AN OPTION FOR THE FUTURE OF MEDICAL REHABILITATION AND OTHER POST ACUTE CARE HOSPITAL PROVIDERS

The Continuing Care Hospital

050409

Summary

This document sets forth a new approach to delivery system reform and financing of the medical rehabilitation services delivered by today's inpatient rehabilitation hospitals and units (IRH/Us), hospital based skilled nursing facilities (HSNFs) and long term care hospitals (LTCHs) and also proposes an alternative to the current proposals regarding bundling of care that would be examined through a demonstration approach. The American Medical Rehabilitation Providers Association (AMRPA) proposes the creation of a Continuing Care Hospital (CCH) that would organize care around the patient instead of the facility. The model could be implemented in a *real* (all levels in a common building), or *virtual* (all levels operated as a single entity, but in physically disparate settings) manner. The CCH would enhance quality of care by eliminating boundaries among the current hospital-based post acute care providers and implementing common quality standards, outcome measures, and accountabilities. It would result in reduced costs to deliver post acute care and also improve the cost benefit and cost effectiveness of post acute services. AMRPA proposes the development of one or more demonstration projects by CMS to test the model of the CCH.

Introduction

Medical rehabilitation is at a crossroads in its history in the United States. The field was developed in the first third of the 20th Century by visionary physicians who believed that there was more to health care than simply diagnosing and medically treating patients with serious permanent impairments. They believed that such patients could, with appropriate therapy, return to active and productive lives and thus contribute to their family, community, and the economic life of the nation. Over the years, physician-directed hospital-based multidisciplinary teams devoted to the principles of rehabilitation evolved into the field of medical rehabilitation as we know it today.

There are now about 1,160 inpatient rehabilitation hospitals or units (IRH/U) organized specifically to provide medical rehabilitation, as well as over 15,000 skilled nursing facilities (SNFs) and over 400 LTCHs, many of which also provide some level of medical rehabilitation services to inpatients.

Starting in the 1960s, reimbursement for IRH/U care became more widely available with the advent of the Medicare program. In the mid-1980s, medical rehabilitation programs expanded significantly in the wake of Medicare's new inpatient prospective payment system (IPPS) for short-term acute care hospitals. With a fixed payment for each diagnosis-related group (DRG), acute care hospitals were incentivized to shorten their lengths of stay by discharging patients earlier to alternative settings, thus increasing the demand for post-acute care. The supply of post-acute hospitals and other facilities increased accordingly.

With the passage of the Balanced Budget Act of 1997 (BBA '97), Congress sought to arrest this growth by also phasing in a PPS for each post-acute venue starting with home health agencies (HHAs) and SNFs and, later, IRH/Us and LTCHs. BBA'97 had varying degrees of impact on limiting post-acute growth. The number of HHAs declined considerably before increasing again. SNFs and IRH/Us grew more modestly; LTCHs became the fastest growing post-acute segment in the post-BBA'97 era.

With this growth has come confusion about how best to distinguish among the various post-acute facilities and the services they provide. Moreover, there is confusion about what care is clinically necessary, what is effective, what the best practices are, and what value is being received by patients and payers for that care. With increasing pressure on the funding for this care, and the growing numbers of facilities competing to offer these services, it is not surprising that many perceive that the current post acute care market is chaotic, confusing, costly, and less than clinically optimal. Geographically, post-acute facilities are unevenly distributed across the nation with an apparent oversupply in some markets and significant undersupply in others. The new Obama Administration has proposed a number of budget changes that directly impact the providers of medical rehabilitation. At least one of these proposals (bundling) seeks to realign financing and the delivery system.

AMRPA, as an organization representing IRH/Us that first and foremost offer IRH/U care, has been examining alternatives to how the care delivery system is organized and financed for the treatment of persons with serious functional and medical impairments who need comprehensive medical rehabilitation services.

This document describes a new approach to the delivery and financing of the medical rehabilitation services delivered by today's IRH/Us, HSNFs and LTCHs. As part of its deliberations, AMRPA articulated several guiding principles in order to reshape the future of medical rehabilitation. These principles include:

- Any health care delivery system change needs to be patient-centered with a focus on restoring health, enhancing function, and returning patients to their homes, schools, jobs and communities.

- Any change in the delivery or financing of health care services must serve the needs of persons with disabilities and chronic conditions in particular, as well as those with acute health problems.

- Physician direction and oversight are key and essential to medical rehabilitation care delivery.

