History of post-acute care in the U.S.

Anne Deutsch, RN, PhD, CRRN

Clinical Research Scientist, Shirley Ryan Ability Lab's Center for Rehabilitation

Research Associate Professor, Department of Physical Medicine & Rehabilitation, Feinberg School of Medicine

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Anne Deutsch, PhD, RN, CRRN
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Shirley Ryan Abilitylab

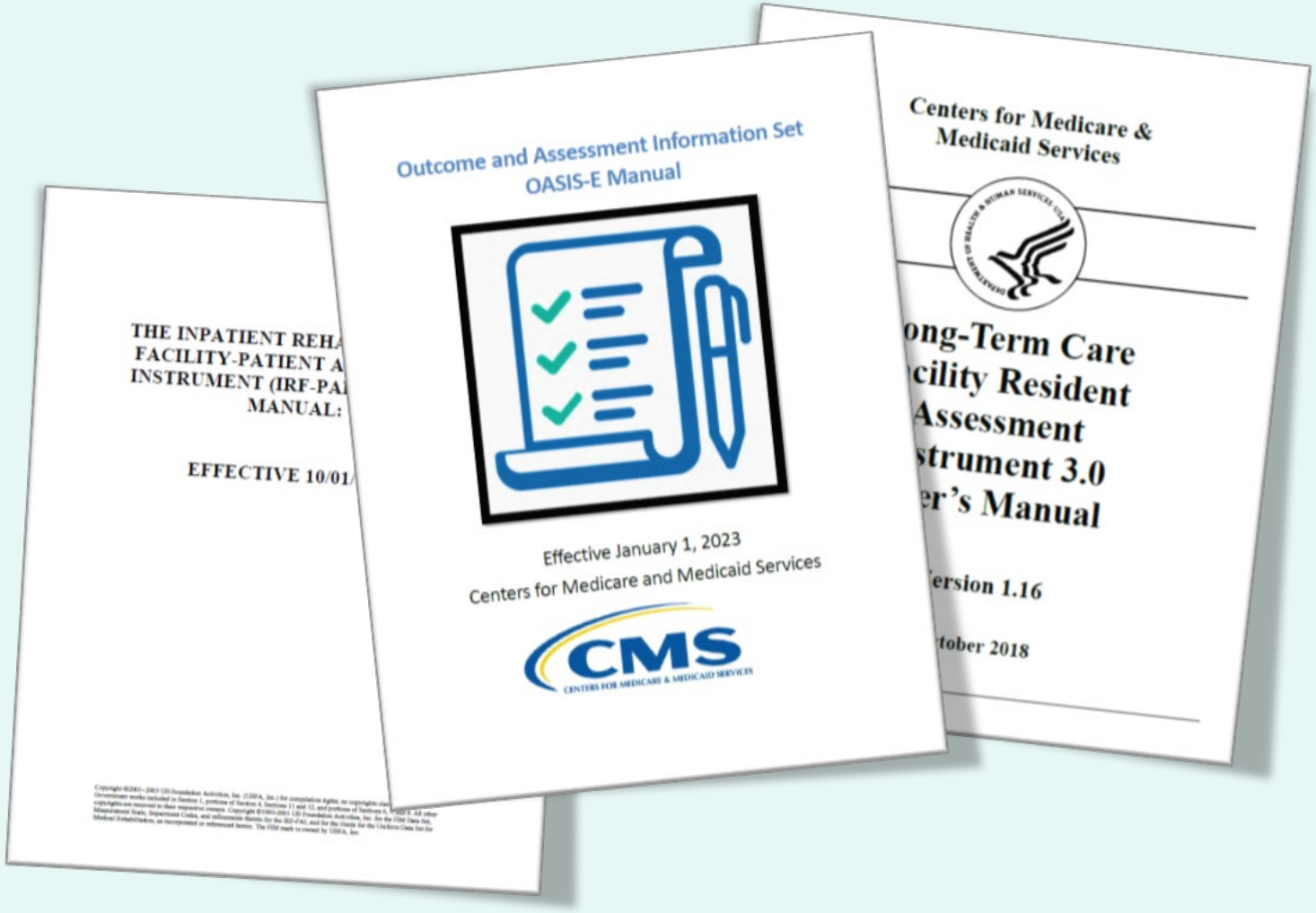
NORTHWESTERN UNIVERSITY FEINBERG SCHOOL OF MEDICINE

Post-Acute Care in the U.S.

- Type of Post-Acute Care Providers :
  - Inpatient Rehabilitation Facilities (IRFs)
  - Skilled Nursing Facilities (SNFs)
  - Home Health Agencies (HHAs)
  - Long-Term Care Hospitals (LTCHs)

- By the early 1990s, care in post-acute settings had become the fastest growing area of the Medicare program

Post Acute Care Patient Assessment Instruments



- IRF: Inpatient Rehabilitation Facility Patient Assessment Instrument
- HHA: Outcome and Assessment Information Set (OASIS)
- SNF: Minimum Data Set 3.0

Post Acute Care	Year Prospective Payment System Began	Original Payment Unit	Payment Incentives
Skilled Nursing Facilities	1998	per diem	reduce daily costs; reduce access to patients who may have high daily costs
Home Health Agencies	2000	60-day episode	reduce episode costs (e.g., fewer or shorter visits)
Inpatient Rehabilitation Facilities	2002	per discharge	reduce stay-level costs (e.g., reduce length of stay); reduced access to patients who may have high stay costs
Long-Term Care Hospitals	2002	per discharge	reduce stay-level costs

Questions From Policymakers

- Who receives post-acute care?
- What factors are associated with receipt of care in the different post-acute care settings?
- What are the costs of care in the different post-acute care settings?
- Do short-term and longer-term patient outcomes vary across post-acute care settings?

