WISCONSIN LEGISLATURE
P.O. BOX 8952 • MADISON, WI 53708

Testimony before the Assembly Committee on Health
Assembly Bill 679
Rep. Amy Loudenbeck and Sen. Dale Kooyenga

Good Morning and thank you Chairman Sanfelippo and the committee for holding a public hearing on Assembly Bill 679 relating to hospital services provided in a home setting.

Over the last several sessions, the Legislature has worked with stakeholders from across the health care industry to improve access to quality healthcare by increasing opportunities for innovative and cost effective programs.

Last session, we passed an important bill to expand access to telehealth for Medicaid recipients. This health care delivery option has seen dramatic utilization increases during the COVID-19 pandemic, allowing essential care to be delivered in a timely fashion regardless of location.

Also during the last session, we passed a bill granting the provisional use of an innovative healthcare payment and service delivery model called ET3 to reduce the cost of healthcare to both the patient and the taxpayer. ET3 (emergency triage, treatment transport) provides flexibility to ambulance teams to address the healthcare needs of a patient following a 911 call, allowing them to transport to alternative destinations if an emergency room visit is not required.

In the 2017-2019 session, we passed Community EMS which allows EMS providers to respond in a non-emergency setting to work with frequent 911 callers for non-emergent health issues. This program allows EMS providers to provide or connect patients with the care they need without using the emergency care systems. The pilot programs in the state have seen impressive results with reducing non-emergent 911 calls and partnering with local hospitals. The administrative rules for the program went into effect in October, and we're looking forward to seeing more statewide data on the success of programs across the state.

These new care delivery models provide the flexibility needed to provide medically appropriate health care in alternate settings. They allow Wisconsinites to receive the right care at the right time in the right place while improving patient outcomes and avoiding high cost, emergency care.

AB 679 seeks to continue to build on these ideals by extending yet another innovative and cost-saving program (*Acute Hospital Care at Home*) that was created in 2021 Act 10 but will sunset in January 2022 without legislative action.

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During the early parts of the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) proposed a variety of ideas for payment and regulatory flexibility reforms. One of these ideas is a program called *Acute Hospital Care at Home* which allows hospitals to provide hospital level care in a patient's home. CMS believes *Acute Hospital Care* could work well for many acute conditions including asthma, congestive heart failure, pneumonia and chronic obstructive pulmonary disease (COPD).

AB 679 embraces the regulatory flexibilities proposed by CMS for the *Acute Hospital Care at Home* program, while also allowing the state Department of Health Services to use federal requirements as the state regulatory standard for *Acute Hospital Care at Home* programs.

These regulatory flexibilities will create additional capacity options and allow hospitals to provide a high quality of care in a patient's home prior to discharge from an inpatient service. It's important to note this is not a replacement or substitute for home health care. The requirements and quality review process are much broader in scope than what is traditionally allowed under home health. It's meant to deliver hospital quality care at home.

AB 679 will allow more hospital systems to offer programs like Marshfield Clinic Health System (MCHS)'s Home Recovery Program. The Home Recovery Program takes patients out of impatient settings and allows them to be treated in their own home - it was one of the first nine health care institutions in the country to be granted a Section 1135 waiver from CMS to implement an *Acute Hospital Care at Home* program. MCHS's program has treated over 100 conditions through home visiting and telehealth. They have high rates of patient satisfaction, improved outcomes and meaningful reductions in costs.

It is also important to note that reimbursement for this program is ***only*** *allowed under Medicare, and is paid for by federal dollars. The program is not eligible for state reimbursement under Medicaid, therefore no state funds are provided under the bill.* This is how the program is running under current law- simply allowing the hospitals to receive the federal reimbursement for services.

We believe these types of innovative programs will continue to show beneficial results for patient outcomes and reduce overall costs of care. We hope you will agree that we should continue the good work we have been doing and support AB 679 to remove the sunset for the Acute Hospital Care at Home program.

Thank you for your consideration of AB 679.

WISCONSIN HOSPITAL ASSOCIATION

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TO: **Members of the Assembly Committee on Health**

FROM: **Kyle O'Brien, Senior Vice President Government Relations**
Laura Leitch, Policy Counsel

DATE: **November 10, 2021**

RE: **Support Assembly Bill 679 Regarding Acute Hospital Care at Home**

In November 2020, the Centers for Medicare and Medicaid Services (CMS) announced the innovative Acute Hospital Care at Home program that provides eligible hospitals with certain regulatory flexibilities to treat patients in their homes.

