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Statement

of the

American Hospital Association

for the

Committee on Ways and Means

Subcommittee on Health

of the

U.S. House of Representatives

"After the Hospital: Ensuring Access to Quality Post-Acute Care"

March 11, 2025

On behalf of our nearly 5,000 member hospitals and health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and our 2,425 post-acute care members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record to the Ways and Means Subcommittee on Health on the value of post-acute care and how Congress can better support patients' access to these critical services.

GENERAL POLICY & REGULATORY CHALLENGES

Post-acute care is provided to patients who have been discharged from an acute-care hospital but still require services such as close medical supervision, nursing care, therapies and other support. Long-term care hospitals (LTCHs) act as a pressure relief valve for high-acuity patients needing extended hospital stays, thereby easing the burden on intensive care units (ICUs). Inpatient rehabilitation facilities (IRFs) assist patients recovering from life-changing illnesses like brain injuries, spinal cord injuries and amputations. Skilled nursing facilities (SNFs) offer rehabilitation therapy services

aimed at strengthening patients and making them more independent before they return home. Home health agencies (HHs) enable seniors to remain independent by providing medical or non-medical care in their homes. Each of these facilities plays a crucial role across the continuum of care.

While each specific post-acute sector faces unique challenges, there are several policy and regulatory issues that are universal.

Medicare Advantage

Medicare Advantage (MA) plans are an increasingly popular choice for older Americans, and measures must be taken to ensure that patients who require post-acute care services are able to access them in a timely manner. Perhaps the biggest challenge facing post-acute care providers and their patients is the ongoing restrictions that MA plans place on access to care. The issue has been well documented by providers as well as by Department of Health and Human Services Office of Inspector General and congressional investigations.[1,2] The prior authorization process used by MA plans places significant administrative burden on both acute-care hospitals and post-acute care providers. Perhaps more importantly, it is directly harmful to Medicare beneficiaries — at best delaying their care and at worst outright denying medically necessary treatment.

MA plans' practices have directly contributed to the growing discharge delay problems plaguing acute-care hospitals. While all beneficiaries have faced these delays, the increase in length of stay for MA beneficiaries seeking post-acute care has increased twice as much compared to Traditional Medicare beneficiaries. Specifically, the average length of stay (ALOS) prior to discharge to post-acute care settings has grown by 11.3% for MA patients between 2019 and 2024. However, for patients in Traditional Medicare, the ALOS has grown by only 5.2%, according to industry benchmark data from Strata Decision Technology, LLC.

Despite steps taken by the Centers for Medicare & Medicaid Services (CMS) in recent years, providers have seen little to no meaningful change in MA plan behavior and no increased access for beneficiaries. Additionally, post-acute care providers still face challenges with MA plans listing them within their networks. CMS should conduct regular audits to ensure that MA plans include robust post-acute care options with sufficient bed spaces and resources to provide the in-network care that patients need. As MA enrollment continues to grow, it is imperative that Congress continue to rein in these harmful practices to ensure that beneficiaries are not denied the care to which they are entitled.

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[1] HHS, Office of Inspector General (OIG); Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (April 2022) (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf).

[2] https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf.

Ongoing Workforce Challenges

The U.S. health care system is facing unprecedented workforce shortages, with the Bureau of Labor Statics estimating there will be 193,100 openings for nurses in each of the next 10 years.[3] For physicians, there could be a shortage of between 37,800 and 124,000 physicians by 2034 for both primary and specialty care.[4] Since mid-2020, post-acute care providers have seen a significant number of patient care technicians, registered nurses, and respiratory therapists, among other vital professionals, shifting employment to other organizations. Some post-acute care providers in rural areas have experienced significant challenges in filling open positions, sometimes going months without receiving an application for open registered nurses, licensed practical nurses, certified nursing assistants or key leadership roles. Staffing challenges jeopardize the ability of seniors to access the care they need and deserve.

To ensure residents and families have access to high-quality care close to home, meaningful, long-term solutions and investments in workforce development must replace stop-gap measures, reimbursement cuts and punitive regulations. The AHA encourages Congress to pass the Conrad State 30 and Physician Access Reauthorization Act (S.709/H.R.1585) and the Healthcare Workforce Resilience Act, as well as support visa recapture initiatives and continue support for the Health Resources and Services Administration's (HRSA) health professions and nursing workforce development programs.

