Today, patients often require a diverse array of services to treat major health episodes, manage chronic disease and pursue independent, healthy living. While many patients receive care in the physician's office or inpatient hospital settings, a variety of other settings are available to patients who need certain specialized follow-up care, also known as post-acute care services. Research suggests that patients who receive post-acute care following a major health episode see greater and more rapid clinical improvements compared to patients discharged to their homes without follow-up.

The American Hospital Association (AHA) believes that coordination between acute-care hospitals and post-acute care providers is essential to improving overall quality of care and reducing health spending. Outlined below are just some of the ways the AHA works on behalf of post-acute care providers to fulfill this vision.

Working for Post-acute Care Providers

Outdated regulations, duplicative or conflicting rules, unworkable timelines – all of these – increase the burden on all providers, including post-acute providers, and draw much-needed resources away from patient care. Time and again, AHA demonstrated the need for streamlined regulations, common sense rules and manageable timelines, as outlined below.

- **Patient Protection and Affordable Care Act (ACA) Implementation:** AHA and other national hospital groups urged the Supreme Court in June 2012 to rule the ACA's individual mandate and Medicaid expansion constitutional. Although the court struck down the penalty for a state declining to expand its Medicaid program, states that do participate in the Medicaid expansion will receive the federal financial supports included in the ACA. AHA will continue to follow the development of state exchanges – especially if states include and reimburse inpatient rehabilitation and long-term care hospital (LTCH) levels of care.

- **Fair Medicare Practices:** Recovery audit contractors (RACs) and a host of others have been enlisted by the Centers for Medicare & Medicaid Services (CMS) to help detect and correct billing errors and abuses. No one questions the need for auditors to identify billing mistakes, but hospitals continued to be frustrated with inaccuracies and payment denials, and overwhelmed by the significant overlap and duplication of efforts among the contractors. AHA, along with four health systems, recently filed a federal lawsuit challenging HHS's refusal to reimburse hospitals for reasonable and necessary care that RACs later decide could have been provided in an outpatient setting. Sens. Mark Pryor (D-AR) and Roy Blunt (R-MO) and Reps. Sam Graves (R-MO) and Adam Schiff (D-CA) introduced the *Medicare Audit Improvement Act of 2013*, AHA-supported legislation that would make much needed improvements to the RACs and other Medicare audit programs.

- **2013 Payment Rates:** Urged CMS to provide positive payment updates in 2013; as a result, LTCH payments increased a net 1.7%.

- **Medicare Physician Payment:** Worked with Congress to prevent a 27.4% cut to Medicare physician payments in calendar year 2012.

- **LTCH 25% Rule:** Successfully urged CMS to delay full implementation of the "25% Rule" for one year for cost reports beginning between Oct. 1, 2012 and Oct. 1, 2013. LTCHs with cost reports beginning between July 1 and Sept. 20, 2012 no longer have to wait until next year for relief from full implementation of the 25% Rule.

- **Rehabilitation and Respiratory Care Services:** Successfully urged CMS to rescind interpretive guidance pertaining to rehabilitation and respiratory care services under the hospital Conditions of Participation (CoPs), issuing revised guidance that allows non-privileged practitioners to order outpatient rehabilitation and respiratory care services in accordance with state license/scope of practice and written hospital policy.

- **Inpatient Rehabilitation Facility (IRF) Local Coverage Determination (LCD):** Convinced a Medicare Administrative Contractor to rescind a draft LCD that would have prohibited payment in IRF hospitals/units for patients with certain lower extremity joint replacements.

- **Proposed Documentation and Coding Cut:** Convinced the CMS to rescind a proposed new 0.8% cut to inpatient prospective payment system (PPS) payments to permanently eliminate what the agency claimed was the effect of documentation and coding changes from fiscal year 2010.

- **Improving Health Care Quality:** IRF data collection began Oct. 1, 2012 on two quality measures (CAUTI and new or worsening pressure ulcers). AHA's concern that the measures be endorsed by National Quality Forum for the IRF and other settings was met. (This is the position for all quality measures and includes post-acute care and inpatient PPS hospitals.)

- **ICD-10 Delay:** Successfully urged CMS to delay the deadline for implementing ICD-10 diagnosis and procedure codes to Oct. 1, 2014. CMS also delayed enforcement of the new Version 5010 and D.0 transaction standards for electronic health care claims.

- **Stage 2 Meaningful Use:** Secured a delay in the start of the Stage 2 meaningful use requirements under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs until FY 2014 and a shorter reporting period in FY 2014 to ensure a safe and orderly transition from Stage 1 to Stage 2.

- **Collaboration with National Organizations:** AHA works closely with many other national organizations to drive positive change in federal policies and improve post-acute care across the continuum including major post-acute trade organizations and accrediting groups (i.e., American Medical Rehabilitation Providers Association, American Academy of Physician Medicine and Rehabilitation, CARF International, The Joint Commission, Leading Age and the National Home Care Organization).

- **Preparing the Next Generation of Health Care Providers:** AHA worked with Congress as it approved legislation extending the J-1 visa waiver program, which allows foreign-born physicians to remain in the U.S. for three years after medical school to serve in medically underserved areas.