CMS developed the program in consultation with academic and provider sector industry leaders to ensure appropriate safeguards are in place to protect patients. Based on this work, the program is aimed at about 60 different acute-level conditions that CMS believes can be treated appropriately and safely in the home with proper monitoring and treatment protocols.

CMS emphasizes that the program clearly differentiates the delivery of acute hospital care from more traditional home health services. While home health care provides important skilled nursing and other skilled care services, hospital at home is for patients who require acute-level care after being seen in hospital and who require regular rounding and monitoring by a medical team on an ongoing basis.

Four hospital systems in WI have been approved by CMS to provide hospital at home services: Marshfield Clinic Health System, Mayo Clinic Health System, Bellin Health, and Gundersen Health System.

Although through 2013 Wis. Act 236, the state aligned state and federal hospital regulatory requirements, we understood from DQA that, generally, hospitals could not operate a hospital at home program under their state hospital license because:

- A patient's home does not meeting meet the ch. 50 definition of a hospital.
- The services would meet the definition of home health services and, thus, would require a home health agency license.

The hospital at home provisions in Act 10 addressed those issues by:

- Creating a definition for "hospital-associated services" for hospital services provided in a home setting.
- Allowing DQA to apply the hospital at home federal standards as the state standards if the hospital has been approved by CMS to provide the services.
- Creating an exception from the home health agency licensing requirements for CMS approved hospitals that are subject to the federal and state hospital standards in the home setting.

Act 10, however, included a January 1, 2022 sunset of the ch. 50 provisions. The hospital at home program remains a popular and important option for hospitals and their patients as hospitals continue to face capacity issues. AB 679 would remove the state sunset, preserving hospital at home services as an available tool for hospitals working to provide needed care in their communities.

Testimony of Dr. Bill Melms

Chief Medical Officer
Marshfield Clinic Health System
before
Wisconsin Assembly Committee on Health
November 10, 2021

Good Morning, Chairman Sanfelippo. I am honored to be here today to represent Marshfield Clinic Health System in support of Assembly Bill 679.

As you know, Marshfield Clinic Health System is an integrated health system serving northern, central, and western Wisconsin. We are one of the nation's largest fully integrated systems serving a predominantly rural population. Our 1,400 physicians and providers accommodate 3.5 million patient encounters each year across our 10 hospitals and over 60 ambulatory clinical sites. Our primary service area encompasses over 80 percent of the rural population of the state of Wisconsin. We are the largest provider of primary and specialty care in our region. Throughout our over 100 year history, our organization has focused on being at the forefront of innovation and improved patient care, to best serve the patients we see.

In recent years, one of our most innovative programs has been the development and implementation of a Home Recovery program. This program, developed after consultation with organizations across the country, provides hospital-level care to patients in the comfort of their home. Variations of this innovative model had been tried in other hospital settings before we took the challenge on at Marshfield. I am proud to say that our hard work has created a model that is being replicated nationwide, with the sometimes hard learned lessons and innovations developed at Marshfield. We are truly national leaders.

The outline of the program is that if a provider encounters an eligible patient, that patient can be offered the option of being admitted to the traditional hospital setting, or be given the chance to transition to the Home Recovery program. When a patient is "admitted" to the Home Recovery program, they receive home medical care from a nurse or other provider, and are cared for by a traditional hospitalist virtually. There is usually an acute phase of monitoring and tracking the patient that lasts for a matter of days, and longer-term follow-up for the patient up to 30 days after being admitted to the program.

Initially, we were able to offer this type of care for 4 diagnosis classes. Now today, it is well over 100 diagnoses. It is almost easier to list what diagnoses don't qualify for Home Recovery than it is to list the full spectrum of diagnoses that can be cared for under our protocols. And, I am proud to say that the data we have collected clearly demonstrates the effectiveness of this program.

Our patient satisfaction rate with Home Recovery is well over 90% positive, and the rate of readmissions is significantly reduced (44%) and the mean length of stay in the acute phase is 35% less for Home Recovery patients compared to patients actually hospitalized. In addition, it can be more cost-effective and reduce ER visits and transfers to skilled-nursing facilities.

