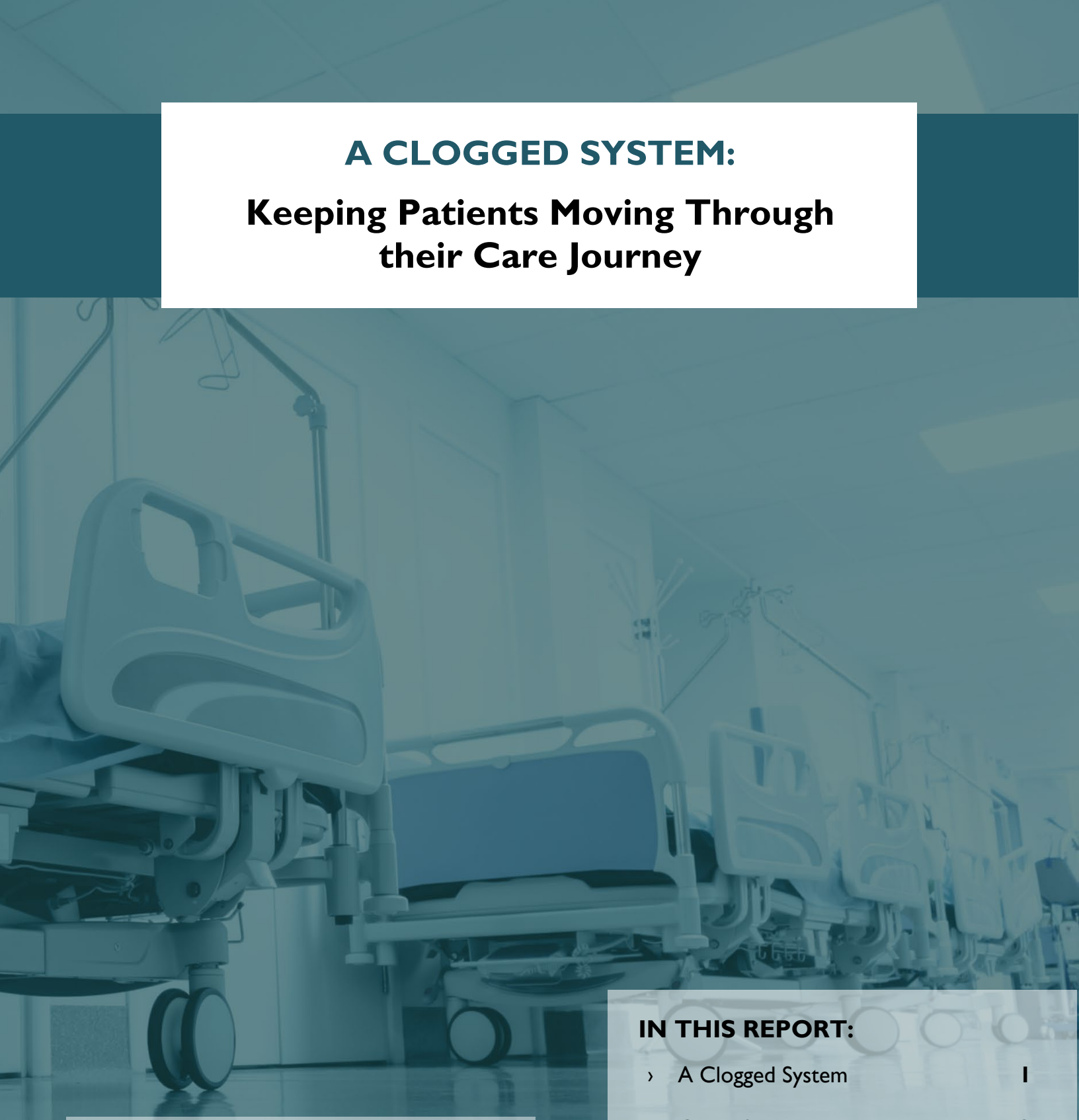
A CLOGGED SYSTEM:

Keeping Patients Moving Through their Care Journey



MASSACHUSETTS Health & Hospital ASSOCIATION

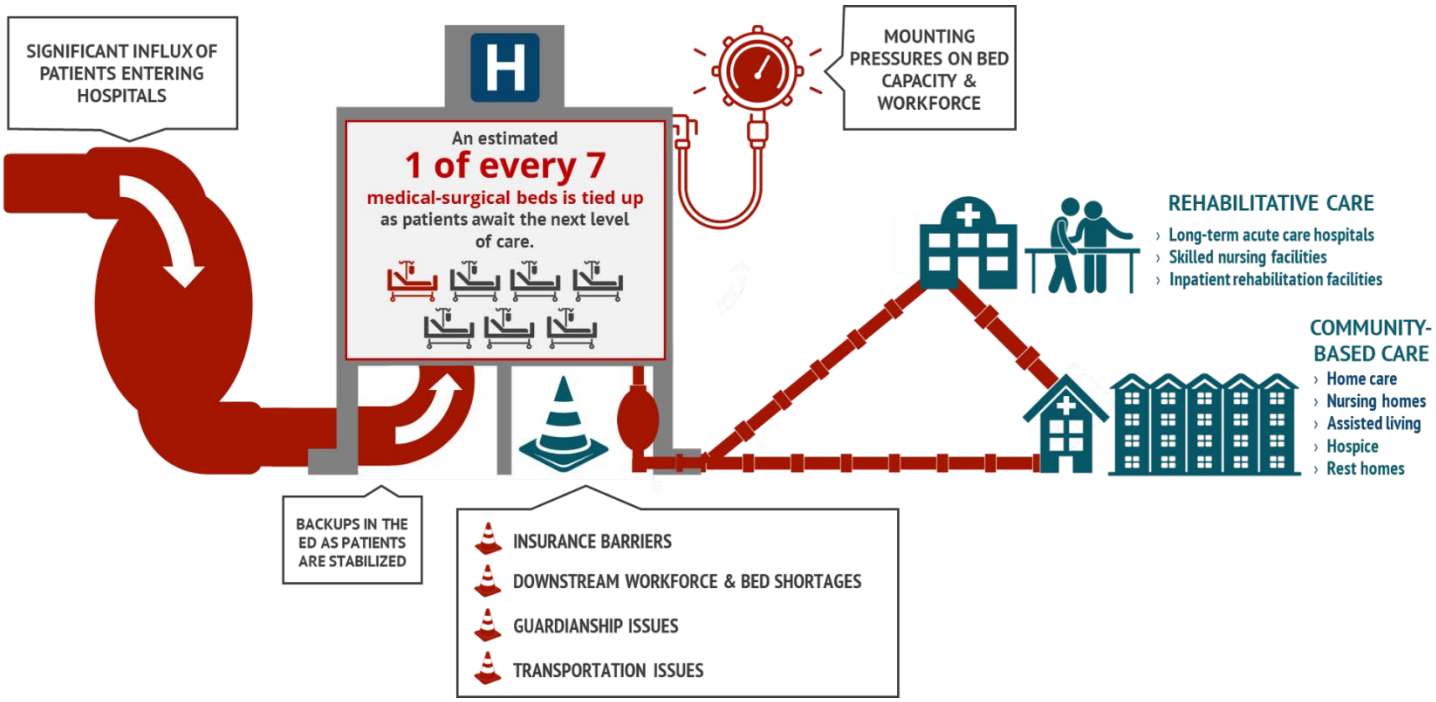
June 2023

IN THIS REPORT:

Across the nation, hospital wait times are up and access to care is threatened.

In Massachusetts, a leading contributor to this problem is the fact that nearly one out of every seven medical-surgical beds (or 15% of those in the state) is currently "tied-up." That is, they are occupied by patients who no longer need to be in an acute care hospital. These patients – approximately 1,200 in the commonwealth – are "stuck" in hospital beds as they await discharge to a post-acute care facility (such as a nursing home or rehabilitation hospital), a community based-setting (such as an assisted living residence, group home, or home), or a psychiatric unit. At the same time, post-acute providers themselves face backups due to limited community-based resources and support systems that help transition patients home.

A CLOGGED SYSTEM: *How Hospital Backups Happen*



The 15% of "tied up" beds was calculated by dividing the average number of patients in medical-surgical beds who were awaiting post-acute care or psychiatric discharge over the past 12 months by the average number of staffed medical-surgical beds in the 55 responding hospitals. Data was sourced from the Massachusetts Department of Public Health and MHA's monthly Throughput Survey and weekly Behavioral Health Boarding Survey. Non-participating hospitals were excluded from calculations.

The result is a clogged healthcare system that cannot best serve the commonwealth. The 1,200 patients awaiting post-acute placement are not getting the specialized treatment they need. And because these beds are tied up, patients requiring hospital-level care often must wait longer in emergency departments or other units until the bed *they* need becomes available.

This report from the Massachusetts Health & Hospital Association (MHA) shines a light on this often-overlooked driver of the current capacity crisis and offers solutions to improve the flow of patients from hospitals to post-acute care settings.

