WHEREAS, During the COVID-19 pandemic, federal and state governments issued waiver flexibilities that allowed hospitals to provide advanced level services to patients at home under certain circumstances; and

WHEREAS, The waiver flexibilities built on the success of previous acute care at home models that have been tested over decades, showing that advanced care at home can be a safe, effective way to provide care to patients that is associated with lower costs and better patient outcomes and satisfaction compared with inpatient hospitalization; and

WHEREAS, As part of the omnibus spending bill that became law December 29, 2022, the Centers for Medicare & Medicaid Services (CMS) extended, through December 31, 2024, the Acute Hospital Care at Home initiative whereby individual hospitals may seek waivers to operate acute care at home programs; and

WHEREAS, The State Departments of Health serve as regulators for CMS and in many cases state and federal laws/regulations conflict making implementation of acute care at home impossible or much more difficult than CMS likely anticipated. For example, in Wisconsin, fire safety regulations for hospitals cannot be met in a home setting resulting in barriers to acute care at home; and

WHEREAS, Currently, advocacy groups such as Advanced Care at Home and AmediSys are actively lobbying CMS and the legislature to extend the Hospital at Home Waiver to a permanent CMS program. The AMA could work in partnership with these and other key stakeholders on addressing state regulatory barriers; and

WHEREAS, There has been opposition by nursing unions engendered by perceived or real changes in work requirements, patient safety and job security concern; and

WHEREAS, The AMA’s Council on Medical Services issued a report I-21, Financing of Home and Community-Based Services, that noted “The hospital at home model is an important component of the shift away from institutionalized care and has been successful in allowing patients with particular conditions to remain in their homes and avoid risks associated with inpatient admission and care.” The Council recommended that CMS and private insurers offer flexibility to implement hospital at home programs for the subset of patients who meet the criteria; therefore be it

RESOLVED, that the AMA advocate for passage of federal legislation that provides permanence to the Centers for Medicare and Medicaid Services acute care at home model (Directive to Take Action); and be it further
RESOLVED, that the AMA work with interested state medical associations to identify state-level barriers to implementing acute care at home, to include but not be limited to: health and safety regulation applicability to services in the home, union opposition to acute care at home, and Mobile Integrated Health/Community Paramedicine limitations in states (Directive to Take Action); and be it further

RESOLVED, That the AMA, in coordination with other acute care at home advocacy groups, advocate that the federal government work with states to address the concerns of current state regulators (Directive to Take Action); and be it further

RESOLVED, That the AMA engage with nursing organizations to share perspectives and address concerns about the benefits and challenges of acute care at home (Directive to Take Action).

Fiscal Note: TBD (Approx. $15,000)

Received: 5/16/2023

References:

1. A variety of terminology has been traditionally used to refer to this health care delivery model, such as Acute Care at Home, Hospital at Home, Advanced Care at Home, etc. For the sake of simplicity, here it is referred to as Acute Care at Home and, where necessary, Hospital at Home.

RELEVANT AMA POLICY:

N-21-CMS Report 4: Financing of Home and Community-Based Services

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support federal funding for payment rates that promote access and greater utilization of home and community-based services (HCBS). (New HOD Policy)

2. That our AMA support policies that help train, retain, and develop an adequate HCBS workforce (New HOD Policy)

3. That our AMA support efforts to simplify state plan amendments and Medicaid waivers to allow additional state flexibility to offer HCBS. (New HOD Policy)

4. That our AMA support that Medicaid’s Money Follows the Person demonstration program be extended or made permanent. (New HOD Policy)

5. That our AMA support cross-agency and federal-state strategies that can help improve coordination among HCBS programs and streamline funding and the provision of services. (New HOD Policy)

6. That our AMA support HCBS programs tracking protocols and outcomes to make meaningful comparisons across states and identify best practices. (New HOD Policy)

7. That our AMA support that the Centers for Medicare & Medicaid Services and private insurers extend flexibility to implement innovative programs including but not limited to hospital at home programs. (New HOD Policy)

8. That our AMA reaffirm Policy H-280.945, which provides a comprehensive set of principles to improve the financing of long-term services and supports and supports incentivizing states to expand the availability of and access to HCBS and permitting Medigap and Medicare Advantage plans to offer a respite care benefit. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-290.958 which supports increases in states’ Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment. (Reaffirm HOD Policy)
Financing of Long-Term Services and Supports H-280.945

Our AMA supports:

(1) policies that standardize and simplify private LTCI to achieve increased coverage and improved affordability;

(2) adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees;

(3) allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI;

(4) innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities;

(5) permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy;

(6) Medicare Advantage plans offering LTSS in their benefit packages;

(7) permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit;

(8) a back-end public catastrophic long-term care insurance program;

(9) incentivizing states to expand the availability of and access to home and community-based services; and

(10) better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly.


Policy Directions for the Financing of Long-Term Care H-280.991

The AMA believes that programs to finance long-term care should: (1) assure access to needed services when personal resources are inadequate to finance care; (2) protect personal autonomy and responsibility in the selection of LTC service providers; (3) prevent impoverishment of the individual or family in the face of extended or catastrophic service costs; (4) cover needed services in a timely, coordinated manner in the least restrictive setting
appropriate to the health care needs of the individual; (5) coordinate benefits across different LTC financing programs; (6) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level; (7) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level; (8) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased; (9) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and (10) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care. The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states’ flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms.


Medicaid Reform H-290.958

Our AMA supports increases in states’ Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

Citation: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 4, I-21
Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;

(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.

(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;

(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;

(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;

(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;

(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;

(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing
vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;

(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;

(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;

(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;

(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;

(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;

(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and

(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.