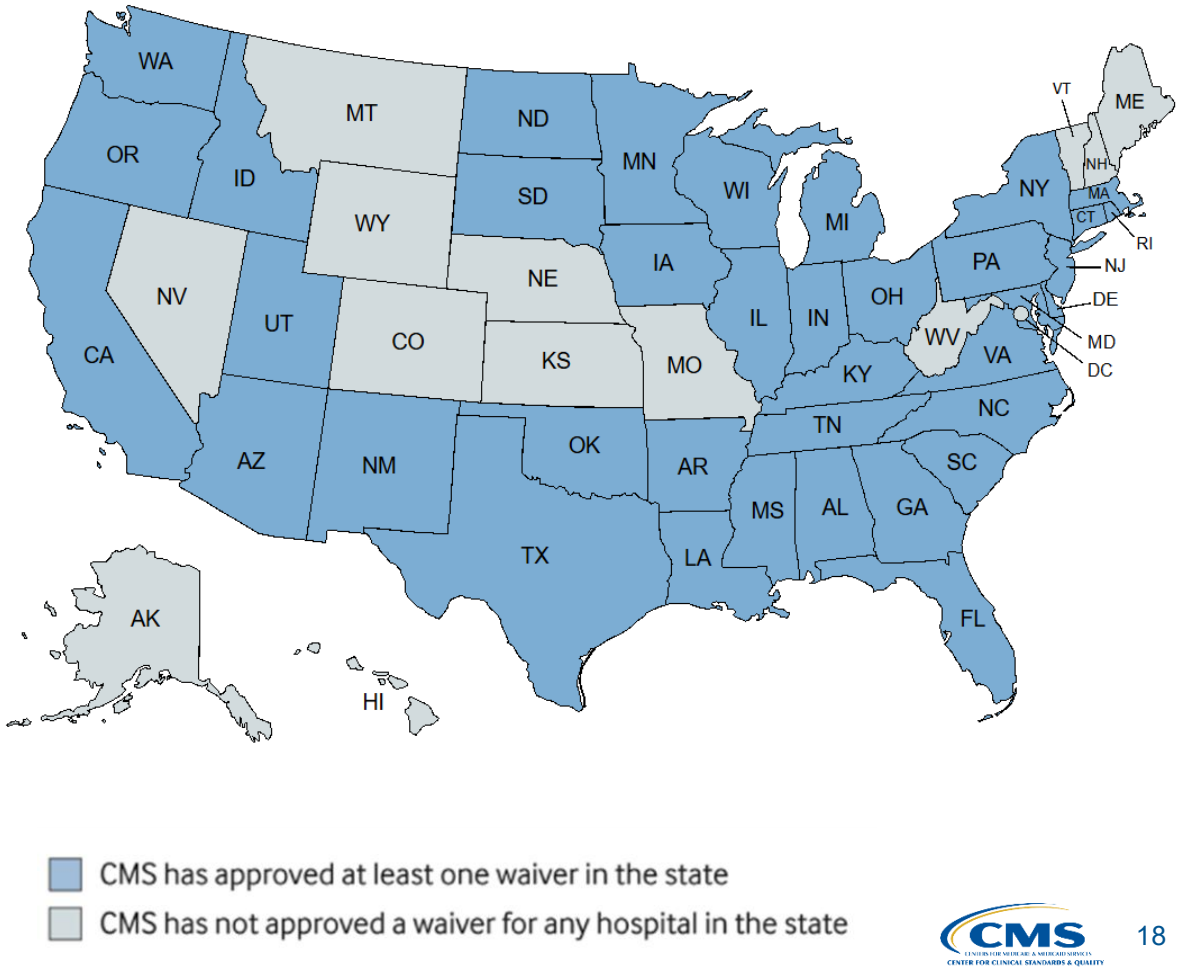
* The data collected as part of the waiver process during the COVID-19 Public Health Emergency were intended to quickly highlight potential problems or unintended uses of the waiver, as well as to ensure ongoing monitoring of patient safety. In the approval of each AHCAH waiver, CMS works to ensure the same/comparable standard of care is provided to patients on the Hospital-at-Home service as those physically located in the brick-and-mortar facility.