AN ALL-TOO-COMMON EXAMPLE

The following is just one example of what hospital case managers experience when trying to discharge patients each day:

A 74-year-old patient – we'll call her Sarah Smith – fell at home and required hospital care for her fractured shoulder. Sarah is overweight, has diabetic kidney disease that requires dialysis treatment three times a week, and is showing signs of dementia. These are common comorbidities.

Sarah is insured through a Medicare Advantage plan.

At her local acute care hospital, Sarah's shoulder was repaired and her kidney disease stabilized. But she now requires physical therapy and continuing hemodialysis – services she should access in a community setting. Her family lives out of state and is not able to care for her and her ability to care for herself is becoming more difficult due to her increasing dementia. Like many individuals, Sarah never completed a healthcare proxy document, which would empower someone to make care decisions for her if she were unable to care for herself.

Due to these lack of supports, Sarah cannot safely return home for physical therapy, meaning she will need to seek short-term rehabilitation at a skilled nursing facility.

Here are the problems Sarah and the healthcare system are facing:

- The skilled nursing facility (SNF) she should be discharged to may not have enough physical therapists or nursing assistants due to workforce shortages.

- Medicare does not pay for outpatient hemodialysis transport. The SNF may not be able to shoulder the costs of transporting Sarah three times a week to her dialysis treatment or may not have a contract with an ambulance company to conduct a transport. In addition, there is a shortage of workers in the healthcare transport sector. The acute care hospital may end up paying for the transport in its effort to discharge Sarah and free up the needed bed – an uncompensated cost that the hospital must absorb.

- Because Sarah's dementia is worsening, she may need to be in a specialized memory care unit. There is a limited supply of these units in the state and high demand for them, which further stalls her discharge from the hospital. An alternative may be to provide her with a one-to-one sitter, but there are worker shortages in this area as well and a locked unit may be more appropriate.

- Another alternative would be to place Sarah in assisted living-based memory care, with home health support for her short-term rehabilitation needs. But this is costly, and financial assistance is not available.

In the interim, the hospital will attempt to provide her with physical therapy. However, acute care hospitals are not designed to provide this type of care and, due to workforce shortages, have difficulty staffing rehabilitation services.

So, Sarah waits for a bed to open in a skilled nursing facility.

The hospital is shouldering the costs of her care, as her Medicare Advantage plan is only paying for the portion of her stay in the hospital for when she was acutely ill.

- Sarah's best financial option is to enroll in MassHealth, which is the only payer that covers long-term care. But to find out if she qualifies, she needs help from a designated healthcare decisionmaker (or guardian) – which she does not have. And because she never filled out a proxy document, she may now have trouble doing so due to her dementia. The hospital may go to the courts on her behalf to appoint a guardian, but that takes time. If a guardian is appointed, he/she must analyze Sarah's finances to determine if she qualifies for MassHealth, which may require the court appointment of a conservator, and then the hospital has to help fill out the MassHealth application, which also takes time. The state usually responds within 45 days to such applications, meaning that Sarah has been in the acute care hospital for months. And her bed cannot be made available to others with pressing medical needs.

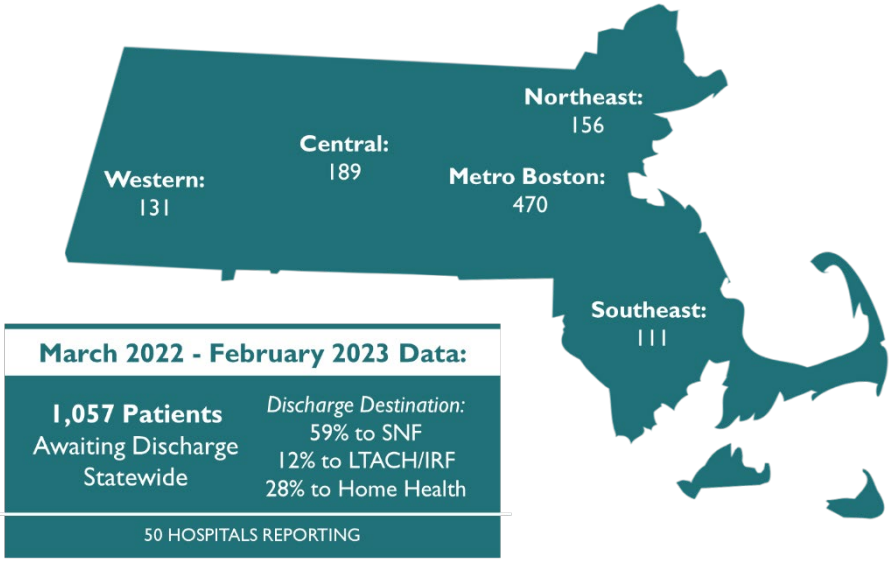
Sarah's guardianship, MassHealth qualifications, and the availability of the right kind of unit, staff, and transportation must all come together for her to be discharged from the hospital. People who are housing insecure or who have behavioral health and brain injury diagnoses face similar – or even longer – delays for discharge to a post-acute care setting.

