American Hospital Association®

Post-acute Care Providers

Background

Many patients receiving care in the inpatient hospital setting require specialized follow-up care by a post-acute care provider. Post-acute care covers a wide range of services that facilitate continued recovery with a focus on restoring medical and functional capacity to enable the patient to return to the community and preventing further medical deterioration. Post-acute care settings include long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and home health agencies.

AHA View

The AHA supports enhanced coordination between general acute-care hospitals and post-acute providers to improve overall quality of care and reduce total health spending. We continue to urge policymakers to protect access to medically necessary post-acute services and recognize the important role of post-acute care.

Long-term Care Hospitals (LTCHs). Following several years of strong advocacy by the AHA, new LTCH patient admission criteria were authorized by the Bipartisan Budget Act of 2013. These new criteria will bring substantial change to the LTCH field when implementation begins in October 2015, including lower site-neutral payments for approximately half of the current LTCH patient population. The new criteria will be phased in over a two-year period. While these new admissions standards are more stringent than what the AHA proposed and will present a challenge to the field, overall they bring clarity to the role of LTCHs relative to other hospitals and post-acute providers, provide LTCHs with a bridge to future delivery system reforms and, importantly, these standards are far less severe than the LTCH criteria that were under development by the Centers for Medicare & Medicaid Services (CMS). In addition, the AHA is pleased that the Bipartisan Budget Act also provides substantial 25% Rule relief for cost reporting periods beginning October 2013 through September 2017. The AHA and our member LTCHs have now pivoted to the analysis and planning needed to prepare for implementation of the new criteria. In addition, Congress passed a number of further changes to the LTCH provisions. In 2014, the AHA will engage in outreach to Congress and the regulatory agencies about adjustments to the criteria, which are needed to make the new guidelines more balanced.

Inpatient Rehabilitation Facilities (IRFs). IRFs provide a distinct clinical value to Medicare beneficiaries who need both intensive rehabilitation and hospital-level care. The uniqueness of IRFs is ensured by several policies, including the IRF 60% Rule and stringent Medicare patient criteria that restrict IRF admissions to patients requiring hospital-level care including physician oversight. These policies have led to relatively stable Medicare IRF payments and a dramatic drop in overall volume of IRF cases. In fact, 122,000 fewer cases were treated in IRFs in 2011 than 2004. IRFs produce more positive clinical outcomes than other post-acute settings, such as higher rates of discharge to the community. IRFs continue to be targeted for savings through proposals such as site-neutral payment for IRFs and 60% Rule change. Thus, the AHA continues to oppose any proposals to raise the 60% Rule threshold or to pay skilled-nursing rates for hospital-level

IRF care. Access to IRF services must be ensured for beneficiaries who clinically require hospital-level care *and* intensive rehabilitation, such as brain injury, spinal cord injury and stroke patients.

Post-acute Bundle. The AHA supports bundled payment, including a post-acute bundle, but much work is needed to ensure that bundling is workable for patients and providers. A combination of AHA's general acute-care hospital and post-acute members are currently engaged in testing bundling approaches through initiatives with Medicare and private payers. In 2014, the AHA will host an educational series on potential partnerships between general acute-care hospitals and post-acute providers.

Post-acute Care Quality Measurement. Quality reporting efforts for post-acute providers have greatly expanded in recent years. Congressional committees are currently working on legislation to address a number of issues related to post-acute quality and resource measures and assessment data. In addition to the previously existing quality reporting programs for nursing homes and home health providers, the Affordable Care Act mandated quality reporting for LTCHs and IRFs beginning in October 2012. In general, the AHA believes that rigorous, transparent measure reporting efforts are critically important to improving the quality, safety and value of post-acute care.

To ensure the long-term credibility of such efforts, the AHA will continue to urge CMS to select only post-acute quality measures that are specified, tested, and endorsed by the National Quality Forum (NQF) for the care setting (e.g., LTCHs, IRFs) in which they will be used. Selecting such measures provides assurance that a measure can be feasibly collected by providers, and that the measure results accurately reflect provider performance. To date, unfortunately, CMS has included measures in post-acute quality reporting programs that do not meet these standards. For instance, CMS finalized a measure assessing the proportion of patients experiencing one or more major falls with injury for the LTCH Quality Reporting (LTCHQR) program. Reducing patient falls is a critically important goal; however, the measure in the LTCHQR is specified, tested and endorsed by the NQF for use in nursing homes, not LTCHs. The practice of developing measures for one care setting and applying them to another *without* adequate specification and testing compromises the accuracy and credibility of results, making it difficult to determine whether improvements are being realized.

The AHA believes that post-acute providers are critically important to reducing hospital readmissions. And we have weighed in as CMS has added readmission measures to the quality reporting programs for LTCHs, home health agencies, and IRFs, with reporting beginning during calendar year 2014. Our primary concern is that the readmission measures finalized for CMS's post-acute reporting programs have not yet been NQF-endorsed, and as a result, the field has limited

information about their validity, reliability and usefulness in reducing unnecessary readmissions. Moreover, these measures lack adequate risk adjustment to ensure that providers do not score poorly because of factors beyond their control, such as severity of illness, or community factors that compromise access to needed support resources. As the AHA has urged, CMS intends to submit readmission measures as part of an upcoming NQF endorsement review committee on readmission measures. The AHA will carefully monitor this project and advocate that CMS use only those readmission measures that successfully attain NQF endorsement to help ensure that measurement efforts are carefully structured to help, and not hinder, collaborations across the entire care continuum to prevent unnecessary hospital readmissions.