Moving Health Home
An Alliance to Advance Home-based Care Policy

Statement for the Record:
"Enhancing Access to Care at Home in Rural and Underserved Communities"
U.S. House Ways and Means Committee

Moving Health Home
1100 G Street NW, Suite 420, Washington, DC 20005

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Moving Health Home (MHH) appreciates the opportunity to submit testimony for this hearing on enhancing access to care at home in rural and underserved communities. MHH is a coalition of health care organizations with a bold vision to make the home a site of clinical service. Our members share in the belief that experience during the pandemic has accelerated the day when care in the home is an accessible option for patients.

For our members, clinical care in the home refers to a spectrum of health services provided in the home or place of dwelling outside of a facility, such as hospital-level or acute care, primary care office, skilled nursing and therapy services, and hospice. It can mean a house call from a primary care doctor or nurse, a physical therapy session, a laboratory and diagnostic service, a home infusion, or a full complement of hospital-level services. At the core, we want to remove regulatory barriers to ensure all patients may choose to receive clinical care in the home and take advantage of the convenient, high-quality care that comes when patients receive home-based care.

More than 60 million Americans live in rural areas. On average, rural residents are older and generally have worse health conditions than urban residents. Despite this, rural residents face more barriers to accessing health care like local hospital closures or traveling far for the nearest health care service. Technologies like telehealth and remote patient monitoring support care in the home and reduces barriers to care. MHH believes that broadened access to care in the home has the potential to improve access and outcomes for health care in rural areas. In particular, MHH supports H.R. 2853, The Expanding Care in the Home Act, as introduced by Reps. Smith (R-NE) and Dingell (D-MI).

MHH will focus comments on 1) the need for a five-year extension of the Acute Hospital Care at Home (AHCaH) program; 2) data around Americans wanting to age in place; and 3) the integration of technologies toward a care model where home is a site of clinical service.

Extend the Acute Hospital Care at Home Program

The AHCaH program is a care delivery model that allows some patients to receive acute, hospital-level care in their homes, as opposed to a traditional, in-patient hospital setting. Hospitals that have a Hospital at Home program evaluate patients to determine whether in-home care is appropriate, and while the structure of each program differs, only patients that are stable enough for in-home monitoring are admitted to the home. Monitoring may happen via in-person visits, as well as through remote patient monitoring and telehealth visits. Patients can receive clinically appropriate care in the home, including but not limited to diagnostic procedures, oxygen therapy, intravenous fluids and medicines, respiratory therapy, pharmacy services and skilled nursing.

The AHCaH program is an expansion of the Centers for Medicare and Medicaid Services (CMS) Hospital Without Walls program. Launched in March 2020, the Hospital Without Walls initiative was part of a comprehensive effort to increase hospital capacity, maximize resources, and combat COVID-19 to keep

Americans safe. The program also allowed additional flexibility that allowed certain health care services to be provided outside of a traditional hospital setting and within a patient's home.

The AHCaH program has been extremely popular, and as of March 2024, there are 131 health systems and 315 hospitals in 37 states participating in the program. The success of the AHCAH waiver builds on decades of evidence generated by acute care at home programs in the United States. Research shows that these programs are at least as safe as facility-based inpatient care and result in improved clinical outcomes, higher rates of patient satisfaction, and reduced health care costs. One study found evidence suggesting AHCaH is an important care model for managing acute illness, including among socially vulnerable and medically complex patients.

On December 29, 2022, the Consolidated Appropriations Act (CAA) for Fiscal Year 2023 (H.R. 2716) included a two-year extension of the AHCaH waiver, which was a product of Representatives Earl Blumenauer (D-OR) and Brad Wenstrup (R-OH) legislation: the Hospital Inpatient Services Modernization Act (S. 3792/H.R. 7053).

MHH and its members urge the Committee to extend the Medicare ACHaH waiver program for at least five years, prior to the expiration on December 31, 2024 to allow for implementation time. Without timely and decisive action from Congress, many Medicare beneficiaries will lose access to ACHaH programs that have been demonstrated to provide excellent clinical outcomes and lower the costs of care.

Seniors Want to Home to Be a Clinical Site of Care

According to the U.S. Census, more than one in five older Americans living in rural areas, many concentrated in states where more than half of their older populations are in rural areas. Despite being the sickest population, they face barriers to health care including transportation difficulties, limited health care supply, and financial constraints. Additionally, many rural older adults, after hospitalization, do not wish to move. Many rural older adults have lived their whole lives in the same small towns, some in the same homes. Allowing home to be a clinical site of care allows older adults to be comfortable in the setting where they receive their clinical care.