The AHC@H Initiative: Current Status

Current list of approved hospitals actively participating in AHC@H

As of September 9, 2026, this initiative has:

- Provided inpatient-level care in the home setting to **63,814 beneficiaries** with Original Medicare and/or non-managed Medicaid coverage
- **364 hospitals actively participating** across 136 health systems in 37 states
- Outcomes data showing an escalation rate of 7.64% (consistent with national standards) and **a mortality rate of 0.22%**



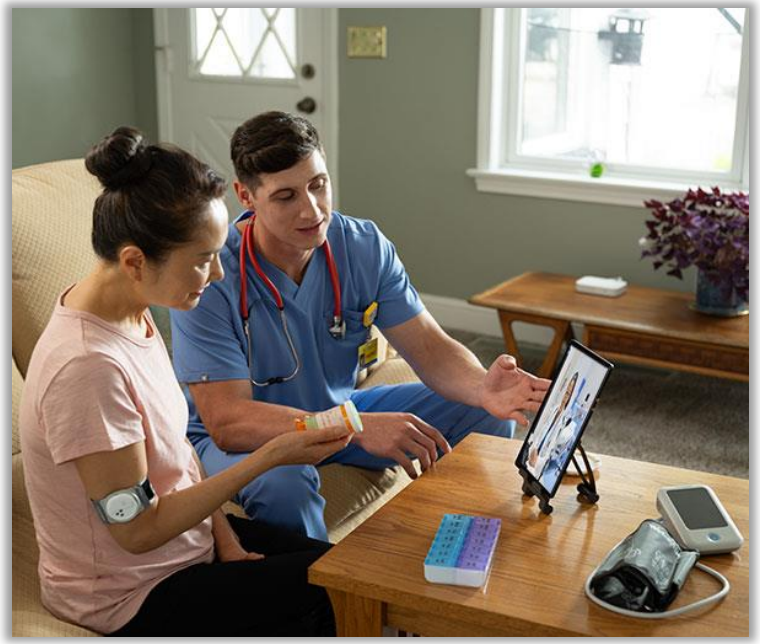
The Work Continues: Now and Into The Future

"It's a completely different kind of medicine"

~ Heather Orkis, Hospital at Home paramedic

The team continues:

- Ongoing **review of waiver requests, data monitoring**, and preparations for future analysis of the existing dataset
- Providing **technical assistance** to hospitals considering a waiver request
- Engaging with participating hospitals to **learn and understand best practices for care delivery** in the home environment



- Collaborating with external partners to translate AHCAH to **rural communities**, empower patients to **manage their acute and chronic care**, and identifying opportunities to support overall wellness.

Thank you!

- Visit the CMS Acute Hospital Care at Home website for waiver submission information and updates
- Frequently Asked Questions and other Resources
- Contact us at AcuteHospitalCareAtHome@cms.hhs.gov