Quantifying the Problem

For the past year, MHA has been surveying hospitals to understand and quantify this "throughput" problem – that is, the process of transferring a patient who is no longer acutely ill to the next appropriate care setting.

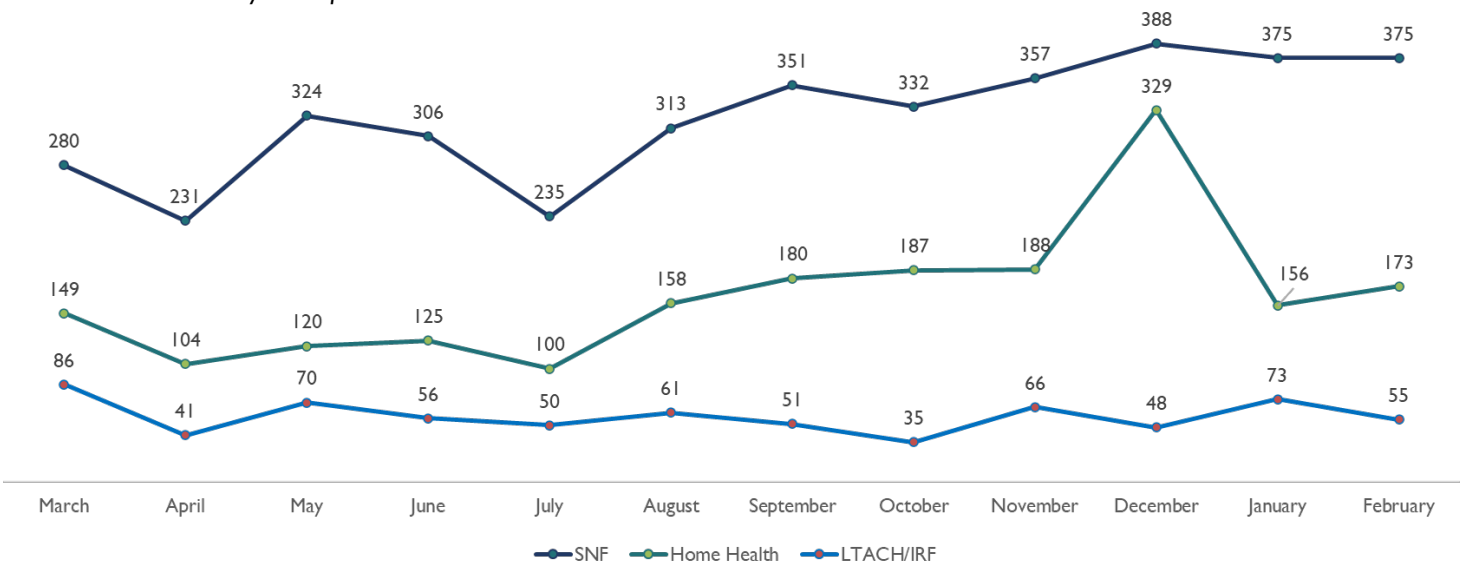
The data shows that there are often more than one thousand patients who could be discharged from an acute care hospital but are stuck waiting to be discharged to a post-acute care facility. Hospitals are often not equipped to best provide that next level care – whether it involves skilled nursing facility care for bariatric patients; occupational, speech, or physical therapy; nursing-home level dementia care; or some other specialized service.

Average Number of Patients Awaiting Discharge to Post-Acute Settings
March 2022- February 2023 point-in-time data



Even while COVID-19 cases and hospitalizations are winding down, MHA data shows a steady *increase* in the demand for post-acute care beds, with minor monthly variations.

Trend in Number of Patients Awaiting Discharge to Post-Acute Care Settings
March 2022 – February 2023 point-in-time data



Data is from a consistent cohort of hospitals that responded to every survey from March 2022 through February 2023

Despite studies showing that patients do best when they are transferred within seven days of being ready for discharge, **an alarming number of patients are now waiting from 30 days to more than six months for a post-acute care bed to become available**. This is not only challenging for the patients awaiting transfer, but equally challenging for those in need of a hospital bed.

