American Hospital Association

The Value of AHA Membership for Long-term and Post-acute Care Providers

Many patients receiving care in the inpatient hospital setting require specialized follow-up care known as post-acute care. 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 prevention of further medical deterioration. Post-acute care settings include long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health agencies. AHA supports enhanced coordination between general acute-care hospitals and post-acute providers to improve overall quality of care and reduce total health spending.

Outlined below are some of the ways AHA is:
- *Working on behalf of post-acute care providers;*
- *Engaging post-acute care providers; and*
- *Providing key resources.*

Working for Post-acute Care Providers

Examples of how AHA is working for post-acute care providers are outlined below.

- **Opposed Cuts to Post-acute Care Payment.** AHA opposed payment reductions in the president's fiscal year (FY) 2017 budget, as well as in proposals from the Medicare Payment Advisory Commission (MedPAC) and Centers for Medicare & Medicaid Services (CMS) that would threaten patient access to post-acute care services. AHA stressed, in repeated communications to Congress and the administration, the importance of adequate payment for this growing post-acute care segment and weighed in with recommendations on bundled payment models for post-acute care.

- **Monitoring Unified Payment System for Post-acute Care.** As reported in AHA News in March 2016, MedPAC discussed its pending report to Congress on a prototype payment system that could replace the current payment systems for home health, SNF, IRF and LTCH services. AHA is monitoring the prototype, and CMS could be charged with using it to develop a new, unified payment system for post-acute care that would be presented to Congress for consideration in 2023.

- **Made Recommendations for the Medicare Post-acute Care Transformation (IMPACT) Act of 2014.** The IMPACT Act expands the reporting requirements for post-acute care providers. Specifically, it requires LTCHs, IRFs, SNFs and home health agencies to report standardized patient assessment data, in addition to quality and resource measures. The initial round of these new requirements are currently being phased in by CMS through its rulemaking for 2016, with subsequent rounds to follow in upcoming years. In addition, MedPAC has launched its effort to develop an IMPACT Act-mandated combined payment system prototype that would be used for all post-acute settings, which is intended to replace the current, distinct prospective payment systems for home health, SNF, IRF and LTCH providers. AHA has weighed in on CMS's rulemaking on new IMPACT Act-mandated reporting requirements and has engaged with MedPAC on its work on the new payment system prototype.

- **Influenced LTCH Final Rule for FY 2016.** In October 2015, CMS began to roll out a new, two-tiered payment system for LTCHs under the mandate of the Bipartisan Budget Act of 2013. In its final LTCH PPS rule for FY 2016, CMS implemented this dual-rate structure which, when fully phased in, will pay approximately 50 percent of the current LTCH population at far lower, inpatient PPS rates. This final rule includes many improvements over the agency's initial proposal to add the site-neutral payment component of the LTCH PPS. AHA engaged in extensive data analysis to support ongoing advocacy with CMS to help shape the final rule, and we are pleased the agency incorporated many AHA suggestions. With regard to this transformative LTCH change, AHA will continue to seek and share input proactively with the agency and our LTCH members, with plans to provide a forum for early adopters of site-neutral payment to share their experiences. In our continuing advocacy on behalf of LTCH members, AHA will hold member calls and comment on new proposed rulemaking for LTCH PPS impacting site-neutral payment, standard LTCH PPS rates for higher-acuity cases and quality reporting.

- **Urged CMS for IRF Payment Changes.** In August 2015, CMS published its FY 2016 final rule for IRF PPS. We were pleased that, as we urged, CMS finalized a positive net update for IRFs and improved its methodology for the new IRF-specific market basket. However, we were deeply disappointed by CMS's decision to finalize functional status measures that are duplicative of data IRFs already collect, and which may create confusion and unnecessary provider burden. AHA urged the agency to delay implementation of the new measures and find a less burdensome approach to fulfill IMPACT Act requirements. AHA will advocate to convince lawmakers of the value of inpatient rehabilitation in relation to the high cost of the setting in light of the overall episode of care.

- **Helped Improve the Comprehensive Care for Joint Replacement Bundled Payment Program.** AHA's fall 2015 comment letter supported hospitals serving as episode initiators in CMS's proposed new payment model that would bundle payment to acute care hospitals for hip and knee replacement surgery from the date of surgery through 90 days post-discharge. AHA urged and received a delay in the start date until April 1, 2016. In additional to incorporating a risk-adjustment methodology, AHA urged CMS to consider ways to allow for efficiencies that are achieved in the IRF setting to actually be reflected in their payments. AHA hosted a special call for post-acute provider members on this topic and is monitoring implementation impacts on hospitals.