- Medical rehabilitation service delivery should be organized to optimize serving the needs of patients.

- High quality care should be sought, delivered and fairly reimbursed.

- Providers should be able to receive reasonable returns for delivering high quality care.

- Cost-effective and cost-efficient care should be promoted.

- Care should be provided based on the best available clinical evidence and expert judgment.

- Incentives should encourage facilities to care for more complex and needy patients without fear of adverse consequences.

- Reimbursement and measures of success for providers should be risk-adjusted to promote the care of those with the greatest need.

- Persons with functional loss must have access to medical rehabilitation that is:

  - Expert and based on the best available evidence;

  - Delivered in the medically appropriate setting;

  - Focused on prevention of further medical complications;

  - Intended to optimize function; and

  - Based on goals that are relevant to health, function, activity and participation in society, not just survival.

  - Care should be provided in the least expensive setting that will provide high quality care.

AMRPA has developed a proposed change in the post acute care delivery system structure that it believes would be compatible with these principles, strengthen the delivery system and improve its cost benefit and cost effectiveness in the delivery of post acute services.

Background

Prior to BBA'97, Medicare paid DRG-exempt providers on the basis of costs up to a ceiling (TEFRA), routine costs plus uncapped ancillary services (as in the case of HSNFs) or the lower of cost or charges (as with CORFs). As a result of the multiple PPSs, each provider type gained

further identity, for better or worse. For example, the "non-subsection (d)" hospitals, known as the TEFRA hospitals, are now separately recognized as long-term care hospitals with the long term care hospital prospective payment system (LTCH –PPS); psychiatric facilities with the inpatient psychiatric services PPS (IPS-PPS); rehabilitation hospitals and units became inpatient rehabilitation facilities with the IRF-PPS; skilled nursing facilities had a skilled nursing facility PPS (SNF-PPS); and home health agencies were subject to several reductions in payment before the home health agencies PPS (HH PPS) was implemented. Outpatient rehabilitation providers continue to be paid under the Medicare Part B physician fee schedule. Physical, occupational and speech therapy services that are not hospital-based are also currently subject to the financial limitations of the therapy cap.

In policy circles these payment systems and types of providers are commonly referred to as "silos." In short, the BBA'97 helped to reinforce and harden each silo with its own payment system, patient assessment instrument, and institutional culture. It also made working across silos difficult and costly, especially if a patient needed more than one level of care during the course of his or her recovery.

Currently, each of these entities, or silos, must meet specific conditions of participation, and in some cases, specific additional exclusion criteria, under the Medicare program in order to be reimbursed. All hospitals must meet the hospital conditions of participation and have participation agreements with Medicare. Rehabilitation hospitals and units must also meet specific exclusion criteria in order to further distinguish themselves from acute care hospitals. LTCHs have several specific exclusion criteria they must meet as well such as the 25 day length of stay requirement. Skilled nursing units must address the three day prior hospital stay –and 30 day admission requirement among others.

In addition to conditions of participation criteria, Medicare regulations address coverage criteria for individual patients. In general, Medicare will pay only for services that are deemed reasonable and necessary. Such coverage criteria exist for inpatient rehabilitation hospitals and units (see Medicare Benefit Policy Manual [MBPM] Section 110). There are certain Medicare regulations for SNF and LTCH coverage criteria as well.

The plethora of coverage criteria and definitional standards regarding either the types of patients or processes of care in each of these post acute care venues has raised concerns in policy circles (such as Med PAC) that there are few accepted objective standards or criteria to assign individual patients to specific facility types. The MBPM and HCFA Ruling 85-2 provide certain criteria that are heatedly contested by providers. The American Academy of Physical Medicine and Rehabilitation (AAPM&R) has promulgated medical standards for determining the appropriateness of an IRH/U patient admission, but these are largely based on a consensus of expert opinion, and subject to differences of interpretation.

These factors point to a need to improve the post-acute care delivery system by focusing on patient, not facility, centered care. AMRPA proposes the creation of a Continuing Care Hospital to strengthen the delivery system, focus on patient's clinical needs first and improve its cost benefit and cost effectiveness in the delivery of inpatient post acute services.

