Statement for the Record:
"After the Hospital: Ensuring Access to Quality Post-Acute Care"
U.S. House of Representatives
Ways and Means Committee
Health Subcommittee

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 to examine the post-acute care landscape and the challenges and opportunities to improve access to such care for Medicare beneficiaries. 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.

Patients have indicated that they want to receive care at home, with the demand for services provided in the safety of a patient's home soaring during the pandemic. In fact, according to a recent survey, 85 percent of adults say it should be a high priority for the federal government to expand Medicare coverage for at-home health care. At the same time, an overwhelming majority of people who have received care in the home were satisfied (88 percent) and would be likely to recommend to family and friends (85 percent). We believe older adults should have the opportunity to choose the best site of care for their medical needs and preference, whether that be in the home or the facility.

Hospital overcrowding, patient and caregiver choice, and the need for increased capacity for post-acute care make post-acute recovery at home an urgent need. Tens of thousands of patients are unnecessarily stuck in the hospital because there are not enough beds in skilled nursing facilities (SNFs) or home health providers in their area, thereby creating back-ups among patients in the ER waiting for admission. In Nebraska, some patients are waiting up to six months to be admitted into a post-acute care bed, while in Minnesota, patients are spending over 65,000 days than needed. While there are multiple root causes for today's discharge crisis, the delays can be immediately addressed by creating capacity for patients that qualify to receive post-acute care in home settings.

We urge the Subcommittee to consider post-acute recovery at home as an option for eligible patients. The creation of a post-acute recovery at home program would allow patients to access these services from the home using a mix of skilled care, personal care, and telehealth services. Post-acute recovery 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. Post-acute recovery at home may not be a fit for every patient, but it is an important option for patients

and providers to have. An integrated post-acute recovery at home program can bring services directly to the patient, allowing them to recover in a familiar environment.

We applaud the Committee for examining the post-acute care landscape and considering opportunities to improve access to such care for Medicare beneficiaries. To create expanded capacity, Congress must invest in the drive toward home-based care coupled with the movement in the direction of value over volume. Unfortunately, our system is biased against home-based care. Our long-term goal is to dismantle that bias. **In our response, we outline a proposal that will expand Medicare's post-acute options by creating a five-year waiver of certain skilled nursing facility (SNF) requirements to allow for a demonstration of SNF at Home.**

The Hospital Discharge Crisis

Tens of thousands of Americans are stuck in hospital beds every day, in large part because they cannot find an available SNF bed. Hospitals are backed up because people can't be discharged when they are ready. Patients are "boarding" in the emergency department, which contributes to lower quality of care, decreased patient safety, reduced timeliness of care, reduced patient satisfaction, an increased number of patients leaving without being seen, and increased mortality.

Boarding leads to increased cases of mortality related to downstream delays of treatment for both high and low acuity patients. The Joint Commission identifies boarding as a patient safety risk that should not exceed 4 hours. Yet, the American College of Emergency Physicians (ACEP) found over 97 percent of respondents cited boarding times of more than 24 hours, 33 percent over one week, and 28 percent over two weeks.

Boarding also leads to costly waste in the health care system, with some hospitals seeing a total daily cost per patient of $1,856 for those boarding, which is nearly double the $993 for those receiving inpatient care.

Hospital discharge delays and costly and wasteful unnecessary patient days have been documented throughout the United States. In Massachusetts, nearly 1 in 7 non-ICU hospital beds are currently occupied by a patient who no longer needs acute hospital care, and in Nebraska in January 2023, more than 100 patients waited more than 30 days to be discharged to a post-acute care facility. The Minnesota Hospital Association found that patients spent 65,000 patient days of avoidable and unpaid care, costing Minnesota health systems an estimated $487 million in unpaid care. Florida saw similar findings, showing over $540 million in estimated avoidable costs as well as almost 50 percent of its patients waiting more than 10 days were awaiting discharge to a SNF. In California, an estimated 300,000 hospital patients face discharge delays of at least three days after medical clearance, adding 14 days to their hospital stays on average. New York echoed findings, with 60,000 delayed days and $169 million in estimated costs.

A Solution to Expanding Post-Acute Care Options

A five-year waiver for a demonstration of skilled nursing facility services available at home will expand Medicare's post-acute options, free up hospital's limited facility capacity, reduces stress on family caregivers, and patients recover faster at home. As part of the hospital discharge planning process, Medicare beneficiaries who qualify for skilled nursing benefits would be given the choice to recover at

home with traditional SNF services. Patients become eligible based on an assessment tool that includes consideration of an individual's place of care preferences, functionality, medical conditions, and questions regarding care and family caregiver concerns. Hospitals, SNFs, and home health agencies can participate in the waiver and furnish or arrange for SNF at Home services in the beneficiaries' home.

During the COVID-19 pandemic, CMS waived the requirement that Medicare beneficiaries have a three-day hospital stay before being admitted to a SNF. Medicare beneficiaries with COVID-19 were 66 percent more likely to be discharged from the hospital to a SNF than non-COVID patients, increasing occupancy levels above what they would have been otherwise. A study of a SNF-at-Home pilot found improved health outcomes, lower rehospitalization admissions, and cost savings. The pilot has since received additional funding and will undergo a larger trial.

Medicare beneficiaries and their caregivers want care at home. A survey found that 94 percent of Medicare beneficiaries prefer care at home after hospitalization. A Moving Health Home survey found similar results. A 2021 study conducted by the National Institutes of Health (NIH) found that at-home patients had a 26 percent lower risk for readmissions. A case-study found that 96% of caregivers found in-home care less stressful than a previous health care experience.

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Thank you for considering our comments. We look forward to working with the House Ways and Means Committee and welcome the opportunity to provide further feedback on how to achieve this waiver. Please do not hesitate to reach out to Rikki Cheung at rcheung@movinghealthhome.org with any questions regarding our comments or if we can be a resource to you in any way.

Sincerely,

Krista Drobac
Executive Director
Moving Health Home