Engaging Post-acute Leaders

Post-acute care leaders have a strong voice in the AHA. They help shape key advocacy activities, policy positions and member services of particular interest to post-acute care providers through their active involvement in many forums.

- **A Role in Governance and Policy-Making:** The AHA offers long-term care, rehabilitation and post-acute care leaders many opportunities to take an active role in shaping AHA policies and setting the direction for the association. They can play a formal role in association governance and policy formation by serving on the AHA's Board of Trustees, Regional Policy Boards, Governing Councils and committees. In addition, the association creates short-term advisory and work groups where members weigh in on more focused, time-sensitive policy issues.

- **AHA Section for Long-Term Care and Rehabilitation:** The AHA Section for Long-Term Care and Rehabilitation currently has more than 2,100 members from across the country and comprises executives from general and freestanding specialty hospitals that provide acute and post-acute care services. The section provides forums linking members with shared interests and missions to advise AHA on policy and advocacy activities and to discuss issues of great importance to acute and post-acute care providers and the field as a whole. These efforts are led by the Long-Term Care and Rehabilitation Governing Council, which meets at least three times a year. Valuable opportunities are also provided for executives to interact and network with one another through special member conference calls and meetings.

- **Advocacy Alliances:** The AHA's Advocacy Alliances provide members with another way to engage legislators on the specific issue or issues that have a direct impact on their ability to continue providing quality health care services in their communities. The **Advocacy Alliance for Coordinated Care** focuses on ensuring payment rates remain fair and equitable in the hospital outpatient setting for evaluation and management and other services and for post-acute care providers.

- **Member Outreach:** Several times throughout the year, AHA's hospital member CEOs are individually contacted by AHA staff and/or are invited to participate in small group conference calls to discuss key AHA initiatives. During the calls members contribute their perspectives and often receive additional tools and resources to address key challenges shared during the discussions.

Providing Key Resources for Post-acute Care Providers

Membership in the AHA means more than representation on critical regulatory and legislative issues. The AHA offers post-acute care providers the tools and resources to navigate today's changing landscape of health care delivery and to support the efforts to improve quality of care for the communities served.

- **Best Practices that Improve Health Care Quality and Outcomes:** AHA serves as a conduit for health care providers to share best practices that accelerate performance improvement and support delivery system transformation through the AHA's Health Research & Educational Trust's Hospitals in Pursuit of Excellence (HPOE) initiative. In addition, best practices and research developed by award-winning and innovative post-acute care providers were presented and discussed during Member Dialogues hosted by the Section for Long-Term Care and Rehabilitation. A few of the topics featured in 2012 included Post-Acute Care Network Re-Design, Making Palliative Care a Strategic Priority for the Health System and Community Health Needs Assessment Informs Health Care System's Post-Acute Transition.

- **Moving Toward Bundled Payment:** AHA published a January 2013 issue brief, "Moving Toward Bundled Payment," which outlines the growing interest from payers and providers in developing and testing this model. Whether or not providers pursue this model, there is much to learn from examining data for a range of care coordination initiatives including medical homes, readmission reduction programs and accountable care organizations. In addition, the data can support an enhanced understanding of performance under the Medicare spending per beneficiary measure in the value-based purchasing system.

- **Workforce Roles in a Redesigned Primary Care Model:** AHA's January 2013 report, "Workforce Roles in a Redesigned Primary Care Model," examined how to define workforce roles for a new primary care environment and develop a new, more effective model of primary care delivery that encompasses the birth to end-of-life continuum. The recommendations took into account a variety of facility resources, including those related to finances and staffing, that must be considered if the redesign is to be successful.

- **Impact of Increasing Medicare Patient Acuity on Payment Policies:** AHA's December 2012 TrendWatch report, "Are Medicare Patients Getting Sicker," suggested that policymakers carefully consider the trends of increasing acuity in the Medicare population as changes are made to payment policy.

- **Maximizing the Value of Post-acute Care:** AHA's 2010 TrendWatch, "Maximizing the Value of Post-acute Care," describes the wide array of specialized services delivered by post-acute care providers following treatment in a general acute-care hospital. The report highlights that in addition to offering these essential services to their patients, post-acute care providers can serve as important partners – both for acute-care hospitals and for one another – in improving quality and reducing costs over an episode of care.

- **Palliative Care:** An HPOE report provided hospital and health system leaders with the knowledge and resources necessary to understand the benefits and opportunities of providing high-quality palliative care services and included examples already in play from health care systems across the country.

- **Caring for Dual Eligible and Vulnerable Populations:** In 2011, the AHA Committee on Research examined emerging hospital-centered practices for effective care coordination for vulnerable populations, focusing on the critical "dual eligible" population – individuals eligible for both Medicare and Medicaid. The committee's resulting report, "Caring for Vulnerable Populations," provided case examples from hospitals and health care systems across the country.

- **AHA Resource Center:** Highly trained information specialists assist members in accessing timely and relevant health services articles and data.

- **Advocacy Action Center:** This Web-based kit provides a set of resources and materials tailored to help hospital executives effectively communicate key messages. The kit will help executives explain concerns to legislators, the hospital family and the community at large. These resources can also be accessed through AHA's mobile app, available for both Apple and Android-based devices.