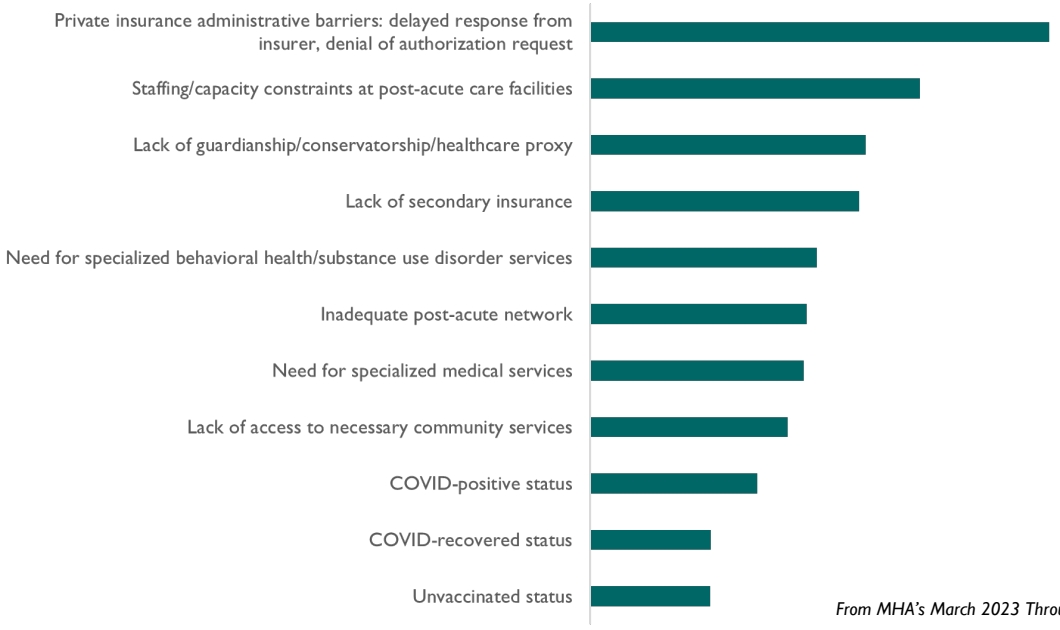
MHA, in collaboration with the Massachusetts Senior Care Association and state government, have worked collaboratively to find solutions to the problem with some success throughout the pandemic. However, the problem persists and demands sustained attention.

Percent of Patients Awaiting Discharge for More Than 30 Days, by Post-Acute Care Setting
March 2022 – February 2023

Month	SNF	LTACH/IRF	Home Health
March 2022	46%	35%	12%
April 2022	36%	34%	11%
May 2022	40%	24%	16%
June 2022	36%	32%	9%
July 2022	41%	36%	12%
August 2022	41%	42%	18%
September 2022	34%	35%	10%
October 2022	40%	36%	22%
November 2022	41%	37%	25%
December 2022	45%	41%	15%
January 2023	45%	36%	38%
February 2023	52%	39%	17%

Reasons for the Delays

The patient throughput problem is the result of many factors, including workforce shortages at post-acute care facilities, the lack of guardianship or healthcare proxy designations that make it difficult to get approvals for transfers, and the need for specialized services, including transportation services between care settings.



Reasons for Delayed Discharge to Post-Acute Care Settings
As Reported by Hospital Case Managers

