<u>Overview of Framework for Post-Acute Reform</u>

The Alliance for Quality Nursing Home Care, American Health Care Association, Acute Long Term Hospital Association, American Medical Rehabilitation Providers Association, Visiting Nurse Associations of America, and National Association for Home Care and Hospice submit this document to provide input to the Senate Finance Committee in developing different approaches to reform the post-acute payment and delivery systems. The framework outlined below reflects loose consensus among the organizations but does not reflect absolute agreement on every detail. It should be noted that many of the organizations have concerns with various individual proposals and that the submission of these ideas does not constitute agreement or support. Rather, they are an array of ideas whose merits must be evaluated by the Senate Finance Committee. In addition, each organization may submit additional information and specific proposals to Congress. Finally, the groups listed above will continue to collaborate with acute, post-acute and other healthcare organizations to solicit feedback and develop consensus and may submit additional information to Congress as the policy process unfolds.

1. **Support Post-Acute Reform**: We support the policy goals of reforming the post-acute payment and delivery systems by improving care coordination, increasing payment efficiencies, reducing unplanned re-hospitalizations, improving quality, and achieving budget savings.

2. **Support Post-Acute Reform Field Tests**: Congress should authorize CMS to expeditiously implement multiple field tests to achieve the goals of post-acute delivery system reform.[1] Multiple approaches are warranted because no single model has been tested at the service delivery level and different approaches may be necessary as part of comprehensive reform due to variation in local healthcare markets' capacity and infrastructure to provide coordinated post-acute care and payment. <u>The following requirements are key to assuring that patient quality, choice and the overall integrity of the models are not compromised.</u>

    A. *Requirements/Prerequisites/Parameters*

    The following elements must be required in any field test:

    (1) A uniform assessment tool is needed to facilitate appropriate patient placement.

    (2) Facility criteria are needed to ensure that post-acute providers have the capacity to meet the needs of patients with different acuity levels.

[1] The organizations submitting this document strongly believe that it is imperative that Congress be required to act before the scope of any field test is expanded. Given the complexity of models under consideration, it is not appropriate to allow the Secretary of Health and Human Services to move forward with a permanent model at his or her discretion without the input of Congress.

(3) A common set of post-acute quality metrics are needed to monitor outcomes and align payments with performance.

(4) Physicians must be included as an integral part of each field test.

(5) Silo-based regulations that inhibit post-acute reform must be waived or mitigated.

(6) Patient choice will have to be addressed in any field test.

(7) Entities in addition to hospitals should be eligible to manage the bundle under any model.

(8) Participation in a field test should be voluntary.

(9) CMS must receive adequate funding to perform multiple field tests. The costs of executing multiple, complex payment system models are likely to be relatively expensive, and Congress must ensure that CMS has the financial stability to properly design and execute selected models.

B. Types of Field Tests

Congress may ultimately draw upon some or all elements of the following models in crafting a post-acute delivery system reform policy.

1) **Site Neutral Payment Option:** Site-neutral post-acute payment would use a uniform patient assessment instrument (e.g., CARE) to establish both the basic elements of payments and the clinical criteria providers must meet to admit post-acute patients for treatment. Payment rates would be based primarily on condition, needs and characteristics of patients regardless of setting, but would be adjusted to take into account variations within condition in patient acuity, resource use, co-morbidities, age and other factors that could maintain certain payment differentials between settings. Patient and facility criteria would be part of the system and independent care coordinators would be responsible, in conjunction with physicians and other providers, for coordinating care across settings throughout an episode of care.

2) **Post-Acute Bundling Option**: This option would create a bundled payment comprised of the post-acute episode of care following an acute hospital discharge. The episode would consist of all post-acute services used following hospital discharge, including LTCH, IRF, SNF (both hospital-based and free-standing), and Home Health services. Physician services should also be included in the bundle. Any

“qualified” entity would be eligible to “coordinate” the bundle, either through direct provision of care or arranging for services. As with other proposals, there would be patient criteria to facilitate appropriate patient placement, facility criteria to ensure that providers have the capability to treat patients with varying degrees of severity, a common set of post-acute quality metrics, and other elements identified in the overview document.