When the program first started, it was a collaborative program with our health insurance plan, Security Health Plan, to offer this service to Medicare Advantage patients and a limited number of their commercial clients. We were recognized for our success by an endorsement of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in 2018. And, we have regularly engaged with leadership at the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) on our success.

However, we were hamstrung from further expanding the program because of enrollees in traditional Medicare Fee-For-Service not being allowed to use the program because a patient's home could not be a site of service in the Medicare program. As you likely know, private insurers are usually reluctant to cover services not covered by CMS. Then, when the COVID-19 pandemic hit, CMS recognized the ability of hospital-level care at home to alleviate capacity issues for tertiary hospitals, and help increase patient access.

In November of 2020, CMS issued a series of regulatory waivers to allow hospitals to treat patients at home. I am pleased to say Marshfield Clinic Health System's Home Recovery program was one of the first recipients of the waivers. Additionally, we were pleased to work directly with the legislature, as well as with similar programs across the state, to come together on the necessary legislative changes necessary to make this program come to life for patients in Wisconsin.

The legislation that passed last year included a one year sunset. Current circumstances and demonstrated success of the program warrant removing the sunset. While not a silver bullet, this program is popular with patients, providing them the choice to be closer to their family while receiving care, while also helps us alleviate higher patient volumes and capacity issues due to COVID-19 and delayed care that has occurred over the last few years.

Plainly stated, removing the sunset will allow us the ability to continue to innovate and transform our Home Recovery care delivery model to best meet the needs of our patients, and continue to provide high-quality, accessible and affordable care to the patients and communities we serve each and every day.

I thank you for your time today, and your consideration of this important legislation. I am happy to answer any questions you may have.

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Hello, thank you for having me. My name is Andrea Hauser. I am a Registered Nurse from Gundersen Health System. I serve as the Vice President of Nursing and Patient Experience. I have been with Gundersen Health system for nearly 20 years.

Gundersen Health System is a non-profit, integrated healthcare network headquartered in La Crosse, Wis. We have more than 9,000 employees, serving 22 counties in western Wisconsin, southeastern Minnesota, and northeast Iowa. With well over one million patient visits every year across our seven hospitals and more than 70 clinic locations, Gundersen's purpose is to enhance the health and well-being of our communities and enrich every life we touch.

A new way that we have been enriching the lives our of our patients is through a home hospital model. It is an honor and a privilege for me to be here to speak on behalf on this program and our patients. Which is why I am here today representing Gundersen in full support of AB679.

Patients who have one or more of approximately 40 major medical conditions, such as asthma, dehydration, or pneumonia, can safely receive medical care in the comfort of their homes after being evaluated by a doctor. All patients admitted to home hospital are managed by a Hospitalist Telemedicine team during their acute phase in their own home, when they would have otherwise been in the hospital.

Patients have 2-3 daily visits by an acute care nurse in their home, who perform assessments, medication administration (both by mouth and IV), teaching, lab draws, and telemedicine rounds with the attending provider. We work to ensure that all the services you see the hospital can be accessed in the home, for example, physical, occupational, and speech therapy social services, delivery of additional medical equipment and even and mobile imaging.

Patients who have been a part of programs like this have seen positive benefits such as a reduction in hospital acquired infections, reduced readmission rates to the hospital or emergency room, shorter length of stays, and patient satisfaction scores often exceed 90 percent.

Our first patient actually was so excited about her experience that she shared her story with our local newspaper. She shared that waking up at home, in her own bed, with her own food, helped her to heal more quickly. This patient shared with us that she was able to take the time to heal, in her own home, with the supportive help of our clinical team.

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As a nurse, we are taught about patient centered care and meeting the patient where they are at. Hospital at home takes this concept to a new and more meaningful level. Being able to see how a patient functions in their home, how they cope, how they adapt, can help a nurse and a clinical team, such as physical therapist, truly individualize the patient's plan of care.

Offering this model of care to those patients who are eligible creates a ripple across the system. For example, opening a bed within the brick-and-mortar hospital. This was critical this past fall when we were at capacity during the height of the covid surge. Having even a hand full of our home hospital patients, meant a couple of beds were open to other patients in need.

I am passionate about the hospital at home model and the early results show just how much promise this type of care holds. Please support AB679 today. And please encourage your colleagues to take up this bill in the full Assembly and Senate. Thank you for your attention; I'm happy to answer any questions.