Continuing Care Hospital (CCH)

We propose a significant change in the delivery system for post acute care to resolve the problems and issues discussed above: creation of the Continuing Care Hospital (CCH) that would be an amalgam of the care settings currently described as LTCHs, IRH/Us, and HSNFs that are organized, in part, to deliver rehabilitation therapy programs. The CCH would also provide or coordinate home health and outpatient rehabilitation services for those patients who need them after discharge. It would be paid on a per-episode basis. The episode of care recommended is the full period of stay in the CCH (which, obviously, would vary by patient characteristics) plus the first 30 days following discharge. The data analysis mentioned below may lead to a different definition of the episode however.

The CCH could be an actual building (a hospital offering some or all three levels of care) or a virtual entity (an organization that provides under common management the three levels of care in more than one building or unit). A physician would make the admission decision regarding whether a patient should receive care within the CCH and also determine which level of care the patient would need. Payment would be determined by the patient's clinical and functional characteristics and the program resources needed to provide that care. A prospective payment method would be constructed using data currently being collected by the Post Acute Care Payment Reform Demonstration project (PAC- PRD) being conducted by RTI or the next iteration. Providers would be allowed to care for certain types of patients if they demonstrated the ability to provide care, as defined by law and regulation, met specific program standards of care, and demonstrated certain outcomes.

Each CCH could accept patients of the highest level of complexity for which it is licensed by the state as well as any patient whose needs are less complex. Such a system would account for the intensity of services provided, patient complexity and need for care by physicians and nurses and the skill set of those available to treat patients. For example, a patient with both intense continuing medical needs and functional deficits could be served by a CCH provider that met specific standards regarding the provision of intense medical care, rehabilitation services, and follow up care. Payment would be determined prospectively based on both medical and functional resources that were anticipated to be required (as developed from the data now being collected by the PAC-PRD project).

CCHs could operate distinct units that correspond to different levels of care recognized today by Medicare. In such cases, the facility would admit the patient, and the clinical staff would place the patient in the appropriate specific unit or building (which might resemble today's LTCH), and move the patient from setting (to what today looks like an IRH/U) to setting (to what today looks like an HSNF) as clinical needs dictated (all within the single payment). This is similar in principle to how an acute hospital admits a patient to the ER; transfers them to an ICU; moves them to an OR; cares for them in a recovery room; transfers back to an ICU; then to a ward, and finally to discharge. Payment would generally be pre-determined by the CCH predetermined payment (PDP) and an outlier payment methodology to acknowledge extraordinary circumstances and other adjustments would be required.

A. Performance and Quality Measures
Creating and using performance and quality measures would be a key and critical component of this model. The performance measures selected would need to include those currently available such as discharge destination, mortality, presence of co-morbidities on admission, and improvement in medical and functional status. As the ICD-10 coding system becomes adopted, the parallel adoption of the World Health Organization's International Classification of Function (ICF) should also be pursued. This would provide data to monitor the CCH outcomes in the domains of Activity and Participation, as well as disease and disability.

Despite the desirability of using measures of functional improvement as an important assessment factor, there needs to be clear recognition that the current functional measures do not capture some important benefits in the quality of life domain for certain extreme patient conditions, such as severely impaired tetraplegics and brain injured patients, among others. In these types of cases, other measures of benefit will need to be developed and adopted.

Use of performance measures would allow development of incentive payment methods to reward those institutions that constantly achieve better risk-adjusted medical and functional outcomes, which probably require longer lengths of stay. Such performance incentives can be developed in a budget neutral manner. Development of performance measures would be coordinated with those entities that have already been exploring the issue such as CMS, the AAPM&R Clinical Quality Improvement Committee, CARF, the Joint Commission, NQF, IOM, etc.

***B.* Special Care and Other Considerations**
The CCH model is intended to create incentives to treat patients with special care needs and hence, increased cost. Therefore special payment policies would be included and carved out of any payment model such as:

- High cost outliers
- Patients receiving special care such as dialysis and high cost drugs such as chemotherapy, other
- High cost DME

Other cost variations that are not within the providers' control should also be accommodated for in the payment system. They may be a function of governmental (state, local, or federal) requirements or unique system delivery factors and need to be recognized. These may include:

- Wage adjustment
- Teaching adjustment
- Geographic location
- Low income patient load
- Local market conditions
- Local practice patterns

C. Advantages and Disadvantages

1. ***Advantages***

- The CCH would allow for appropriate patient care based on patient characteristics and not on provider type or payment incentives.