3) **Community-based Bundling Option:** This option would create a “community-based care” bundle for patients assessed as appropriate for home or community-based care following acute hospital discharge. Under this proposal a Home Health Agency or other “qualified entity” would be eligible to coordinate this bundled payment either through direct provision of care or arranging for services. For patients determined not to be eligible for home and community-based care, either the Post-Acute Bundling Option or the Continuing Care Hospital Option would be appropriate.

4) **Continuing Care Hospital Option:** The Continuing Care Hospital (CCH) would be an amalgam of the care settings currently described as LTCHs, IRH/Us, and hospital-based SNFs. 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 most or all of the three levels of care in more than one building or unit). CCHs could operate distinct units or distinct levels of service that correspond to different levels of care recognized by Medicare. A physician would make the admission decision regarding whether a patient should receive care within the CCH and determine which level of care the patient would need. Payment would be determined by the patient’s clinical and functional characteristics and resource use. Care coordination and the use of quality measures are included. The recommended episode of care is the stay in the CCH plus the first 30 days following discharge.

5) **Virtual Bundling Option:** This option could be some form of “virtual” bundling (i.e., episode based pay for performance) of post-acute services, including unplanned hospitalizations and other pay for performance mechanisms.

C. Size: The field tests should be robust enough to evaluate the system-wide impact of various approaches and in the aggregate should include approximately 10% of the current Medicare population, focusing initially on high-volume, high-cost patients.

D. *Timing and Process*

(1) 2009-2010: CMS would convene Technical Advisory Groups to design the various field tests.

(2) 2010-2013: Field tests begin and are evaluated for effectiveness on cost, quality and access grounds, among others;

(3) 2014: Report to Congress and legislation considered to implement post-acute delivery system reform.

(4) Late 2014: Delivery system reform(s) approved by Congress and phase-in begins.

E. *Role of Congress vs. CMS*: Congress should grant HHS the authority to test a variety of approaches for post-acute delivery system reform but HHS should not be given the authority to proceed with full implementation without Congress acting first. Accordingly, Congress must act before HHS expands the field tests beyond their original scope.

Post-Acute Delivery System Reform Options

There are several potential post-acute delivery system reform options that Congress should consider testing, described in more detail in the following pages.

Site Neutral Payment Option: This option was developed by AQNHC and AHCA and would use a uniform patient assessment instrument (e.g., CARE) to establish both the basic elements of payments and the clinical criteria providers must meet to admit post-acute patients for treatment. Payment rates would be based primarily on condition, needs and characteristics of patients regardless of setting, but would be adjusted to take into account variations within condition in patient acuity, resource use, co-morbidities, age and other factors that could maintain certain payment differentials between settings. Patient and facility criteria would be part of the system and independent care coordinators would be responsible, in conjunction with physicians and other providers, for coordinating care across settings throughout an episode of care.

Post-Acute Bundling Option: This option would create a bundled payment comprised of the post-acute episode of care following an acute hospital discharge. The episode would consist of all post-acute services used following hospital discharge, including LTCH, IRF, SNF (both hospital-based and free-standing), and Home Health services. Physician services should also be included in the bundle. Any "qualified" entity (as defined pursuant to criteria) would be eligible to "coordinate" the bundle, either through direct provision of services or arranging for services. As with other proposals, there would be patient criteria to determine appropriate patient placement, facility criteria to ensure that providers have the capability to treat patients with varying degrees of severity, a common set of post-acute quality metrics, and other elements identified in the overview document.

Community-based Bundling Option: This option was developed by NAHC and VNAA and would create two separate post-acute bundles following an acute hospital discharge. For patients determined prior to hospital discharge as appropriate for home or community-based care, a "community-based care bundle" would be created to reflect that episode of care (including any required admissions to "institutional" post-acute providers from the community). Under this proposal a Home Health Agency or other "qualified entity" would be eligible to coordinate this bundled payment either through direct provision of care or arranging for services. For patients determined not to be eligible for home and community-based care, either the Post-Acute Bundling Option or the Continuing Care Hospital Option would be appropriate.