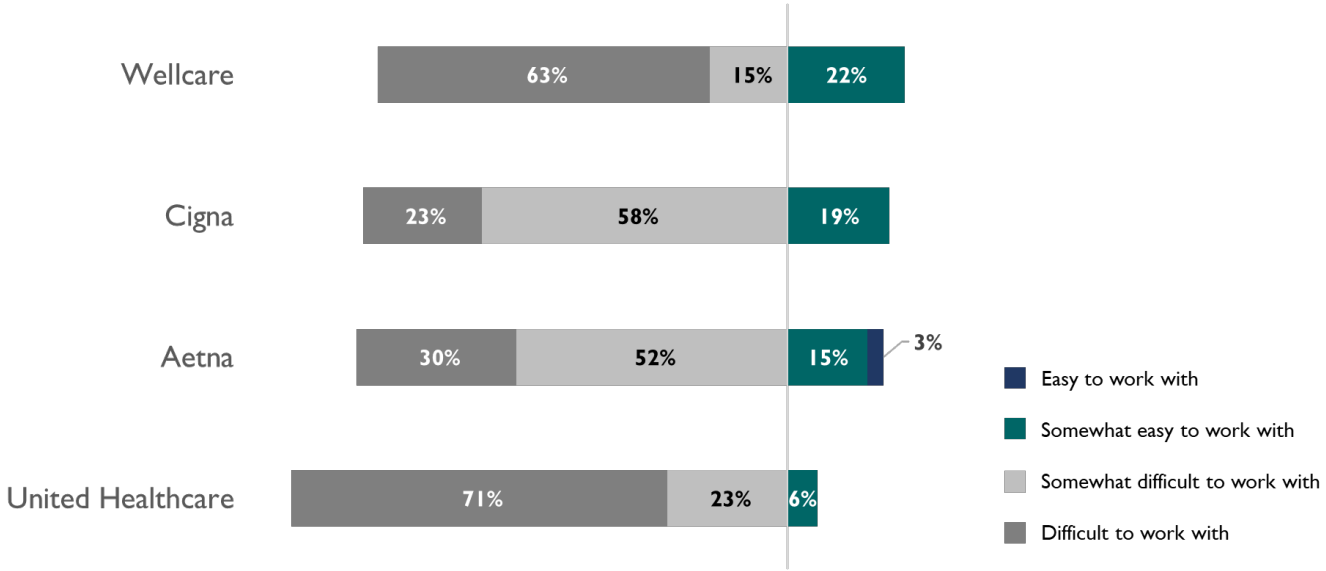
From MHA's March 2023 Throughput Survey

The Insurance Conundrum

The most frequently cited reasons for discharge delays are administrative delays and prior authorization decisions from commercial insurers, especially from national Medicare Advantage plans.

Some national Medicare Advantage plans, which represent a growing share of the Medicare marketplace, have caused significant transfer roadblocks. Case managers tell of prolonged periods of time to receive responses from insurers to approve transfers, or of insurers denying the stays completely.

Ease of Working with National Payers on Discharges to Post-Acute Care Settings:
As Reported by Hospital Case Managers



MHA asked hospital case management directors to rank their experiences with national insurers based on challenges encountered discharging patients to post-acute care, including delayed responses, authorization denials, inadequate post-acute care networks, and sub-par coverage of needed services. The chart shows (in light and dark grey) that an insurer was more difficult to work with; responses in blue or green indicate that an insurer was easier to work with.

Case managers are then forced to appeal the insurer decisions through peer-to-peer conversations between physicians at the hospitals and physicians at the insurance company. Often, the insurer's physician has never practiced in the same specialty as the doctor treating the patient, creating a situation where individuals without expertise in treating particular conditions and diseases are making care decisions, which leads to potential patient harm, further delays, or outright denials.

Many insurers also have inadequate networks of post-acute care providers and are reluctant to approve a patient transfer to any facility outside of their network. This leads to more delays. Some insurers contract with third-party vendors to determine medical necessity and provide little or no oversight for these decisions. Some use artificial intelligence to arbitrarily determine the length of coverage for a particular treatment, or use internal decision tools that are more exclusive than traditional Medicare in dictating denials or peer-to-peer reviews. Each of these factors further complicate the transfer process and jeopardize care.

Massachusetts-based health insurance companies were helpful in supporting discharges by voluntarily waiving prior authorizations in late 2022 and early 2023, and guaranteeing expedited turn-around-times. Some insurers – but not all – continued these flexibilities for additional months. Today, prior authorization barriers remain especially problematic for people in need of post-acute care.

Other Reasons for Delays

Workforce Shortages

Post-acute care facilities – especially nursing homes – are facing dramatic workforce vacancies, limiting their ability to accept new patients. Nursing homes are challenged in finding nurses, care assistants, physical and occupational therapists, speech pathologists, and other specialists. Home care agencies and visiting nurse groups are facing the same workforce problems.

A January 2023 report from the American Health Care Association and National Center for Assisted Living shows nursing homes lost 210,000 jobs during the pandemic and are not expected to return to pre-pandemic workforce levels until 2027. And an April 2023 survey from the Massachusetts Senior Care Association noted there are 3,000 licensed but unstaffed nursing home beds in Massachusetts, and that one out of every five positions in nursing homes is currently unfilled. Skilled nursing facilities in the state report that they are 12,000 full-time employees below pre-pandemic levels.

Patient Factors

The behavioral health boarding crisis has been well documented. Some patients "board" within a hospital awaiting an inpatient psychiatric bed to open. Other patients have certain diagnoses that do not require a psychiatric bed, but which make it difficult for them to thrive within a community setting. Patients could be housing insecure or have greater care needs than their families or community-based settings can provide. These factors make it difficult to transfer patients from one facility to another.