Home-based care refers a spectrum of health services provided in the home or place of dwelling, such as hospital-level or acute care, primary care, skilled nursing and therapy services, and hospice. Services may include routine physician visits, chronic disease management (such as remote patient monitoring), laboratory and diagnostic services (such as blood draws and x-rays), home infusion (such as antibiotics), wound care, physical or occupational therapy, in-home dialysis, and other care provided in the home setting rather than a facility, and regardless of age and health conditions.

A national survey found that there is widespread support by adults for receiving care in their homes across the care continuum. Specifically:

- **Americans Are Comfortable Receiving Care in the Home**
  - 70 percent of those surveyed are comfortable with care in the home citing that familiarity helps alleviate anxiety and improve communication. This is especially important for those from underserved and minority communities.
- **Americans Are Confident in the Quality of Receiving Care in the Home**
  - 73 percent of adults are confident in the quality of receiving care in the home.
  - 85 percent of caregivers are confident in the quality of receiving care in the home.

  - 88 percent of adults were satisfied with the clinical care services they received in the home.

- **Americans Prefer and Would Recommend Care in the Home**
  - 85 percent of people who have had experience with care in the home would recommend it to family and friends.

- **Americans Support Expanded Care in the Home**
  - A bipartisan majority of consumers say it should be a priority for the federal government to increase access to clinical care in the home (73 percent Democrats, 61 percent Republicans).

Care in the home models supports older adults that wish to age in place. A survey conducted by AARP found that 77 percent of older adults want to remain in their homes for the long term.

Innovative Models and Technologies Toward Care in the Home

Rural hospitals provide essential health care to rural communities. Yet, over 100 rural hospitals closed from January 2013 – February 2020. When rural hospitals closed, people living in areas that received health care from them had to travel farther to get the same health care services—about 20 miles farther for common services like inpatient care or even face delays in discharges from emergency and inpatient care. Innovative models and technologies can help connect care for Medicare beneficiaries living in rural and underserved communities and allow them to receive care from their homes.

Skilled Nursing Facility at Home

Skilled Nursing Facility (SNF) at home is the option of receiving SNF-level services in the home that otherwise would have been provided in a facility. The creation of a SNF-at-Home program would allow patients to access these services from the home using a mix of skilled care, personal care, and telehealth services.

Skilled nursing facilities primarily provide inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services, but does not provide the level of care or treatment available in a hospital. Medicare pays SNFs a predetermined amount per day that a beneficiary receives care, up to 100 days.

According to data from 2019 and 2020, total Medicare SNF spending increased $1.1 billion (4.4 percent), despite 200,000 fewer traditional Medicare beneficiaries using SNF services in 2020. Average spending per SNF user was $2,724 (16.3 percent) higher in 2020 compared to 2019, driven by an increase in average spending per day (+$44), with an increase in the average length of stay (+1.6 days) also contributing. Additionally, rural Medicare enrollees use the SNF benefit at a rate that is 15 percent higher than the rate for urban enrollees.

SNF-at-home provides opportunities for payers, health systems, and providers to lower costs, facility-associated infections, promote patient compliance, free up capacity in facilities, and address practitioner burnout. SNF-at-Home may not be a fit for every patient, but it is an important option for patients and providers to have, especially for rural patients. An integrated SNF-at-home program can bring services directly to the patient, allowing them to recover in a familiar environment. **MHH understands the Committee is interested in post-acute care, and urges the Committee to discuss a model for SNF-at-Home.**

In-Home Primary Care

Access to primary care providers (PCPs) in rural areas is significantly hampered. According to the National Rural Health Association, "the patient-to-primary care physician ratio in rural areas of only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas." MHH believes that expanding access to in-home primary care has the potential to increase rural access to routine medical visits. Specifically, MHH recommends creating capitated arrangements to allow primary care providers to better care for patients in the home without the constraints of fee-for-service (FFS) billing and documentation. These visits may happen via telemedicine or telephone check-ins with a physician, or nurse, group, and home visits. Identification and care management of high-risk patients and integration of mental health services may also be considered.

H.R. 2853 would direct the Health and Human Services Secretary to allow PCPs enrolled in Medicare Part B to elect to receive a monthly capitated payment for Primary Care Qualified Evaluation and Management Services (PQEM) as an alternative to FFS reimbursement. **MHH believes that this care model would increase access to primary care in rural areas**, thereby increasing regular health checks and screenings that may help to address poor long-term health outcomes in rural areas.

