



Questions and Answers for the Continuing Care Hospital (CCH) Concept

050409

1. Is the CCH concept a stand-alone concept or an alternative to bundling?

A. The concept may be viewed separately from the bundling discussion. Yet given the current interest in bundling, it provides an alternative to some of the concepts being discussed such as total acute –post acute bundling by focusing first on the post acute care hospital continuum. It may be accomplished initially via a demonstration program before being expanded to home health, freestanding nursing homes and outpatient facilities.

2. Is the CCH concept part of the overall health care reform debate?

A. The CCH focuses on the post acute rehabilitation and medical continuum under the Medicare program as a way of focusing on patient needs. It maintains a focus on needed medical rehabilitation and other complex medical services for the Medicare population. However it can also be utilized as a concept in the overall health care reform debate. AMRPA believes that any health care reform proposals must recognize the complete continuum of care including rehabilitation. This continuum includes inpatient hospital and unit rehabilitation care (IRH/U), recuperative care (SNF and other long term care), outpatient care (day programs, single therapy services, multiple therapy services) home care, and DME including prosthetics and orthotics. AMRPA has articulated its overall health care reform principles in other documents.

3. What is the entity that is accountable for and accepts the risk?

A. The CCH accepts the risk for the patient’s post acute care (medical and rehabilitation) for the entire CCH stay and 30 days after discharge from the CCH. In return for accepting that economic risk, the CCH has the freedom to place the patient in the specific level of care that is clinically appropriate and best matches the resources available to the patient’s need. This allows improved efficiencies and lower overall operating costs for the CCH.

4. How are care coordination/ transition of care addressed?

A. The CCH would work closely with the acute care hospitals in its market (or other referral sources) to provide as seamless a transition as possible to assure proper placements and prevent unneeded hospital readmissions. In addition the CCH may use the CARE tool (or the next iteration) as an assessment tool for patients. CMS has included the use of the CARE tool in the 9th Scope of Work for the Quality

Improvement Organizations (QIOs) and as the assessment tool for the Care Transition Project announced on April 13.

5. Will the CCH save the Medicare program money?

A. The first goal of any health care delivery system reform should be to assure access to high quality care. We believe that the CCH concept meets that goal. In addition, streamlining transitions between levels of care will save funds and reduce readmissions to acute care. Eliminating unnecessary federal regulations such as the IRF PPS, LTCH PPS and the SNF PPS will accomplish the same goal. It may also require amending the 25% rule for LTCHs, 60% rule for IRFs, one day rule for LTCHs and IRFs, and 3 day and 30 day rule for HSNFs. Other standards focused on clinical care and quality, including outcome and performance measures, would be established.

6. What is the Episode of Care?

A. It is the CCH admission and the next 30 days. Subsequent health care costs after discharge from the CCH resulting from clearly unrelated events or illnesses (for example, a patient discharged to home subsequently experiences burns in a car fire and requires care for a new illness or injury) would be carved out from the CCH's accountability. Hence when the CCH feels the patient is ready to be discharged it would contract with another provider such as a home health agency, FSNF, or outpatient provider for the services and coordinate the discharge and follow up for 30 days.

7. How is payment determined per episode?

A. It would be based on a patient classification system of Continuing Care Hospital Care Groups (CCHCGs). These would be devised from data from the various settings and cover a number of domains. The data could be from the CARE tool or its next iteration and it should also utilize the ICD-10s and ICF nomenclature. The initial patient classification system thus created would be further analyzed with cost reports, claims, Med PAR, and other information to develop weights and a standard payment amount.

8. Are there any adjustments to this one per episode CCHCG payment?

A. Yes, as with current payment systems there will need to be adjustments for geographical differences, and acknowledgement of specific adjustments for the level of care. For example, depending on the structure of the data, there may also be special payment policies such as transfers, outliers etc.

9. How will health information technology be used in the CCH concept?

A. Enhanced coordination of patient care is a key goal of this approach. In order to aid that goal, the CCH will need to utilize electronic medical records, or transition to them, throughout the system, be it real or virtual. These records will also need to be coordinated with the acute hospitals. Ideally, federal economic incentives will be provided to nurture the development of cross-facility electronic health record systems to accelerate the savings and care enhancement potentially available.

10. Will there be any changes to federal regulations and statutes? What about state regulations?

A. We anticipate that several sets of regulations need to be examined and either amended or deleted. These would include those mentioned above such as the separate payment systems for the current entities, exclusion criteria for IRH/Us and LTCHs, medical necessity criteria, etc. State regulations may also need to be amended, however since the CCH would require state licensure as a hospital (of any sort) then the threshold requirement would be met. SNF licensure and HSNF regulations would also likely need to be examined. Virtual CCHs that form may face CON and licensure barriers in some states that will also need to be addressed.

11. If so many statutes and regulations may be changed in the implementation of a real CCH, what will be done to assure that the government is purchasing the kind and quality of care it expects in lieu of the current model of just paying?

A. The creation and availability of outcomes data from the CCH is one of the major benefits of this delivery system change. Information will become available to monitor facility function both medically and also with regard to increased quality of life (QOL). It will measure discharge destination, changes in functional status, mortality, unplanned readmissions to acute care, acquired conditions, etc. The CCHs would be held accountable for these outcomes and payment incentives would need to be considered to recognize them.

12. What type of implementation for the CCH model should be followed?

A. Initial demonstration projects should be created by CMS to study the model. Once demonstrated to be effective, statutory changes would be required, federal rules and regulations should be published and model state law and regulation revision guidance documents should be developed to assist each state to enable this new model of health care delivery.

In addition, no change in payment should be transitioned over so that there is adequate experience and then data to develop baselines for outcomes. At the same time pre-CCH outcomes information for the three entities should be retained to the extent it exists. Incentives payments would include reductions in payment for failure to report certain information and/or reach certain outcomes standards. Incentives payments would also include increases in payment for exceeding certain outcomes standards. The overall objective would be to assure that final payment aligns patients, payers and providers needs.

13. Why are freestanding SNFs excluded from the CCH concept?

A. Freestanding SNFs would be eligible to participate if they met the same standards, requirements, and outcome requirements that all other components of the CCH model would be required to meet, be it real or virtual.

14. What happens if a patient needs home health or FSNF care during the episode of care?

- A. The HHA or FSNF could contract with the CCH to provide the care and those costs would be accounted for in the original design of the CCH payment groups.

15. What would happen to a patient who required home health or was discharged to a freestanding SNF directly from acute care?

- A. The HHA and FSNF would continue to be paid based on the current payment systems, or any alternative system devised such as an acute – HHA–SNF bundle.

16. How would the system account for patients who are transferred back to the acute care hospital? How would the cost of care be addressed?

- A. The demonstration needs to consider several approaches. These include a “transfer rule” that cuts the CCH payment short; an examination of the type of readmission—was it a preventable readmission by virtue of the acute hospital discharging the patient too soon (and the CCH would not have to pay); was it a planned readmission at the time of discharge from the acute hospital? Was it completely unforeseen and the patient had a new medical condition or acute change in the current condition?

17. How will services be paid for after the end of the episode of care? For example patients sometimes require home health care beyond 30 days; a patient may be admitted to and remain in a SNF over 30 days and still be qualified for Medicare?

- A. The demonstration program, in modeling the original episodes, should address the incidence of the length of this type of care post current IRF, LTCH or HSHF care as part of the study. Having done so, it might consider additional payments under the current payment systems (if retained) to the HHAs and the SNFs.