SECTOR SPECIFIC COMMENTS

Long-Term Care Hospitals

LTCHs play a unique role for Medicare and other beneficiaries by caring for the most severely ill patients who require extended hospitalization. LTCHs offer an intensive, hospital-level of care that may not be available in other post-acute care settings. LTCH patients are typically very medically complex, with multiple organ failures, and stay in LTCHs on average for at least 25 days. Many LTCH patients depend on ventilators due to respiratory failure or similar ailments, which require highly specialized care and extended stays. In addition, LTCHs are critical partners for acute-care hospitals, alleviating capacity for overburdened ICUs and other parts of the care continuum that would otherwise be further strained without access to LTCHs for these patients.

In 2016, Congress put in place a dual-rate payment system under the LTCH prospective payment system (PPS) for Traditional Medicare beneficiaries.[5] This fundamental change in the payment system and other coinciding market factors dramatically reshaped the landscape of both LTCHs and the beneficiaries they serve. Since implementation of the dual-rate payment system, the volume of standard LTCH cases has fallen by approximately 70% from its peak under the legacy payment system and

[3] https://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-6"
[4] https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage
[5] Bipartisan Budget Act Of 2013 (P.L. 113–67).

the number of LTCH providers also has decreased by 20%. At the same time, the average acuity of LTCH patients has risen by 20% or more in that same period, and these patients are increasingly consolidated into a limited number of Diagnosis-Related Groups (DRGs).[6] In addition, approximately one-third of all Medicare LTCH discharges nationally are paid the inpatient PPS-equivalent rate. However, these reimbursements fall well short of the cost of care. AHA's analysis shows that as of fiscal year 2020 reimbursement for these cases totaled only 46% of the cost of care.[7] Finally, the growth of MA has further shrunk the patient population for LTCHs as MA plans routinely inappropriately deny access to LTCHs.

The smaller, sicker patient population and dwindling reimbursement has created many challenges for LTCHs, as evidenced by the closure of so many of these facilities. The remaining patient pool is notably more acute and costly to treat, resulting in cases increasingly qualifying for high-cost outlier (HCO) payments to compensate for lack of precision in the DRGs as so many cases are consolidated into a limited number of DRGs. In 2016, the fixed-loss amount (FLA) for HCO cases, which is the amount of financial loss an LTCH must incur before qualifying for an HCO payment, was $16,423. Since that time, the FLA has risen by more than 300% to $77,048. This unsustainable figure puts LTCHs in the untenable position of having to lose tens of thousands of dollars in order to care for some of the sickest patients. Unfortunately, CMS has been unable to deviate from its current methodology to provide relief from this policy due to a congressional mandate to cap total outlier payments at 8% of total payments.[8]

The AHA appreciates this Subcommittee's awareness of the need to provide relief to the LTCH sector and supports efforts to provide additional flexibility and funding for HCO cases, and additional flexibility to provide care for different types of patients through the standard payment system.

Inpatient Rehabilitation Facilities

IRF patients are typically admitted directly from an acute-care hospital following a serious accident or illness such as stroke, brain injury, amputation or others that have resulted in serious functional deficits and medical complications. IRFs provide hospital-level care, which means they are closely supervised by a physician who also oversees patients' overall rehabilitation. The intensive course of rehabilitation provided in IRFs must include a minimum of 15 hours per week of intensive therapy services involving multiple therapy disciplines, as well as around-the-clock specialized nursing care. This level of care is critical for debilitated patients who are stable enough to be discharged from the acute-care hospital to begin intensive rehabilitation but are at risk for medical complications without continued close medical management.

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[6] https://www.aha.org/white-papers/2023-12-29-white-paper-medicares-ltch-outlier-policy-needs-reforms-protect-extremely-ill-beneficiaries

[7] https://www.aha.org/system/files/media/file/2019/06/aha-cms-long-term-care-proposed-rule-fy2020-6-21-2019_0.pdf

[8] Section 15009(b) of the 21ST Century Cures Act added section 1886(m)(7) to the Act.