Continuing Care Hospital Option: This option was developed by AMRPA and would be an amalgam of the care settings currently described as LTCHs, IRH/Us, and hospital-based SNFs. 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 most or all of the three levels of care in more than one building or unit). CCHs could operate distinct units or distinct levels of service that correspond to different levels of care recognized by Medicare. A physician would make the admission decision regarding whether a patient should receive care within the CCH and determine which level of care the patient would need. Payment would be determined by the patient's clinical and functional characteristics and resource use. Care

coordination and the use of quality measures are included. The recommended episode of care is the stay in the CCH plus the first 30 days following discharge.

Virtual Bundling Option: This option would create a form of "virtual" bundling (i.e., episode-based pay for performance) of post-acute services, including unplanned hospitalizations and other pay for performance mechanisms. It should be noted that the national organizations perceive that implementation of this concept would be an enormously complex undertaking and there are significant concerns with this approach but we want to be responsive to the Committee staff request for assistance.

DRAFT Explanatory Table of the Senate Finance Committee Questions
June 5, 2009

Site Neutral Payment Option

Background: Site-neutral post-acute payment would use a uniform patient assessment instrument (e.g., CARE) to establish both the basic elements of payments and the clinical criteria providers must meet to admit post-acute patients for treatment. Payment rates would be based primarily of condition, needs and characteristics of patients regardless of setting, but would be adjusted to take into account variations within condition in patient acuity, resource use, comorbidities, age and other factors that could maintain certain payment differentials between settings. Independent care coordinators would be responsible, in conjunction with physicians and other providers, for coordinating care across settings throughout an episode of care.

Committee Question	*Response*	*Items for Consideration*
Participating Entities	1. LTACHs, IRFs, SNFs and HHAs 2. Independent care coordinators 3. Physicians	HHS must establish participation criteria for LTACHs, IRFs, SNFs and HHAs. All patients may not be eligible for placement in every setting (depends on care needs and provider satisfaction of relevant criteria) Independent care coordinators follow patients across settings and are paid separately from anticipated savings Physicians have responsibility for care determinations and management. Test will mandate physician-level reporting to the extent possible, but do not have financial incentives/ disincentives
Payment to Entities	1. LTACHs, IRFs, SNFs and HHAs 2. Care Coordinators	HHS will use CARE to establish placement and consistent payment rates that cross settings for LTACHs, IRFs, SNFs and HHAs. Payment rates for LTACHs, IRFs, SNFs and HHAs based primarily on condition, needs and characteristics of patient regardless of setting; HHS made adjust for variations within conditions in patient acuity, resource use, comorbidities, age and other factors. HHS will set payment rates for care coordinators. HHS will define standards for independence of care

		coordinators.
Timeline	1. HHS establishes Advisory Council within 3 months of enactment 2. HHS begins test within 12 months of enactment 3. Test lasts 3 years. 4. HHS report to Congress due within 6 months following completion of test	
Regulatory Barriers	HHS has authority to waive regulations as needed for test to be completed	Barriers to be considered include the 60% rule, LTACH 25% rule and LOS requirement, the IRH/U 3 hour rule and the SNF 3 day prior hospitalization rule, etc.
Scope	HHS charged with determining sample size and scope so that results are statistically valid and representative of Medicare patients and markets	
Definition of Success	HHS charged to evaluate whether: (1) overall post-acute expenditures were less than otherwise would have been spent; (2) quality of patient outcomes improved; (3) patients were appropriately placed, taking into care needs, costs of care and outcomes; and (4) use of care coordinators effectively improved quality of care and reduced costs	
Episode Defined	Patients who require post-acute care within 30 days following discharge from hospital are eligible. Episode of care based on CARE either before hospital discharge or by independent care coordinator in community if patient already discharged.	30 day framework, while discussed in professional literature, may not be the appropriate cut point. HHS should be charged with investigating this question and including recommendations in its report to Congress.
Quality Overlay/Methods of Evaluation	HHS must create risk-adjusted quality measures to be reported by all participants in test. Measures should be derived from CARE and may include: functional status improvement; rates of readmission; rates of avoidable readmission; rates of return to community.	
Conditions Included	As drafted, site-neutral payment would apply to all post-acute care and treatment	It is possible to limit test to certain conditions. A sensible approach would be to authorize HHS to select a set number of conditions (e.g., 5) based on volume, intensity, cost and readmission rates
Determination of performance on quality measures and spending benchmarks	See “Definition of Success” and “Quality Overlay” above	

