American Hospital Association

The Value of Membership in the American Hospital Association

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, inpatient rehabilitation facilities, skilled nursing facilities and home health agencies.

The American Hospital Association (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 works on behalf of post-acute care providers to fulfill this vision.

Related Resources

- AHA Advocacy Alliances
- AHA Section for Long-Term Care and Rehabilitation
- Factsheet for Post-acute Providers
- Post-acute Homepage

Working for Post-acute Care Providers | Engaging Post-acute Care Leaders | Providing Key Resources for Post-acute Care Providers

Working for Post-acute Care Providers

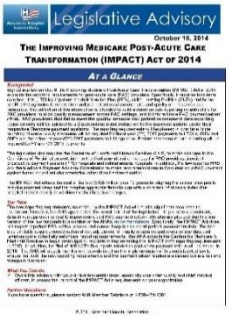
The primary mission of the AHA is to advocate on behalf of the nation's hospitals and health systems on issues that impact their organizations, patients and communities. The AHA ensures that members' perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates, judicial matters and with the media and consumers. Recent examples are highlighted below.

- **Opposed Arbitrary Cuts to Post-acute Care Payment.** AHA opposed arbitrary cuts in the President's fiscal year (FY) 2014 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. Specifically, the AHA voiced concerns with MedPAC proposals regarding site-neutral payments for inpatient rehabilitation facilities (IRFs). AHA urged MedPAC to pursue a "cautious exploration"; use only the most recent data; avoid flagging site-neutral cases solely based on prior general acute-care hospital discharge diagnosis; and refine its approach to targeting appropriate patients. In addition, 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.

- **Urged CMS for Payment Changes for IRFs.** On August 6th CMS published its FY 2016 final rule for IRF Prospective Payment System (PPS). We are 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, AHA is deeply disappointed by CMS's decision to finalize functional status measures that are duplicative of data IRFs already collect, 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.
- **Influenced Long-term Care Hospital (LTCH) Final Rule for FY 2016.** In October, 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.
- **Commented on Comprehensive Care for Joint Replacement (CCJR) Bundled Payment Program.** AHA's September 8th 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 recommended that CMS provide necessary tools and balance risks and rewards and suggested that waivers of applicable fraud and abuse laws that inhibit care coordination and necessary financial relationships are needed. AHA urged a delay in the start date until July 1, 2016, and that it be restricted to *elective* hip and knee replacement episodes only. 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 member call for post-acute members on this topic. The final rule for this program is anticipated by December 2015.
- **Made Recommendations for the Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.** The IMPACT Act of 2014 expands the reporting requirements for post-acute care providers. Specifically, it requires LTCHs, IRFs, skilled nursing

facilities (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.


Legislative Advisory

October 16, 2014

THE IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION (IMPACT) ACT OF 2014

AT A GLANCE

- **Supported Strategic Approach for Quality Measurement Efforts.** The 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. 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 hosted member calls for all post-acute members on these proposed changes.
- **Commented on SNF PPS Final Rule for FY 2016.** In addition to finalizing a payment update for FY 2016, the regulation finalized a SNF quality reporting program (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, Value-based Purchasing 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% 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.
- **Advocated for Significant Changes to the Recovery Audit Contractor Program.** H.R. 2156, the *Medicare Audit Improvement Act of 2015* would make significant,

fundamental changes to the Recovery Audit Contractor (RAC) program. The legislation would:
- Eliminate the contingency fee structure
- Reduce payments to RACs that are inaccurate in their audit determinations and have high appeals overturn rates
- Fix the CMS' unfair rebilling rules
- Require RACs to make their inpatient claims decisions using the same information the physician had when treating the patient

AHA is also supporting an updated legislative campaign to bring RAC audit relief to hospitals and post-acute providers.

- **Sponsored Briefing on Adjusting Readmissions Penalties for Socioeconomic Factors.** AHA sponsored a briefing Capitol Hill where hospital leaders called for changes in Medicare's Hospital Readmissions Reduction Program. The panelists urged Congress to support the Establishing Beneficiary Equity in the Hospital Readmission Program Act, S. 688/H.R. 1343. This AHA-supported bill would require CMS account for patient socioeconomic status when making risk adjustments to the readmissions penalties.
- **Collaborated 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.
- **Guided the Work of The Coalition to Protect America's Health Care.** The Coalition is a recognized leader in digital advocacy, forming through social media and online ads a grassroots army of more than one million individuals who communicate directly to Congress about the harm cuts in hospital payments could have on patient care.
- **Provided Resources Via the Advocacy Action Center.** This web-based kit provides a set of resources and materials tailored to help hospital executives effectively communicate key messages and explain concerns to legislators, the hospital family and the community at large.