Scenario 1

68-year-old male | Admitted for CHF

TIMELINE

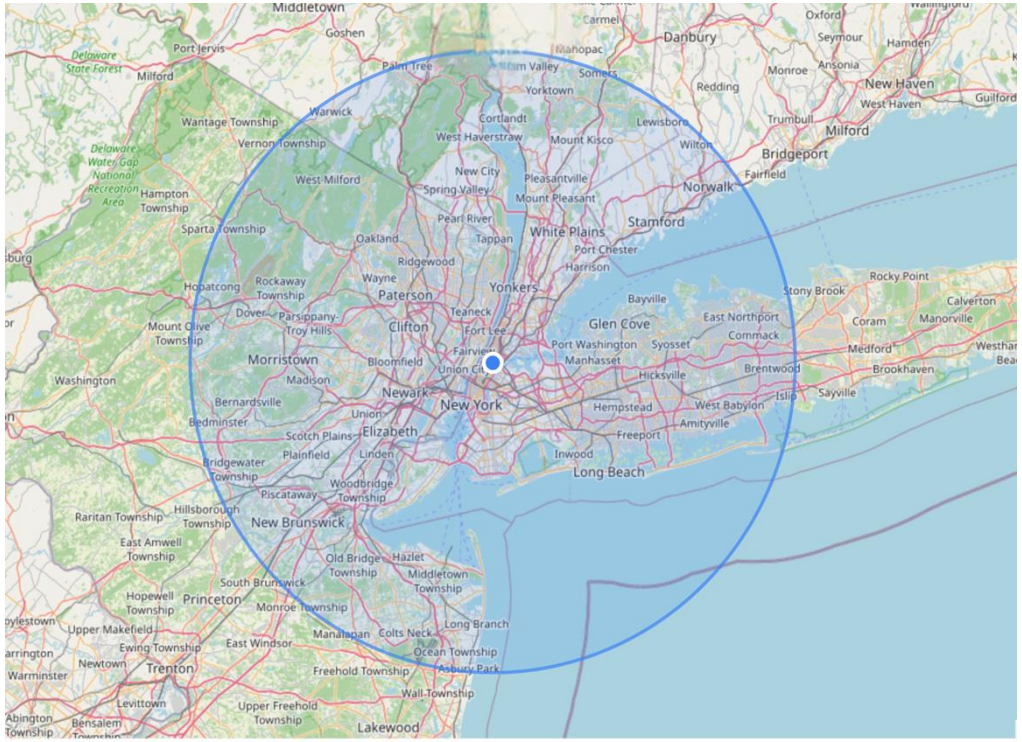
1. **10:00 PM** — **ED Arrival**
2. **Overnight** — **Diuresis & Stabilization**
3. **1:00 PM (Day 2)** — **Ready for HAH Transfer**
4. **2:00 PM (Day 2)** — **Home Arrival & Setup**

QUESTIONS

- **Does he require 2 in home clinical visits (RN or MIH paramedic) on day of admission (and on day of discharge)?**
- **Patient is cognitively intact, assessed by virtual or in-home RN that he demonstrated ability to self-administer some medications without RN on camera or in person, is this allowed under the waiver?**

Scenario 2

88-year-old female | Admitted to the hospital for pneumonia



BACKGROUND

- Evaluated for HaH on day 2
- Lives with her daughter 40 minutes from the hospital
- HaH program has 24/7 command center of virtual RNs who can immediately respond by video or telephone
- Provider available as well

QUESTION

- **Can this patient be transferred to HaH given their distance from the hospital?**

Scenario 3

65-year-old male | Admitted for COPD

BACKGROUND

- Drove himself and his wife to the ED on 2 L portable O2
- Car is parked in the hospital parking lot
- Needs to be admitted and approved for transfer to HaH

QUESTIONS

- **Can this patient transfer to home with friends and family?**
- **This patient lives with his wife and she was talking about all the baking she does (cupcakes, cookies, etc.) Should it be assumed that this patient doesn't need meals?**