Additional patient comments:

- "This program has been great because my wife has difficulty driving and she would have had trouble getting to the hospital and back home."

-"I was reluctant at first but it has been amazing to receive quality hospital care in my home."

-"It was so nice to sleep in my own bed at night. My anxiety would have been elevated in the hospital with all the people in and out of my room."

- "If I was hospitalized my dog would had had to go to the kennel because my husband works and there wouldn't have been anybody here to let her outside."

Testimony of Margaret Paulson, D.O.
Mayo Clinic Health System in Northwest Wisconsin
Wisconsin State Assembly Committee on Health
November 10, 2021

Good morning. My name is Dr. Margaret Paulson. I live and work in Menomonie, WI. I am an Internal Medicine physician, rural hospitalist and Medical Director for Mayo Clinic Health System's hospital at home program, known as Advanced Care at Home.

A few years ago, our CEO at Mayo Clinic, Dr. Gianrico Farrugia, brought forward the hospital at home concept as a vision for how patients would wish to receive care in the year 2030. We began our implementation plans in 2019. The Covid-19 pandemic only highlighted the urgent need for this type of acute care available to patients outside of hospital walls. Since its inception, we have has seen over 230 patients from Eau Claire, Menomonie, and other northwest Wisconsin communities. Our program delivers innovative, comprehensive, and complex care to patients—all from the comfort of home complemented by a technology platform.

Through Advanced Care at Home, patients with conditions previously managed in a hospital – such as pneumonia, gastroenteritis, urinary tract infections, skin and bloodstream infections, heart failure, and COPD – have the option to transition to a home setting and receive compassionate, high-quality virtual and in-person acute care and recovery services. The medical literature shows home hospitalization to reduce hospital readmissions with improved clinical outcomes and patient satisfaction, reduced cost and avoidance of the inherent risks of hospitalization.

Our patients receive 24/7 access to Mayo Clinic providers including immediate video access and real-time monitoring. Under the direction of a physician team, they receive remote monitoring and other essential services from a network of nurses, pharmacists and other care providers. Advanced Care at Home equips patients with a technology suite that includes secure, HIPAA-compliant Wi-Fi, bio-metric

monitoring devices, a tablet that provides 24/7 virtual connection to Mayo Clinic experts, and a "life alert" device that looks like a watch and can initiate an emergency two-way voice communication with the healthcare team. Patients also receive a schedule, so they know what to expect and who is coming to their home. Everything is set up, connected, and tested, and the patient receives a physical exam to ensure the transfer is safe and successful.

This program offers patients with the choice to receive care in the comfort and safety of the home while ensuring the patient receives clinically directed acute care treatment and recovery services.

In addition, having patients who can transition home frees resources to respond to other patient needs such as COVID-19 and other complex pressures on the health care system.

While making house calls is not a new idea, the modern hospital at home has given patients access to hospital-level care in the home that the medical literature has found to be safer, more cost effective and with higher patient satisfaction than traditional hospitalization for certain patients.

I would like to tell you about one of our patients who gave us permission to share his story. He was one of our first patients, a gentleman in Eau Claire who had recently retired from his position as a pastor at a local church. He unfortunately struggled with an infection in his back which required multiple surgeries to heal this area of infection. He needed surgery again. He and his wife were worried because when he comes into the hospital, he gets confused, and this hospitalization was no different. He was delirious and required continued care. After my home hospital team spoke with his surgeon, the patient and his wife, we all agreed that home was the best place for him to continue his hospitalization where he could receive acute care. When he came home, this man cried tears of joy as he was brought up the sidewalk to his house. His confusion melted away within a few hours. We worked with his surgeon and team to ensure that this patient was getting all of the care he would receive in the bricks and mortar hospital, only in the comfort of his own home. A day or so later, members from his old congregation surprised

him at home with a visit, socially distancing on his lawn and singing church hymns while he received his IV antibiotics on his porch.

This is the power of acute hospital care at home, especially in the time of covid when hospital beds are scarce and visitor restrictions remain in place. At Mayo Clinic, we believe that the needs of the patient come first and this program is a prime example of this. Thank you for helping us continue to offer acute hospital care in the home for our patients in northwest Wisconsin.