Post-Acute Bundling Option: Post-Acute Continuing Care Entity (PACCE)

Post-Acute Continuing Care Entity		
Committee Question	***Response***	***Items for Consideration***
Participating Entities	Long-term care hospitals, Inpatient Rehabilitation Facilities, hospital-based SNFs, Free-Standing SNFs, Home Health Agencies PACCE would be authorized to provide or coordinate all post-acute services.	This can be "real" or "virtual" and should include physicians. Broad, voluntary demonstration approach. Further discussion is needed regarding inclusion of physicians to include in the bundle and the PAC physicians? Acute physicians?
Payment To Entities	CMS would pay the PACCE	CMS may adjust payments for incentives after base rates are established.
Episode Defined	The Institutional PAC stay plus 30 days post discharge from the Institutional PAC.	Highly complex, involved patients may require care beyond the defined episode of care. Hence, an issue is treatment of services/payments beyond the episode, which raises the question of continuing the FFS-PPSs or creating an "outlier" pool. Beneficiary cost sharing is another issue to be addressed.
Quality overlay/ Methods of evaluation	Quality measures, both process and outcome, would be developed through coordination with entities involved in measurement development in the PAC space including CMS, AAPMR Clinical Quality Improvement Committee, CARF, the Joint Commission, stakeholders, and NQF. Measures would relate to patient function, quality of life, extreme conditions, and other factors. Payment incentives could be based on quality measures. The demo should evaluate any impact on patient choice and indirect behavioral changes by providers, which may affect access to care. An Independent Evaluator (not GAO) should	Quality measures may also be used for other payment initiatives such as pay for reporting and pay for performance. Outliers and risk corridors need to be included to assure incentives to serve the most complex patients are retained.

	assess the results of the demonstration. A Post Acute Care Reform Technical Advisory Council (PACRTAC) composed of professionals, associations, and consumers will be established to review the demonstration and make recommendations as to broader implementation.	
Conditions included	All conditions treated in IRFs, LTCHs, SNFs and HHAs would be included or the demo can focus on the high volume and high cost conditions that account for 50% of PAC spending in these settings.	
Determination of performance on quality measures	Benchmarks could be based on quality measures, after a baseline is established.	
Timeline	• Use year 1 (12 months) to start to develop quality measures and to develop the scope of work for the demonstration project • During that first year, the agency could recruit contractors and participants. • Then there would be 2-3 years of testing/piloting, followed by a report to Congress by Jan 2014. Congressional action is required prior to adoption or implementation of a new delivery system change/ new payment system.	
Regulatory barriers	Give the Secretary the discretion to eliminate barriers as appropriate (e.g., IRF 60% rule, LTCH 25% rule and LOS requirement, the IRH/U 3 hour rule and the SNF 3 day prior hospitalization rule).	Secretarial discretion to eliminate additional regulatory barriers as appropriate.
Scope	National, voluntary project with a strong representative sample from all provider groups, various geographic markets (urban/rural). Various adjusters are required for geographic difference, type of hospital/facility. Additionally there must be special payment policies for patients receiving special care, high cost DME. Also adjustments would be needed for cost variations not in the provider's control.	The CARE tool would be used for data collection, development of patient care groups based on patient's clinical characteristics matched with the Medicare cost data (cost reports, claims, etc) to take step 2 to develop care group weights. Step 3 is developing a standard payment rate
Definition of success	Improved coordination of care; coordinated implementation of the patient assessment instrument (CARE tool or next iteration) at	There would need to be a definition of preventable readmissions to the affected sites which may be

	the time of proposed discharge from the acute hospital; lowering readmissions through better coordination of care and increased functional and quality of life outcomes; reduced administrative expenses; increased efficiencies; avoids negative beneficiary impacts.	established based on clinical evidence, or lacking same, based on a consensus of experts, again with a corridor/ flexibility allowed to assure there are no disincentives to admit the most complex and therefore riskier patients.