Scenario 4

98-year-old female | Admitted for UTI

BACKGROUND

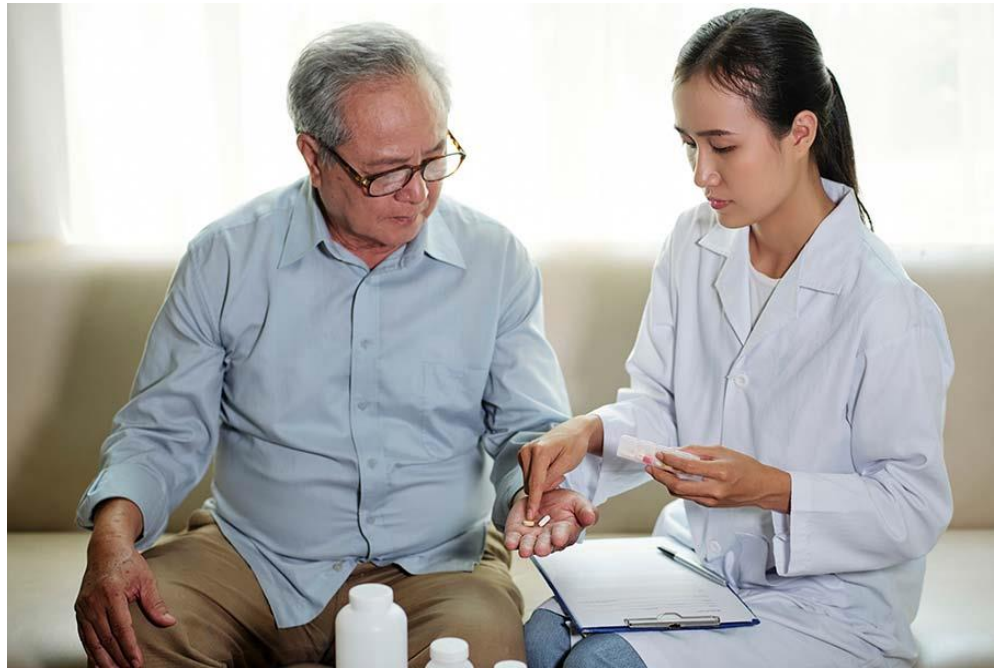
- Transferred to HaH from the ED
- LOS of 4 days
- FFS Medicare

QUESTIONS

- **What billing codes should the various physicians use to bill for professional services?**
- **How does the hospital bill for the facility charges for the hospitalization?**
- **What if this patient was 54 yo and her primary insurance was Medicaid (FFS Medicaid), do states need a state plan amendment or special CMS permissions for Medicaid coverage of HAH?**

Scenario 5

70-year-old male | Admitted for diverticulitis



BACKGROUND

- Surgeons saw him and determined to treat with antibiotics and monitoring while inpatient
- Patient has several comorbid chronic conditions that have been slowly progressing over time
- Increasingly challenging for his primary care team to manage in the community setting

QUESTIONS

- **How should goals of care and advance care planning be managed prior to patient being transferred home?**
- **How is expected vs unexpected mortality determined for CMS reporting purposes?**

Scenario 6

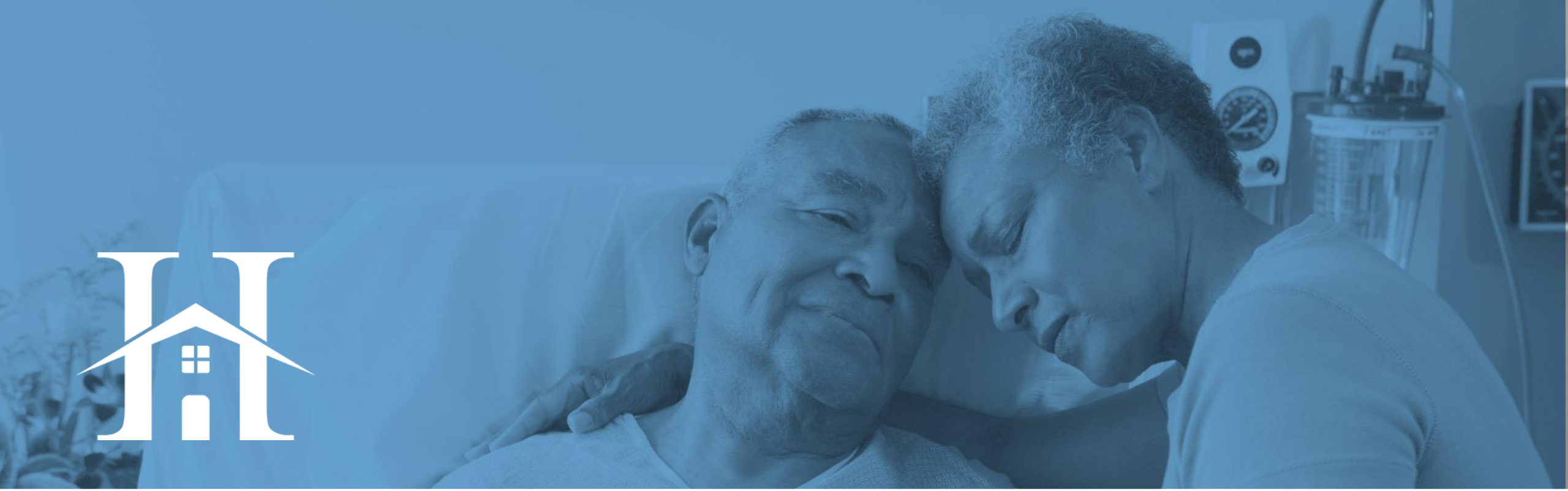
68-year-old female | Admitted for COPD exacerbation