Post-Acute Care Utilization

Utilization of post acute care is associated with:

- Patient factors: diagnosis, functional status, living arrangement, age
- Market (facility) factors: geographic region, supply and ownership of facilities and, managed care penetration
  - An uneven distribution of each type of post-acute care provider meant that some patients with similar characteristics were treated in different types of post-acute care settings with different costs and payments

Testimony: June 16, 2005

Setting	Length of Stay	Medicare Payment (2003 rates)
Inpatient Rehabilitation Facility	14 days	$10,829
Skilled Nursing Facility	14 days	$4,447 to $6,353
Long-Term Care Hospital	14 days	$17,671
Home Health	60-day episode*	$5,165

Source: Statement of Herb Kuhn, Director, Center for Medicare Management, Centers for Medicare & Medicaid Services. Testimony Before the Subcommittee on Health of the House Committee on Ways and Means, June 16, 2005


MARCH 1999
REPORT TO THE CONGRESS:
Medicare Payment Policy
MEDPAC
CHAPTER 6
Prospective payment for post-acute care: current issues and long-term agenda
U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy
ASPE
SUBSTITUTABILITY ACROSS INSTITUTIONAL POST-ACUTE CARE SETTINGS:
1998-2006
September 2009

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- Required post-acute care providers to report standardized patient assessment data, data on quality measures, and data on resource use
- Required the data to be interoperable across post-acute care and other providers
- Required the modification of post-acute care assessment instruments… to enable assessment data comparison across all such providers

A Lesson Learned from the 60% Rule…

- The "IRF 60% rule" is a Medicare regulation that states that at least 60% of a facility's inpatient population at an IRF must have one of 13 specified medical conditions (e.g., TBI) that require intensive rehabilitation therapy to be classified as an IRF and receive the associated Medicare payment

- After enforcement of the "IRF 60% rule“, some IRFs that did not specialize in the care of patients with TBI and SCI began admitted patients with these conditions

Medicare Payment Advisory Commission: Post-Acute Care Competencies

- All PAC providers would have to comply with a common (tier 1) set of requirements essential competencies to treat any beneficiary
- Providers opting to treat patients with specialized care needs—such as patients who require ventilator support or complex wound care—would need to meet additional requirements (tier 2) that spell out the competencies and specialized services required to treat the specific population

Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2016, Medicare Payment Advisory Commission 2023

Caring for Specialized Populations

- Providers who treat multiple specialized patient populations would be required to meet the requirements for each group
  - Similar to licensing by service line
- Requirements and staff competencies would ideally be based on evidence-informed guidelines:
  - Clinical guidelines for stroke patients developed by the American Stroke Association and the American Heart Association (Winstein et al. 2016). Any PAC provider that met the guidelines would be approved to treat stroke patients.
  - The Canadian spinal cord injury guidelines are evidence-based recommendations for care (Praxis Spinal Cord Institute, 2021).

Concerns About Feasibility

- Shifting to skill-based competencies and requirements that are specific to the types of patients a provider treats would be a substantial change from existing regulations that are defined by setting
- A common set of regulations for institutional providers and a modified set for home health agencies may raise requirements and costs for some providers.
- Developing and implementing them would likely take years

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Archives of Physical Medicine and Rehabilitation

journal homepage: www.archives-pmr.org

Archives of Physical Medicine and Rehabilitation 2020;101:1072-89

ACRM ENDORSED POSITION STATEMENT

Check for updates

Minimum Competency Recommendations for Programs That Provide Rehabilitation Services for Persons With Disorders of Consciousness: A Position Statement of the American Congress of Rehabilitation Medicine and the National Institute on Disability, Independent Living and Rehabilitation Research Traumatic Brain Injury Model Systems

Joseph T. Giacino, PhD,[a] John Whyte, MD, PhD,[b] Risa Nakase-Richardson, PhD,[c] Douglas I. Katz, MD,[d,e] David B. Arciniegas, MD,[f] Sonja Blum, MD, PhD,[g] Kristin Day, PT, PhD,[h] Brian D. Greenwald, MD,[i] Flora M. Hammond, MD,[j] Theresa Bender Pape, DrPH, MA, CCC-SLP,[k,l] Amy Rosenbaum, PhD,[m,n] Ronald T. Seel, PhD,[o] Alan Weintraub, MD,[p,q] Stuart Yablon, MD,[r] Ross D. Zafonte, DO,[s] Nathan Zasler, MD[t,u]