- **Supported Strategic Approach for Quality Measurement Efforts.** AHA has strongly advocated for an aligned, strategic approach to national quality measurement and pay-for-performance programs and believes such an approach is critical to the long-term success and sustainability of health care quality improvement efforts. This approach would identify a small number of critically important priority areas across care settings, along with a small number of reliable measures that assess each provider's contribution towards the overall priorities. AHA has actively participated in efforts to convene stakeholders and provide input to HHS on priorities, goals and measures, including on post-acute care quality reporting programs (QRPs). In particular, AHA urged CMS to implement the quality reporting requirements of the IMPACT Act in a way that minimizes unnecessary duplication of data reporting. AHA hosts periodic member calls for all post-acute members on proposed changes.

- **Commented on Proposed Rule Revising Discharge Planning Requirements.** CMS in November 2015 issued a proposed rule that would revise discharge planning requirements for hospitals (including LTCHs, IRFs and psychiatric hospitals), critical access hospitals (CAHs) and home health agencies that participate in the Medicare and Medicaid programs. The rule also would implement discharge-related provisions of the IMPACT Act of 2014. While AHA appreciates the overall intent of the IMPACT legislation – to promote a consistent, data-driven approach to quality improvement and post-acute care payment reform – we are concerned about the resources needed to implement the law. AHA hosted member calls on proposed rule in preparation of our comment letter.

- **Drove Delay of CMS Release of Star Ratings.** Due to significant concerns raised by AHA and others about whether the hospital quality star rating methodology provides a fair, accurate and meaningful representation of hospital performance, CMS delayed until at least July 2016 the release of overall hospital quality "star ratings" on its Hospital Compare website. AHA will continue to work with CMS to refine its methodology.

- **"Two-midnight" Refinements.** In an effort to revise policies with burdensome regulations that divert time and resources away from patient care, AHA has helped persuade CMS to finalize several positive changes to its two-midnight policy. In addition, AHA successfully challenged through the courts CMS's interpretation of its 0.2 percent payment reduction for inpatient services, convincing the agency to restore the resources that hospitals are lawfully due. CMS's recent IPPS proposed rule for FY 2017 proposes two adjustments to reverse the effects of the cut it unlawfully instituted when implementing the policy in FY 2014.

- **Educating Stakeholders on Insurer Consolidation.** AHA is working to ensure that the proposed acquisitions involving four of the five major national insurers receive the highest level of scrutiny. AHA has provided analysis to the Department of Justice and testified before Congress numerous times, introducing into the record concrete reasoning why the acquisitions would decrease competition and hurt the marketplace, in addition to working to educate the media and public on the potential consequences for patients and providers.

- **Commented on SNF PPS Final Rule for FY 2016.** In addition to finalizing a payment update for FY 2016, the regulation finalized a SNF QRP requirement, an all-cause readmission measure for the SNF Value-based Purchasing (VBP) Program that will begin in FY 2019. While relatively brief and straightforward, for hospital-based providers that face significant negative Medicare margins, the payment update continues to be inadequate and SNF QRP requirement entails significant resources to implement. AHA commented on this and especially the newly adopted functional status measure which is duplicative of data SNFs already collect. AHA will continue to urge CMS to incorporate sociodemographic adjustment into the SNF VBP readmission measures.

- **Responded to Home Health PPS Update, VBP Model and Quality Reporting Requirements.** Authorized by the Affordable Care Act (ACA), CMS published its CY 2016 proposed rule for the home health PPS. AHA commented to CMS on the rule suggesting to withdraw the 3.41 percent coding cut citing lack of analyses supporting case-mix change in light of the prominent role in alternative models of care and payment that home health is expected to assume and which would threaten participation in these important initiatives. In addition, AHA urged a limit on the maximum payment adjustment and reduction in number of measures to focus on high-priority issues for improvement. AHA will monitor and comment as appropriate on new developments and proposals for HH prior authorization, VBP and payment.

- **Collaborating with National Organizations.** AHA maintains dialogues with other related national organizations to lay the foundation for aligned positions on behalf of post-acute care providers across the continuum of care.

A comprehensive list of AHA's work can be found at www.aha.org/value.

Engaging Post-acute Care Leaders

Post-acute care leaders have a strong voice in AHA as they help shape key advocacy activities, policy positions and member services.