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. 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.** 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 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.

- **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

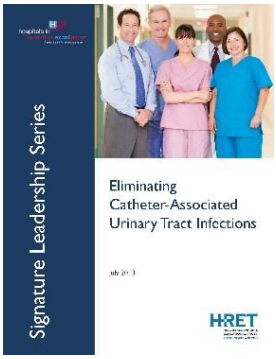
partners as they evaluate new models of care delivery and payment. The addendum provides additional background on post-acute care.

- **Improving Transitions to Post Acute Care.** The AHA January 2015 Report, *A Sample of Private-Sector Hospital Discharge Tools*, found at, http://www.aha.org/content/15/15dischargetools.pdf, provides case studies of hospital discharge planning tools that strive to improve transitions to post-acute care and reduce readmissions.
- **Sharing Best Practices to Improve Performance Improvement.** The 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.
- **Communicating with the Media.** In national news and traditional and social media, in print and on television and radio, the AHA advocates for hospitals and health care systems. The 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 the 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 website, www.AdvancingHealthinAmerica.org, 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.

- **Facilitating Access to Cybersecurity Resources.** The AHA is working with the FBI to share important cybersecurity intelligence. The FBI has asked the AHA to share specific documents with members through a secure communications channel. The members-only page, that also offers resources for CEOs and trustees on cybersecurity leadership roles and risk and gap analysis, can be accessed at www.aha.org/cybersecurity.
- **Supporting Physician and Hospital Collaboration.** The AHA's Physician Leadership Forum (PLF), http://www.aha.org/about/org/plf.shtml, is a way for physicians and hospitals to advance excellence in patient care. Because 25% of all doctors are now employed by hospitals and health care systems, and better communication with physicians is critical to improving health and health care in communities, the PLF works closely with the medical community to identify best practices to deliver value-based care.
- **Preparing for Future Health Care Markets.** *Your Hospital's Path to the Second Curve: Integration and Transformation*, http://www.aha.org/content/14/your_hospitals_path_second_curve.pdf, AHA's Committee on Research 2014 report, outlines must-do strategies, organizational capabilities to master and 10 strategic questions that every organization should answer to prepare for the future. *Workforce Roles in a Redesigned Primary Care Model* examines 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. *Developing an Effective Health Care Workforce Planning*

Model and a companion Assessment Tool helps organizations develop effective workforce planning models, and support excellent patient care.

- **Transitioning to Population Health.** *The Second Curve of Population Health*, found at http://www.hpoe.org/resources/hpoehretaha-guides/1600 , builds upon prior HPOE reports that outline a road map for hospitals and care systems to use as they transition to the second curve of population health. The tactics described in this guide provide a framework for initiatives that hospitals and care systems could pursue to develop an institutional infrastructure that supports population health.
- **Understanding Value-based Care and Payment.** HRET's June 2014, *Navigating the Gap Between Volume and Value*, is a guide that offers hospital leadership step-by-step advice and information on the financial planning process and how it can help organizations plan for value-based care and payment.
- **Moving Toward Bundled Payment.** AHA's 2013 issue brief, "Moving Toward Bundled Payment," outlines the growing interest from payers and providers in developing and testing 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 allows an enhanced understanding of performance under the Medicare spending per beneficiary measure in the value-based purchasing system.
- **Reducing Infections in LTC Facilities.** The AHA's Health Research & Educational Trust (HRET) 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**. An HPOE guide, HPOE Guide, outlines a three-step action plan to CAUTIs and other key lessons from the national On the CUSP Stop CAUTI project.
- **Improving Patient Safety.** This 2013 guide, *Checklists to Improve Patient Safety*, found at http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf, features checklists for improving patient safety in 10 areas including adverse drug events, CAUTI, injuries from falls and immobility, hospital-acquired pressure ulcers, and surgical site infections.
- **Reducing Health Care Disparities.** The guide *Reducing Health Care Disparities: Collection and Use of Race, Ethnicity and Language (REAL) Data*, provides a four-step approach on how to obtain an accurate REAL data set and discusses how hospitals and care systems can use this data to reduce health care disparities and increase equity of care.
- **AHA Resource Center.** Highly trained information specialists assist members in accessing timely and relevant health services articles and data.