- A single post acute care entity has the potential to remove the numerous barriers to access that the current provider requirements and current payment systems create. Hence various disincentives to care could be removed.
- Streamlining care delivery based on patient characteristics would eliminate administrative costs to the payors as well as eliminate costs to providers if the regulations are simplified.
- A single post acute care entity would eliminate the cost of admission and discharge from one post acute setting to another and the need for a separate payment to each post acute setting the patient needs.
- The focus of the system would be on the patient's need for care, and the quality of the care delivered. Care and outcomes would be measured in order to provide disincentives to stinting on care.
- HSNF's, IRH/Us and LTCHs would likely collaborate or merge to form the new CCH entity, simplifying the provider complexity in a community.
- Alliances would emerge among the various providers to create real or virtual CCHs .
- Discharge from acute care hospitals would be simplified by eliminating the confusing array of post-acute care requirements.
- The current Post Acute Care Payment Reform Demonstration (PAC-PRD) project mandated by the Deficit Reduction Act of 2005 would be directly applicable to this type of enterprise, offering a patient assessment tool and possibly a model for payment. From the payer's perspective (primarily Medicare in this instance) once the care entity is paid, the payer is removed from further decision making or expense, except perhaps for monitoring the performance and quality of care given to patients. Theoretically it would save considerable funds now going to administrative expenses for the programs.
- Providers would have a clear picture of the payment for various types of patients, services and period of service, and could structure their care accordingly.
- As a hospital, the CCH could manage all the medical and rehabilitation care for patients through the entire continuum of care and ideally assure overall better outcomes for patients than currently occurs in the non-hospital settings.
- The CCH model is consistent with the conceptual framework of moving toward actual or virtual bundling proposed by the Medicare Payment Advisory Commission (MedPAC) and the Obama Administration's proposal on bundling of care for 30 days subsequent to an acute care hospitalization.
- The model promotes increased continuity of care and smooth transitions.

2. *Disadvantages*

- A CCH runs the risk of diluting or eliminating the distinctions that identify the various types of providers of rehabilitation services, e.g. IRH/Us, SNFs, and LTCHs. All these entities might then be considered inpatient rehabilitation facilities by policy makers in that they all provide some level of rehabilitation services.
- If all IRH/Us, HSNFs and LTCHs are replaced by CCHs, and payment for care in those levels is bundled, patients might not have the ability to choose one provider for an initial level of care and a different provider for a subsequent level of care that is offered by the CCH.
- The final payments may be reduced below the cost of delivering the services in the government's continuing efforts to reduce provider payments.

- State licensing laws and CON constraints might make it difficult to create these new entities.
- Adopting this approach would require time to develop and gain experience with the model through a demonstration project.
- The entity that controls the payment and chooses the providers will have inherent incentives to manage to the dollar and may have less incentive to meet the service needs of the patient, putting access in jeopardy, and promoting competition among facilities on the basis of price rather than service quality or value.
- Current data do not provide adequate information on patients' clinical characteristics and resource use in all post acute settings in order to devise a carefully calibrated payment model, particularly beyond acute care where factors other than medical status are part of the care and cost equation.
- Experience with capitation payment methods popular in the 1990's suggests that managing risk is difficult for entities that do not deliver the care themselves, and care providers will optimize their own primary business needs at the expense of other sectors (hospitals will manage for their benefit first, and shop the patients to the cheapest provider, not the best provider).
- It would be a complex matter to create these standards to assure CCHs can adequately treat different types of patients.
- CCHs would financially be biased against using post-acute providers that they do not own. It is a- choice between marginal cost of using your own facility and the full cost of a non-owned facility.

D. Steps Required to Implement the CCH

1. Data Collection and Data Base Design

Measure all the services received by patients in IRH/Us, HSNFs and LTCHs as well as the following 30 to 60 days, in order to be able to describe attributes such as diagnosis, function on admission, function on discharge, age, co morbidities, LOS, current medical information on admission and discharge, impairments and cost. Also measure discharge destinations, death rates, and readmission rates, status prior to acute care admission, home status, and infection rates. The objective would be to compare medical and functional status among the patients currently being served in various settings. This work, at least conceptually, is part of the focus of the PAC PRD demonstration program currently underway by CMS which is referenced above. Consider collecting the data using the ICD-10 –CM which is to be implemented over the next two years and/or ICF nomenclature.