- **A Role in Governance and Policy-making.** AHA offers long-term care, inpatient rehabilitation and other post-acute care leaders many opportunities to take an active role in shaping AHA policies and influencing the direction for the association. They can play a formal role in association governance and policy formation by serving on AHA's Board of Trustees, Regional Policy Boards, Governing Councils and committees. In addition, short-term advisory and work groups are an excellent opportunity to weigh in on focused, time-sensitive policy issues.
- **AHA Constituency Section for Long-Term Care and Rehabilitation.** The AHA Constituency Section for Long-Term Care and Rehabilitation 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.
- **Post-acute Care Systems Executive Roundtable.** A small group of health care system members with a majority ownership of post-acute care services are invited to meet with AHA's executive team throughout the year to provide their guidance on broad legislative and policy issues related to the continuum of care with a focus on post-acute care.
- **Advocacy Alliances.** 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.

Providing Key Resources for Post-acute Care Providers

AHA offers post-acute care providers myriad tools and resources to support their efforts to improve care for the individuals and communities served.

- **Medicare's Bundled Payment Initiatives: Consideration for Providers.** This 2016 AHA Issue Brief describes the evolution of bundling within the Medicare program, the opportunities bundling creates for hospitals and post-acute care providers, the challenges providers have encountered in recent initiatives, and issues providers should consider when participating in a bundled payment program.
- ***Care and Payment Models to Achieve the Triple Aim.*** This 2016 report, produced by AHA's Committee on Research and Committee on Performance Improvement, identified seven key principles for creating a care delivery system and reviewed new payment models as the health care field moves to a value-based care system.
- **The Role of Post-acute Care in New Care Delivery Models.** The AHA *TrendWatch* series is a periodic publication that reports on the latest trends affecting hospitals and the health care system and informs the policy-making process. The December 2015 edition was designed to provide guidance to post-acute providers and their partners as they evaluate new models of care delivery and payment. The addendum provides additional background on post-acute care.
- **Sharing Best Practices to Improve Performance Improvement.** AHA serves as a conduit for health care providers to share best practices that accelerate performance improvement through interactive member-led conference calls hosted by the Section for Long-Term Care and Rehabilitation. Discussions have been held on topics such as post-acute care network redesign, medical homes, ACOs, bundled payment and palliative care.
- **Equity of Care.** Addressing disparities is essential for performance excellence and improved community health. AHA issued goals and milestones from the National Call to Action, launched in 2011 to end health care disparities and promote diversity, and encourages hospitals to take the #123forEquity Pledge to eliminate health care disparities. For more, visit *www.equityofcare.org*.
- **Telling the Hospital Story.** In national news and traditional and social media, in print and on television and radio, AHA advocates for hospitals and health care systems. AHA also equips health care system executives with tools and strategies to help respond to media inquiries on difficult and challenging issues. Sign up to follow AHA on Twitter, YouTube and Facebook. AHA launched a digital campaign to help patients and consumers better understand the evolving role of the nation's hospitals. The *www.AdvancingHealthinAmerica.org* website features a video and other resources showing how hospitals are creating partnerships and programs that reach beyond their walls to improve community health and access to care.
- **Cybersecurity Resources.** AHA offers cybersecurity resources for hospitals, including cybersecurity alerts, links to tools to assist with risk assessment and gap analysis, and connections to opportunities for information sharing. For more, visit *www.aha.org/cybersecurity*.

- **Telehealth Resource.** AHA offers a web resource with comprehensive information on telehealth. The site includes information on federal and state telehealth initiatives, research documenting telehealth value, AHA-member case studies showing telehealth in action and AHA *TrendWatch* reports on telehealth benefits to patients. For more, visit *www.aha.org/telehealth*.
- **Reducing Infections in LTC Facilities.** AHA's Health Research & Educational Trust was awarded a contract by the Agency for Healthcare Research and Quality to reduce catheter-associated urinary tract infections (CAUTI) and other health care-associated infections in long-term care facilities. The project seeks to implement the Comprehensive Unit-based Safety Program (CUSP) in nursing homes and skilled nursing homes nationwide.
- **Eliminating CAUTI.** A guide for AHA's Hospitals in Pursuit of Excellence outlines a three-step action plan to CAUTIs and other key lessons from the national On the CUSP Stop CAUTI project.
- **AHA Resource Center.** Highly trained information specialists assist members in accessing timely and relevant health services articles and data.