Healthcare Proxies and Guardianships

An elderly patient without a healthcare proxy – that is, the form designating who can make care decisions for them – may not have the capacity to fill out such a form. Hospitals must then go through the courts to designate guardianship, which can take months.

Also, many patients with cognitive or other impairments are unable to fill out a MassHealth application to receive long-term care benefits. This requires intervention by the courts (known as a conservatorship), which further delays the process.

Hemodialysis and Transportation

Patients on hemodialysis may need to be transferred by ambulance up to three times per week to a treatment facility. An acute care hospital may find it challenging to find a transportation provider that prioritizes outpatient hemodialysis and a post-acute care facility to coordinate transportation and drive the patient to an appointment. In addition, post-acute organizations themselves face obstacles in scheduling outpatient hemodialysis appointments, even if they coordinate this care for their patients and/or residents.

Post-Acute Care Facility Closures

One major nursing home group closed four long-term care facilities in the Greater Springfield area this spring, requiring the transfer of 311 elderly residents and increasing the demand for the remaining post-acute care beds in the region. At least eight other nursing homes have closed in Massachusetts since July 2021. In total, 20 nursing facilities have closed since the start of the pandemic.

Short-Term Care versus Long-Term Care

A patient who requires *short-term* rehabilitation care after a hospital stay – say, to receive physical therapy after surgery on a limb – is often more likely to find a placement in a post-acute care facility. Insurance covers such short-term stays because they are part of the recovery process and the cut-off point in the rehab facility – the time when the person is able to be discharged – is usually clear.

Long-term care is a different story. Patients in need of longer stays at post-acute care facilities often face a series of obstacles that delay their transition from the hospital. This is especially true for patients with dementia diagnoses, for those who require one-on-one supervision, or for those who have significant behavioral healthcare needs. Private long-term care insurance is a rarity; even well-insured, employed people may not have it or have enough resources to support a stay in a nursing facility for a significant period.

MassHealth, however, pays for long-term care and at-home care services. Enrolling eligible people in MassHealth before they are unable to do so for themselves because of a medical or cognitive issue is an important step in easing patient flow difficulties.

A Simple Step: Focus on Healthcare Proxies

Anyone over age 18 should complete a healthcare proxy form, designating an agent who can make healthcare decisions for them if they are unable to make decisions for themselves. Healthcare proxies can help eliminate the guardianship issues that are a leading cause of patients being stuck in an inappropriate care setting.

According to MHA survey data from December 2022, there were 166 patients across the state who had delayed discharges due to pending legal actions in the state's courts. More than 60% of these patients were either waiting for the courts to appoint a guardian who could then make healthcare decisions on their behalf or were waiting for the courts to expand their decision-making capabilities on behalf of their patients. On average, patients awaiting the appointment of a guardian wait an additional 41 days before they can be discharged to the next level of care. Another survey in March 2023 found that there were 38 patients in the state who had a pending legal action in the courts to *challenge* the care decisions of their current healthcare proxy.

MHA has joined with Honoring Choices Massachusetts, the Massachusetts Senior Care Association, the Massachusetts Medical Society, Home Care Alliance of Massachusetts, Leading Age Massachusetts, and Hospice and Palliative Care Federation of Massachusetts to stress the importance of completing a health care proxy – the document assigning a trusted someone to make decisions on an individual's behalf if they are unable to themselves. **More information about healthcare proxies is here**.

Ongoing Efforts

State agencies, in partnership with healthcare providers, have taken action to address patient flow and improve hospital capacity for patients in need of acute care. Some of those solutions include:

Skilled Nursing Facility Short-Term Rehab Capacity Program

The Executive Office of Health and Human Services (EOHHS), MassHealth, and the Department of Public Health have worked with the Massachusetts Senior Care Association and its members to implement a temporary program that adds short-term rehabilitation capacity in all regions of Massachusetts. Skilled nursing facilities meeting certain quality criteria receive additional funding from the state and *are required* to accept all hospital referrals for patients that require short-term rehabilitation skilled nursing services if they have the capacity to accept those patients. The facility must be responsive to requests from any hospital for discharge planning and be available to accept all new admissions, including COVID-19 positive patients, from at least 7 a.m. to 7 p.m., seven days a week.

Post-Acute Care Transitions Collaborative

Beginning in early 2022, MHA and the Massachusetts Senior Care Association established a mechanism for hospital case managers to escalate and address challenges around skilled nursing facility placements. In situations where no placement can be found, cases are elevated to the state's hospital discharge ombudsman. This collaborative convenes monthly to serve as a forum where hospital case managers meet with the Senior Care Association, the state ombudsman, state hospitals, and nursing home administrators to triage challenging cases and identify opportunities for discharges. The program is also being expanded to include home care agencies in partnership with the Home Care Alliance of Massachusetts.