Community-based Bundling Option:
Separate Community-Based and Institutional Post-Acute Care Bundles

Background: Generally, post-acute community based care bundling is a system of penalties or rewards paid to home health care providers or other qualified entities based on their ability meet established performance benchmarks regarding post-acute care provided to certain categories of patient following an acute care in-patient hospitalization provided within 60 days of hospital discharge.

In this model, a home health agency (HHA) or other qualified entity is integrated into the hospital discharge planning process upon the admission of a qualified patient to the hospital. The HHA or other qualified entity is responsible for a comprehensive evaluation and post-acute care planning process that is designed to determine whether a patient is medically appropriate and feasible for discharge to the community. This approach is in use in some Medicaid programs with the design to ensure that the patient is cared for in the least restrictive environment appropriate to their clinical needs.

Where the HHA or other qualified entity in concert with the hospital determine that community based care is not appropriate immediately upon hospital discharge, the responsibility for discharge to a post-acute inpatient setting is returned to the hospital. At that point, a post-acute care bundling may be triggered if available.

With this model, the HHA or other qualified entity is responsible for any community-based care related to the patient's inpatient treatment including home health services, physician services, outpatient rehabilitation services, and any intervening stay in an IRF, LTCH, or SNF. Post-acute inpatient stays immediately following hospital discharge are outside of the HHA responsibility.

Benchmarks could be based on existing measurements of quality and patient outcomes in combination with cost avoidance outcomes that relate to re-hospitalizations and use of emergent care.

Under a post-acute community based care bundling approach, providers would receive a case mix related per capita payment that is calculated on the basis of the combination of services in the bundle, adjusted for performance in a positive or negative manner.

Post-Acute Community Based Care Bundling		
Committee Question	*Response*	*Items for Consideration*
Participating Entities/ Services included	Home health agencies, acute care hospitals, physicians, outpatient rehabilitation services and certain services of long-term care hospitals, inpatient rehabilitation facilities, and skilled nursing facilities,)	This model can be coordinated/combined with a PAC bundle that is directed to inpatient PAC that is provided to patients directly discharged from the acute care hospital to a PAC inpatient setting. This model also can be integrated with a community-based chronic care management program that is implement following the conclusion of the PAC bundled episode with similar designs on cost savings and patient outcomes. Physician services are included into the bundle in a manner comparable to the current hospice benefit. In hospice, physician services payments are made directly to the hospice for employed physician services related to the treatment of the terminal condition or directly to the non-employed physician caring for the hospice patient. The attending physician and the hospice medical director are part of an interdisciplinary care team for the patient thereby delivering fully coordinated care. Patients who choose to forego home care or who choose to utilize a post-acute inpatient setting for care should have those options, but would be excluded from the PAC model.
Payment To Entities	The payment would be based on a per capita amount related to the average spending for the population of patients included within the model combined with a withhold from the HHA or other qualified entity used to fund performance rewards and penalties. The physician payment would come through either physician services	The payment model would need to address cash flow considerations. Payment rate adjustments should be made to address wage variation, population density, and other factors related to cost differentials.

	payments direct to the HHA or physician depending on the physician status using Part B physician payment rates and processes.	
Episode Defined	Services delivered by participating entities within 60 days of discharge from an initial short term acute care hospitalization for conditions included in the bundle. The cost of re-hospitalizations would not be included in the bundle, but would be reflected in the performance payment adjustment.	The 60-day episode conforms with the current episodic time frame in the Medicare home health benefit. By using this standard, the model allows for the transition of the patient for continued care to the existing payment model or, alternatively, to the extension of the PAC bundle to additional 60 day episodes.
Quality overlay / Methods of evaluation	Quality and performance metrics already exist that can be adapted to this PAC model. Home health agency quality is measured through evaluation of patient outcomes reported through the OASIS assessments. Further, CMS is developing with industry participation a series of additional process measures. Finally, an ongoing CMS pay for performance demonstration program will be using a variety of outcome measures that include the incidence and impact or re-hospitalizations and use of emergent care.	These quality metrics would also be used for other payment initiatives such as value based purchasing, etc.
Conditions included	Chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes	A recent study by Avalere Health, LLC concludes that the use of early home care for patients with these three conditions significantly reduces Medicare spending. We suggest these chronic conditions because the growth in Medicare expenditures has been fueled primarily by care of chronic conditions. CMS should be able to expand the chronic conditions subject to the model as evidence develops of the value of early home care following inpatient discharge.
Determination of performance on quality measures and spending benchmarks	Benchmarks could be based on quality measures, spending performance, or some combination of the two. Also, participating providers can be readily compared with other HHAs that provide services to a comparable patient	Process measures should be advanced from their current state and included in the performance measurements. Further, NQF developed best practices should be employed/ incorporated to achieve measured results.