BACKGROUND

- Deemed clinically appropriate for admission to HaH
- Patient's daughter does not live with her but expresses interest in staying with the patient while she is under the care of the HaH team
- Transport team departs for home, meets the RN for the intake visit and home assessment
- RN ensures that the patient has the appropriate connectivity with the virtual care team

QUESTIONS

- **What is the role of the family member in the HaH setting?**



Q&A

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Check Out Our TA Center

A comprehensive library of helpful resources on a range of essential HaH topics, updated regularly.

Webinars

WHEN DIGITAL GOES DOWN: ENSURING CARE CONTINUITY IN A CATASTROPHIC TECH CRASH

Recorded September 10th, 2024 The Hospital at Home Users Group, in partnership with the American Academy of Home Care Medicine, is pleased to present our latest webinar for hospital and system...

Learn More

THE STATE OF STATE POLICY: OPPORTUNITIES AND CHALLENGES FOR HOSPITAL AT HOME

Recorded June 24th, 2024 The Hospital at Home Users Group, in partnership with the American Academy of Home Care Medicine, is pleased to present our latest webinar for hospital and system...

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AGE-FRIENDLY BEYOND THE HOSPITAL: INNOVATION IN HOSPITAL AT HOME

Recorded April 11th, 2024 The Hospital at Home Users Group, in partnership with the American Academy of Home Care Medicine, is pleased to present our latest webinar for hospital and system...

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Information/ Research

OFFERING OBSERVATION AT HOME SERVICES: PAYMENT PATHWAYS AND FEASIBILITY

Last updated: March 2024

In January 2024, members of the HaH Users Group assembled to discuss Observation at Home. Dr. Anthony Wehbe of SENA Health described how they are implementing Observation at Home for their health system partner, Inspira Health.

As of this writing, there is no waiver or Medicare payment for Observation care at Home. A few hospital systems and implementation partners have negotiated with commercial payors for an Obs at Home rate. Others, including SENA Health, have navigated a path to operationalize Obs at Home without a direct Obs at Home payment. Typically, it involves treating the patient in the brick-and-mortar through workup and Observation status determination, and billing for an Observation stay. While undergoing Observation care, the patient is discharged from the facility and moved home, where the necessary equipment and supplies are delivered, medications are provided, and ongoing in-person (and, if available, virtual) care continue, as with any HaH episode. Certain elements of the care, such as provider visits (in-person or virtual), are billable to insurance. Costs for care that cannot be billed and that are not covered by the Observation rate would be covered by the hospital or health system, which benefits from additional bed capacity, less burdened brick-and-mortar staff, and satisfied patients. If the patient ultimately requires inpatient admission after their Observation stay, that can potentially occur in the home if the patient is otherwise eligible for HaH care; note that the CMS waiver requires an in-person admission H&P be completed for all HaH waiver episodes.

Offering Observation care at Home at your institution may make sense if:

- You already have the infrastructure (staffing, operations, in-home service providers, etc.) in place to provide acute care in the home – e.g. an existing Hospital at Home or ED in the home service.
- Your institution's observation unit is consistently at or over capacity, with negative downstream effects on other units and the patient and staff experience.
- You have outlined a workflow to admit patients who may need ongoing inpatient care after an Observation episode, including steps to ensure that there is an in-person H&P before a HaH episode, or transfer back to the facility if necessary.

Tools

https://www.hahusersgroup.org/technical-assistance-center/

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