A survey conducted in 2022 to determine the success of the escalation process showed:

- For cases requiring intervention, most patients waiting for discharge needed long-term custodial care, had dementia diagnoses, required one-on-one supervision, or required significant behavioral healthcare services.
- Most had a MassHealth application pending, an uncompleted MassHealth application, or no insurance identified.
- Many required court intervention to establish guardianships, conservatorships, or affirm healthcare proxies.

Additional Needed Solutions

Additional action is needed to free up acute care beds in the months and years ahead, particularly when it comes to long-term placements. MHA has worked with its members and partners across the continuum of care to propose these solutions:

Funding a Complex Care Ombudsman Program

This proposal would fund a program within EOHHS to assist with discharges from both acute and post-acute care facilities to lower-level care settings. It would ensure one complex care case manager is available in each of the state's five EMS regions to assist with complex care discharges.

Increasing Access to Long-Term Care, Dementia & Geriatric-Psychiatric Beds

Leveraging the success of the dedicated program to expand capacity for *short-term* rehabilitation beds, this program would increase the number of staffed long-term care beds, placements for patients with dementia diagnoses, and services for geriatric patients with psychiatric diagnoses.

Number of Patients Awaiting Specialized Care Beds *(February 2023)*

Short-Term Rehabilitation Beds	319
Long-Term Care Beds	313
Dementia Beds	150
Geriatric-Psychiatric Beds	87
Alcohol Use Disorder/Substance Use Disorder Beds	38
Tracheostomy and Percutaneous Endoscopy Gastronomy (PEG Tube) Care	31
Methadone Coordination	15
Bariatric Considerations	10

Expanding the Hospital to Home Partnership Program

This initiative would build off a pilot program that embeds case managers from aging services access points directly into hospitals. The case managers identify wrap-around services to ensure patients can be discharged successfully to their homes. Since only 10 initial partnerships that applied to the program are receiving funding, this proposal would provide an additional five to 10 grants for those partnerships that were unable to apply previously.

Improving Processes to Expedite Guardianship, Conservatorships, and Healthcare Proxy Cases through the Courts

In addition to recommendations that MHA and its partners are developing to expedite cases with pending legal actions, a messaging campaign has been initiated to encourage residents to complete a healthcare proxy and designate a healthcare agent.

Increasing Information, Education, and Communication with all Post-Acute Care Services & Improving Transportation

There is a need to improve the referral process to underutilized settings, such as rest homes, hospice, and palliative care; and to educate hospital discharge planners about new post-acute care services, including home dialysis dens co-located at skilled nursing facilities. There is also room for further collaboration between hospitals and transportation providers to address workforce shortages, transportation bottlenecks, and the ability to meet patient-specific transport needs.

Supporting Enhanced Federal Oversight of Medicare Advantage Plans

A 2022 federal Office of Inspector General report showed that some Medicare Advantage (MA) plans have exhibited a pattern of denying prior authorization and payment requests that would have been covered under traditional Medicare. Beneficiaries enrolled in some MA plans routinely experience inappropriate delays and denials for coverage for medically necessary care. MHA strongly supported a 2023 final rule from the federal Centers for Medicare & Medicaid Services that will require, among other protections, an insurance company physician conducting a medical necessity review to be within the same or similar discipline as the case being reviewed. It also requires Medicare Advantage plans to cover the same services covered by traditional Medicare. Another pending rule MHA supports would require shortened time frames for MA insurers to respond to prior authorization requests.

A More Seamless Patient Journey

With one out of every seven medical-surgical beds currently occupied by patients who no longer require acute hospital care, Massachusetts must continue to work on "unclogging" a system that is currently unable to best meet the needs of patients.

When barriers remain in place for discharges to post-acute care services, wait times and care access suffer.

Improving patient transitions – whether to the home or to post-acute care facilities – can only happen through a sustained, multi-faceted approach that engages stakeholders from across the care continuum, in addition to partners in state government, the federal government, as well as the commercial health insurance industry.

The solution requires boosting the ranks of the healthcare workforce, reducing insurance industry-imposed administrative burdens, increased funding for specialized care beds, and ensuring patients have a completed health proxy, which can expedite the legal process that can stall a discharge to a post-acute care facility.

As the commonwealth's healthcare ecosystem faces mounting pressures coming out of the public health emergency, the continued capacity crisis must remain at the forefront of our collective efforts to ensure patients are able to access the care that they need at the right time and in the right place.

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