	population outside the bundle project.	
Timeline	A demonstration project should be ready for employment by 2012. 2-3 years of testing/piloting, followed by an HHS report to Congress. A Congressional evaluation would be triggered prior to any final adoption or implementation of any permanent system. In addition, GAO should be directed to report to Congress on whether pilot achieved cost savings, improved quality, and how it impacted beneficiaries and providers. GAO report due at the same time as Secretary report to Congress.	CMS might be authorized to expand categories of conditions included within the model beyond the three listed.
Regulatory barriers	The current eligibility requirements for home health services should be relaxed. Specifically, the “confined to home: (homebound), intermittent, and skilled care requirements should be waived. In addition, certain Stark rules regarding fair market value compensation to employed or contracted physicians should be waived or modified to remove the uncertainty related to the nearly undefined concept of “fair market value.”	There may be a limited series of technical rules that would need examination for potential waiver. The Secretary could be empowered to waive any rules deemed necessary to accomplish the purpose of the demonstration/pilot program.
Scope	Include different geographic markets (e.g., rural vs. urban). Demos/pilots should be tried in at least 5-10 sites	
Definition of success	Achieves overall cost savings to Medicare, improves quality and does not negatively impact beneficiaries	

Continuing Care Hospital Option
(Developed by AMRPA)

Continuing Care Hospital		
Committee Question	***Response***	***Items for Consideration***
Participating Entities	Long-term care hospitals, inpatient rehabilitation facilities, hospital based SNFs. Freestanding SNFs would be involved based on specific criteria. CCH would be authorized to provide or coordinate home health, outpatient rehabilitation services, and freestanding SNF services.	This can be "real" or "virtual" and could include physicians. Broad, voluntary demonstration approach. Further discussion is needed regarding inclusion of physicians to include in the bundle and the PAC physicians? Acute physicians?
Payment To Entities	CMS would pay the CCH, be it virtual or real.	CMS may adjust payments for incentives after base rates are established.
Episode Defined	The CCH stay plus 30 days post discharge from the CCH.	Highly complex, involved patients may require care beyond the defined episode of care. Hence, an issue is treatment of services/payments beyond the episode, which raises the question of continuing the FFS-PPSs. Beneficiary cost sharing is another issue to be addressed
Quality overlay/ Methods of evaluation	Quality measures, both process and outcome, would be developed through coordination with entities involved in measurement development in the PAC space including CMS, AAPMR Clinical Quality Improvement Committee, CARF, the Joint Commission, stakeholders, and NQF. Measures would relate to patient function, quality of life, extreme conditions, and other factors. Payment incentives could be based on quality measures. The demo should evaluate any impact on patient choice and indirect behavioral changes by providers which may affect access to care An Independent Evaluator (not GAO) should assess the results of the demonstration	Quality measures may also be used for other payment initiatives such as pay for reporting and pay for performance. Outliers and risk corridors need to be included to assure incentives to serve the most complex patients are retained.