The AHA continues to hear from IRFs regarding their concerns with CMS' IRF Review Choice Demonstration (RCD). CMS initially created the IRF RCD to "assist in developing improved procedures for the identification, investigation, and prosecution of potential Medicare fraud." However, the agency never provided credible evidence to support its belief that there may be high rates of fraud in the IRF field — it only cited its improper payment rate for IRFs, which, as it knows, is not the same as fraud. Since being operationalized by the Biden administration in 2023, CMS has not subsequently provided any evidence that the IRF RCD has revealed or assisted in uncovering any fraud. Specifically, the demonstration currently subjects 100% of IRF claims to review in both Alabama and Pennsylvania. Yet, according to CMS' most recent data collected during fiscal year 2024, approximately 90% of all claims reviewed have been approved. Of those, more than 95% were approved on the initial submission. Despite this high affirmation rate and lack of evidence of any fraud, CMS says it still plans to continue its expansion of the demonstration to more than half of all states and territories, subjecting hundreds of thousands of IRF claims annually to the burdensome manual medical review process. It has become clear that this demonstration is burdensome, diverts valuable clinical resources, and is not achieving its stated objective of uncovering or preventing fraud in the Medicare program.

Therefore, the continued need for the IRF RCD remains highly dubious, and the AHA continues to encourage CMS and Congress to end this program.

Skilled Nursing Facilities

SNFs play another critical role for many hospitalized patients who need continued care after discharge. However, hospitals have faced increasing difficulty discharging patients to post-acute care settings, including SNFs. This challenge has largely been due to staffing shortages and the associated reduced capacity of SNFs and other providers. These shortfalls then place additional burden back on hospitals, including the need for hospitals to board patients until a discharge location can be found. Therefore, it is vital for the entire continuum of care, including for acute-care hospitals, that SNFs are properly resourced.

The AHA and its members are committed to safe staffing to ensure high-quality, patient-centered care in all health care settings, including long-term care (LTC) facilities. Yet, the process of safely staffing any health care facility is about much more than achieving an arbitrary number set by regulation. It requires clinical judgment and flexibility to account for patient needs, facility characteristics, and the expertise and experience of the care team. The Biden administration's one-size-fits-all minimum staffing rule for LTC facilities creates more problems than it solves and could jeopardize access to all types of care across the continuum, especially in rural and underserved communities that may not have the workforce levels to support these requirements.

The AHA supports the Protecting America's Seniors Access to Care Act (H.R. 1683) to prohibit the Department of Health and Human Services from implementing the provisions of the minimum staffing rule. We have recommended to CMS specific

alternative strategies that take more patient- and workforce-centered approaches to ensuring LTC facilities have a strong foundation of policies and processes to continually assess, reassess and adjust their staffing levels. These strategies constitute starting points for further standards development, which we would encourage CMS to engage in with the assistance of patients and the entire health care continuum. Not only would these proposed alternatives support more timely and effective action by LTC facilities to address staffing challenges, but they also would be more consistent with modern clinical practice. Thus, repealing the Biden-era mandate would both protect patient access to care and allow for the development of more effective and clinically appropriate strategies to improve LTC patient outcomes.

Home Health Agencies

Approximately one in five hospitalized Medicare beneficiaries are discharged to HH.[9] These services alleviate pressure on hospitals, other post-acute care sites and caregivers, who would otherwise be responsible for these patients. HH agencies also can prevent rehospitalization by safely providing needed interventions at home thus avoiding potential complications and accidents.

Over the last few years, the AHA has seen a strain on HH operations — along with other post-acute care providers — due to financial challenges, creating ripple effects throughout the continuum of care. Hospitals have seen the length of stay for patients being discharged to HH increase as they face increasing difficulty finding placements for these patients.[10] This has been due in large part to the reductions in reimbursement to HH providers put in place by CMS since its implementation of the new Medicare fee-for-service payment system in 2020. CMS determined it must permanently cut HH payments from between 4% to 8% annually in order to meet statutory budget neutrality requirements. In addition, CMS has indicated that it intends to recoup billions more in temporary reductions in the coming years. These payment reductions, paired with staffing shortages, and other administrative burdens and costs will continue to have serious implications for access to services for Medicare beneficiaries. The AHA is thankful for the Committee's ongoing support of home health agencies.

CONCLUSION

Thank you for your leadership on these important issues and for the opportunity to provide comments. We look forward to continuing to work with you to address these important topics on behalf of our patients and communities.

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[9] MedPAC; July 2024 Data Book; Section 8, Pg. 107 (https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_Sec8_SEC.pdf).

[10] https://www.aha.org/lettercomment/2024-08-26-aha-comments-calendar-year-2025-home-health-prospective-payment-system-proposed-rule