

THE ISSUE

In recent years, post-acute providers have faced scrutiny from Congress and other policymakers that has resulted in substantial payment cuts. Regulatory and statutory payment reductions and restrictions have been considerable for all four post-acute sectors – long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF) and home health (HH). The Patient Protection and Affordable Care Act of 2010 (ACA) included productivity offsets and other reductions to updates, quality reporting requirements and significant HH changes that continually reduce Medicare payments over the next 10 years. Additionally, major regulatory tightening by the Centers for Medicare & Medicaid Services of the post-acute payment system has included coding and documentation offsets, rebasing and significant operational changes. Most recently, The President's Plan for Economic Growth and Deficit Reduction included several across-the-board post-acute update cuts, along with lowering IRF reimbursement for selected patients to a SNF-level payment, and raising the current IRF 60% Rule threshold.

AHA POSITION

Reject further reductions to post-acute providers.

WHY?

- **It is excessive and unjustified to pile additional payment cuts onto the already substantial reductions imposed on post-acute care providers.** Current policies in the ACA and other CMS regulations already are reducing Medicare payments to post-acute care providers. Additional cuts could further exacerbate the financial pressures and limit patient access to needed post-acute care services.
- **The administration's latest proposal would inappropriately restrict access to inpatient rehabilitation facilities.** Such proposals overlook clear distinctions between SNF and IRF patients and services, as recently documented by CMS*. In addition, IRF case mix has increased and the number of IRF patients has dropped by 140,000 cases annually since 2004. Additionally, restrictions on patients' eligibility for IRFs is unwarranted and could lead to inappropriate care settings for patients. Medicare payments to IRFs in recent years have been flat and IRF Medicare margins have declined each year since 2003. These policies would significantly harm not only IRFs and their patients, but also strain the post-acute continuum of care.

Continued on reverse



■ **Instead of new arbitrary, across-the-board cuts to post-acute care (PAC), Congress should allow the ACA provisions that reform the delivery of post-acute services to be implemented.** The ACA included several provisions – PAC quality reporting and value-based purchasing, accountable care organizations and bundling – intended to improve care coordination and heighten accountability for post-acute care and other providers. As a result, proposals are already underway to develop thoughtful and targeted changes to move care delivery away from our current silos to a more integrated care model. It is a complex undertaking to ensure patients have access to medically necessary post-acute care while also implementing more efficient ways of delivering and paying for this care.

■ **There are other ways to generate savings from post-acute care other than piling on arbitrary and across-the-board cuts.** These include passage of S.1486, the LTCH Improvement Act of 2011, which implements criteria to clarify a distinct role for LTCHs and generates overall savings for Medicare.

*CMS's SNF PPS Final Rule for FY 2012, Published May 2011 in the *Federal Register*.