2. Create Patient Groups

From these data, create new patient groups that would reflect function, age, diagnosis, LOS, age, status prior to onset, outcome expectations, and co morbidities for medical status, at a minimum. The conceptual and methodological approach undertaken by the RAND Corporation in the creation of the Case Mix Groups ultimately used in the Inpatient Rehabilitation Facilities Prospective Payment System (IRF PPS) is a good model to follow. Severity adjustments would be included in the creation of the groups to address the impact of single or multiple co-morbidities in lieu of tiers.

3. ***Create Patient Group Weights***
   Match the new patient groups with cost reports, MedPAC, and the additional data from the Cost Resource Utilization tool used in the PAC PRD to create new Continuing Care Hospital Care Groups (CCHCGs) and develop weights.

   This step should result in a patient characteristic sensitive and expanded list of patient groups correlated with costs for the episode of care discussed below. The expectation is that, for example, some of the patients would require fewer rehabilitation services and fewer medical services (such as some current HSNF patients) with lower weights and that some of the higher intensity patients with higher medical and lower rehabilitation needs may result in higher weights. The goal is to assure that the patient groups are risk adjusted and accurately reflect the cost of service delivery.

4. ***Develop the Payment Unit***
   Base the CCHCGs on a per episode unit of payment using the CCH length of stay and the subsequent 30 days. Patients who exhaust their Medicare days should be tracked separately after they exhaust their care and convert to private pay or Medicaid for one year to establish total costs for that period.

5. ***Calculate the Standard Payment Amount (Sometimes Referred to as Standard Conversion Factor)***
   Calculate and norm the standard payment amount to determine the CCHCG payment per episode.

6. ***Provide for Adjusters and Special Payment Rules***
   Provide for facility adjusters (wages, LIP, rural, others) and special payment rules such as transfers, short stay, interrupted stay and outliers as noted above.

7. ***Include Performance and Quality Measures***
   Tie payment incentives to these measures with an emphasis on providing incentives in terms of increased payment for higher quality care, such as increased functional ability even if it requires a longer length of stay.

8. ***Amend Existing Laws and Regulations***
   Rewrite the definitions of HSNFs, LTCHs, and IRH/us to create a category of provider known as a Continuing Care Hospital. This would require amending the Medicare Act, regulations and adjustment by accreditation organizations, and possibly state certifying agencies and laws.

9. ***Outcomes Based Initiative***
   After initial implementation, revise the payment system to be based on bonuses for better functional outcomes.

10. Estimate Savings

Streamlining the delivery system, eliminating various administrative requirements, such as the 25% rule for LTCHs and the 60% rule for IRH/Us as well as others, would result in savings and as would eliminating admissions and discharges internal to the CCH since there would no longer be a need for separate medical records since the care is consolidated within the CCH**.** Improved coordination of care is likely to reduce preventable readmissions to acute care as well.

11. Coordination of Care

The CCH would work directly with the acute care hospitals to assure seamless and complete coordination care. There would be significantly fewer entities participating in the transition to post acute care, and the administrative burden to acute hospitals would be diminished. These efforts will result in process improvements to ensure proper post discharge follow-up on both sides, as well as lower acute care readmissions.

E. Special Considerations for the Virtual CCH

While some of the considerations for the actual CCH model are similar, there are some that are quite different for the virtual model. The separate entities would remain, e.g. IRFs, HSNFs, and LTCHs. A common ownership or management entity would be identified as the provider. Admission and management of the patient would be through a single point of entry. The provider would continue to be responsible for, and be paid based on, the episode of care and receive full payment based also on the outcomes measures.

F. Issues to Be Addressed

Real and Virtual CCHs would need to be held accountable to the same measures and standards. For both, decisions will need to be made as to what shall be considered as the episode of care. At this time, we propose that the episode would be the CCH stay and the 30 days after discharge from the CCH.

Conclusion

This paper is intended to promote consideration, debate and discussion as to how to resolve the major challenges being faced by the American public, patients and families, providers of medical rehabilitation, LTCH services, HSNF services, the Administration, and the Congress in moving to the next phase in the delivery of inpatient medical rehabilitation and other forms of post acute care.

One thing is clear: maintaining the current system of conflicting incentives, restricted access, quality of care risks, and economic jeopardy for patients and providers is untenable. We must all work towards improvement of the current health care system in a deliberate and visionary manner with the needs of people needing inpatient medical rehabilitation services first in mind.

We propose that the development of one or more demonstration projects by CMS to test the model of the CCH should be developed, funded, studied, and considered as a prudent course of action.

Hopefully, this document will facilitate that action.