Home Infusion

Home infusion services can be delivered in rural areas, and with increased access, would help to alleviate the travel burden that many rural patients experience. A recent study showed that 13.1 percent of patients receiving home infusion services lived in rural areas. The study concluded that home infusion use is well-established in rural areas and may increase accessibility to infusion services for rural Americans.

To continue expansion of access to home infusion, the Medicare reimbursement structure must be completed. MHH recommends establishing Medicare Part B coverage of services and supplies associated with the delivery of home infusion. Currently, Medicare Part D covers the cost of most home infused drugs, but excludes the services associated with the delivery of the drugs, including equipment, supplies, and administration. CMS has determined that it does not have the authority to cover infusion-related services, equipment, and supplies under Part D. As a result, rural Medicare beneficiaries may be forced to travel to a hospital or other facility to receive infusion services. **H.R. 2853 would require Medicare Part B to cover the services and supplies associated with the delivery of home infusion, thereby making it more accessible for rural patients.**

Home Dialysis

Approximately 22 percent of those on dialysis live in a rural area and those who live over 100 miles from a dialysis center have higher mortality rates than those who live in closer proximity. Home dialysis offers a potential solution for rural Americans living with end-stage renal disease (ESRD), as they could complete dialysis in the home rather than traveling long distances to receive dialysis multiple times per week. This may also alleviate caregiver burden for those who provide transportation for a loved one on dialysis.

MHH recommends bolstering access to home dialysis by providing Medicare reimbursement for staff assistance for home dialysis treatment. **H.R. 2853 includes the Improving Access to Home Dialysis Act provides a framework for this model.** Specifically, the legislation:

1. Provides for reimbursement through Medicare for in-home assistance by staff of the dialysis facility to patients on home hemodialysis and peritoneal dialysis for the first 90 days of their regimen;
2. Provides for in-home respite staff assistance under certain circumstances outside the initial 90 days;
3. Provides for the possibility of continuous staff assistance without a time limit for patients with certain disabilities;
4. Expands the types of healthcare professionals who can provide home dialysis training;
5. Provides for additional educational opportunities for patients to learn about the entirety of their dialysis options, including opportunities that can be provided in group settings or via telehealth;
6. Provides for training on home dialysis to occur, when possible, in the location the patient intends to use to dialyze.

In-Home Labs

In-home lab testing also can increase access for rural patients who may have limited capacity for travel to a health care facility. Currently, Medicare does not provide ad additional payment for the collection of labs from non-homebound patients or costs of postage and supplies to mail labs. These costs fall on providers or laboratories when services are offered to non-homebound patients. Still, patients in rural areas may benefit from access to in-home labs even though they may not be considered home-bound. MHH recommends that we should ensure receiving preventative and diagnostic labs is as easy as possible for patients in rural areas.

H.R. 2853 would establish reimbursement of an add-on payment to cover travel costs and mail costs associated with specimen collection of in-home lab tests for certain beneficiaries. **MHH recommends that the eligibility for this add-on payment be more comprehensive than the homebound status and take things like barriers to accessing care in rural areas into consideration.**

Advanced Diagnostic Imaging in the Home

MHH also recommends legislation to permit the delivery and reimbursement of ultrasound imaging in the home for certain beneficiaries and require the Secretary of the Department of Health and Human Services to conduct an evaluation of Medicare in-home reimbursable advanced diagnostic imaging.

Currently, there is a Portable X-Ray Benefit in Medicare Part B but it is limited in types of diagnostics reimbursable. However, the Benefit was last updated in 2007. Technologies and capabilities have evolved significantly since then. Now, mobile imaging can provide comprehensive X-Ray, EKG, and ultrasound services quickly, safely, and affordably in the home.

H.R. 2853 provides a model for increased access to advanced diagnostic imaging in the home; it would require HHS to conduct an evaluation of Medicare in-home reimbursable advanced diagnostic imaging. It would permit the delivery and reimbursement of ultrasound imaging in the home for certain beneficiaries, which is currently restricted. Further, the Secretary of HHS would determine the screening tool or utilization management that would trigger beneficiary eligibility.

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Moving Health Home greatly appreciates the House Ways & Means' leadership in working to ensuring patients are able to receive care from their homes, particularly for rural and underserved communities.

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We look forward to working with you to develop and advance bipartisan legislation to enhance care in the home access for Medicare beneficiaries. If you have any questions or would like to hear from Moving Health Home member experts on these topics, please do not hesitate to contact Rikki Cheung at rcheung@movinghealthhome.org.

Sincerely,

Krista Drobac
Executive Director
Moving Health Home