Finally: CMS to Address Allowing Hospitals More Say in Selecting Post Acute Care Providers

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At their October 10, 2014, meeting, members of the Medicare Payment Advisory Commission (MedPAC) finally recommended to CMS that the issue of patient steering by hospitals be addressed.

The crux of the issue is that a condition of participation for providers who want to be part of the Medicare program is "providing patient choice," essentially prohibiting hospitals and physicians from "steering patients" to specific post acute care providers. Since the Affordable Care Act (ACA) passed in 2010, however, this has become a major dilemma for hospitals because many of the financial incentives and penalties for hospitals and accountable care organizations (ACOs) have a direct correlation to the quality of care provided to the patient *after* discharge from the hospital.

During the fee-for-service era, which I refer to as the "fee-for-service free-for-all," hospitals were required to provide a complete list of all local skilled nursing facilities (SNFs) to patients in need of post acute care. Hospitals are also required to have a complete list available of "all home health providers who submit a request to the hospital to be included."

This led to many hospitals having the unwieldy amount of more than 200 home health providers in their "complete list." It also led to rampant Medicare fraud in the home health sector in many regions of the country. Further, these rules are completely unresponsive to the patient's needs and the hospital's ability to ensure quality post acute care—let alone the hospital's ability to communicate with the post acute provider. The problem, the issue at hand, is that these rules remain in place today.

ACOs and Bundle programs have more freedom in selecting post acute providers, and managed care organizations have operated post acute "narrow networks" for many years. Due to the Medicare Condition of Participation for hospitals, however, hospitals have been hesitant to move in this direction for fear of retribution or financial penalty.

"Post acute [care] providers should take the committee's latest discussion to heart," blogged Heather Boyd, LeadingAge director of long term care finance and policy, in regard to the discussion. "Providers should focus on improving their quality measures and forging strong relationships with hospitals." MedPAC committee members suggested that soft-steering is already taking place in hospitals that have narrowed their list of SNFs to 2 or 3, as opposed to including all 8 to 10 in the immediate area, as they previously did. Hospitals across the country have been narrowing their networks by forming Care Transitions programs and other formal relationships that function as a work-around for these antiquated anti-steering regulations.

2015 National Readmission Prevention Collaborative Conference Dates	
National Readmissions Summit Las Vegas	January 15-16, 2015
San Diego Readmissions Summit	February 5, 2015
Arizona Readmissions Summit	February 12, 2015
National Readmissions Summit Florida (Tampa)	March 13, 2015
Colorado Readmissions Summit	April 1-2, 2015
So Cal Readmissions Summit 2015	April 16, 2015
National Readmissions Summit Kansas City	May 13, 2015
Florida Readmissions Summit (Miami/FTL)	May 28, 2015
National Readmissions Summit New York	June 11, 2015
National Readmissions Summit Minneapolis	July 2015 (TBD)
Northern California Readmissions Summit	September 10, 2015
National Readmissions Summit Philadelphia	September 22, 2015
Northwest Readmissions Summit Seattle	October 1, 2015
So Cal Readmissions Update Summit 2015	October 22, 2015

"Some of the most common questions we get on the National Readmission Prevention Collaborative (NRPC) website and at our events are related to narrowing the post acute [care] network, including 'How do you narrow the network?' and "What criteria should be used to select post acute [care] providers?" said Corri Holm, event director for the NRPC, located online at www.NationalReadmissionPrevention.com. The NRPC is featuring presentations and expert panels focused on the topic of narrowing the post acute network at each of its 13 events nationwide in 2015, with speakers including Eric Coleman, MD, MPH, of the Care Transitions program; Diwen Chen of Dignity Health; Upinder Singh, MD, from Kindred Healthcare; and Medicare Spending per Beneficiary expert Chuck Bongiovanni, MSW, MBA. (The event dates are listed below.)

The new Medicare Spending per Beneficiary measurement, the latest ACA program that launched as part of the Hospital Value-Based Purchasing program effective October 1, 2014, is one that holds hospitals accountable for the quality of the care its patients receive from post acute care providers. The quality of care delivered by post acute care providers is also an important factor in the ACA's hospital readmission penalty program, now in year 4. Post acute care providers in many markets have been keeping their fingers crossed, hoping anti-steering regulations would remain, as these rules led to a vibrant financial era in the SNF sector and particularly in the home health sector. However, it is looking more likely that hospitals and health systems will venture back into owning system-operated home health agencies.

Buyer beware, however: almost every hospital struggles to prioritize the system-owned home health agency as part of the continuum. The seasoned hospital executive remains focused on driving inpatient volume and margin, and, for the most part, struggles to embrace the fact that the central focus of managing a patient in a post ACA model must be a setting outside the hospital's own walls.

While inpatient revenue remains the gold standard for reimbursement, increasing capabilities in wellness and home-based care will actually ensure market share growth and that the patients who are ultimately admitted to the hospital truly need acute care. Further, this level of care coordination greatly increases the likelihood that the hospital will be reimbursed appropriately for the care and not questioned through unnecessary and tedious documentation audits.

Narrowing of the network will be just one more challenge for Long Term Acute Care Hospitals (LTACHs) and Inpatient (Acute) Rehab Facilities (IRFs), which are starting to feel the impact of the post ACA model as they experience diminishing referrals and shorter length of stay for those admitted. Due to the Medicare Spending per Beneficiary measure and other incentives, particularly in states converting dual eligibles into managed care, higher-cost post acute care providers such as LTACHs and IRFs will continue to be tightly squeezed out of the networks. Hospitals will start to leave them off the narrow network list and rely much more heavily on SNFs and home health to provide this level of service while controlling costs. This is true even when LTACHs and IRFs are included in the bundle, as they are the least cost-efficient options.

While CMS has not officially addressed the topic of narrowing the post acute care network to date, and it is not required to address MedPAC's recommendations, hospitals are hopeful that these anti-steering regulations are loosened to reflect the changes and mandates already imposed on hospitals by the ACA—and more importantly, that are in the best interests of the patient.

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