	A Post Acute Care Reform Technical Advisory Council (PACRTAC) composed of professionals, associations, and consumers will be established to review the demonstration and make recommendations as to broader implementation.	
Conditions included	All conditions treated in IRFs, LTCHs, and HSNFs may be included or the demo can focus on the high volume and high cost conditions that account for 50% of PAC spending in these settings.	
Determination of performance on quality measures	Benchmarks could be based on quality measures, after a baseline is established.	
Timeline	• Use year 1 (12 months) to start to develop quality measures and to develop the scope of work for the demonstration project • During that first year, the agency could recruit contractors and participants. • Then there would be 2-4 years of testing/piloting, followed by a report to Congress by Jan. 2015. Congressional action is required prior to adoption or implementation of a new delivery system change/ new payment system.	
Regulatory barriers	Give the Secretary the discretion to eliminate barriers as appropriate such as the IRF 60% rule, LTCH 25% rule and LOS requirement, the IRH/U 3 hour rule and the SNF 3 day prior hospitalization rule.	Secretarial discretion to eliminate additional regulatory barriers as appropriate.
Scope	National, voluntary project with a strong representative sample from all provider groups, various geographic markets (urban/rural). Various adjusters are required for geographic difference, type of hospital/facility. Additionally there must be special payment policies for patients receiving special care, high cost DME. Also adjustments would be needed for cost variations not in the provider's control.	The CARE tool would be used for data collection, development of patient care groups based on patient's clinical characteristics matched with the Medicare cost data (cost reports, claims, etc) to take step 2 to develop care group weights. Step 3 is developing a standard payment rate
Definition of success	Improved coordination of care; coordinated implementation of the patient assessment instrument (CARE tool or next iteration) at the time of proposed discharge from the acute hospital; lowering readmissions	There would need to be a definition of preventable readmissions to the affected sites which may be established based on clinical evidence, or lacking same, based on a

	through better coordination of care and increased functional and quality of life outcomes; reduced administrative expenses; increased efficiencies; avoids negative beneficiary impacts; achieves patient satisfaction.	consensus of experts, again with a corridor/ flexibility allowed to assure there are no disincentives to admit the most complex and therefore riskier patients.

Virtual Bundling Option

Background: According to MedPAC, virtual bundling is a system of penalties or rewards paid to providers based on their aggregate ability to meet certain benchmarks for the care of a given condition during a hospitalization episode, usually defined as an initial hospitalization plus any treatments provided within 30 days of discharge.

Under a virtual bundling approach, post-acute providers would retain their existing prospective payment systems and be subject to pay-for-performance objectives that could result in higher or lower payments.

Virtual Bundling		
Committee Question	*Response*	*Items for Consideration*
Participating Entities	Acute care hospitals, physicians, and post-acute care (PAC) providers (long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies)	One variation would place PAC providers in the virtual bundle, with hospitals and physicians operating under an actual bundle. PAC providers would be linked to hospitals/physicians through performance on hospital readmissions. *Further discussion is needed to define which physicians are included in the bundle- is it any physician treating the patient during an episode?*
Payment To Entities	CMS would control the virtual bundle and oversee the distribution of penalties or incentives	CMS could retroactively adjust payments for incentives / penalties at the end of a pre-defined period based on provider performance; OR CMS could implement a payment withhold system. However, cash flow problems for providers could persist under either option. *Are there other ways to structure the payment?*
Episode Defined	Services delivered by participating entities within 30 days of an initial short term acute care hospitalization for conditions included in the bundle. Planned rehospitalizations would not be included in the bundle.	Provider experience indicates that some patients will remain in a PAC setting longer than the episode window. How should payments be transitioned at the end of the bundle and what payment methodology would be used for the post-30 day period?
Quality overlay / Methods of evaluation	A common set of PAC quality metrics should be developed by a consensus-	These quality metrics would also be used for other payment

	based organization such as NQF or NCQA. The metrics should evaluate quality of care across settings and episodes and must be developed with provider input. Payment incentives / penalties should be based on performance on benchmarks Virtual bundling should integrate patient and facility criteria to ensure patients are placed in the most appropriate facility for their care needs. Patient and facility criteria could build upon the current PAC demo. The demo should evaluate any impact on patient choice and indirect behavior changes in the overall health care system.	initiatives such as value based purchasing, etc. *Does the implementation of virtual bundling impact future policies related to value-based purchasing since some portion of payment is already being tied to quality measures?*
Conditions included	Current virtual bundling models focus on chronic obstructive pulmonary disease (COPD); acute myocardial infarction, coronary artery bypass graft; percutaneous transluminal coronary angioplasty; Heart failure; pneumonia; hip and knee replacement surgery	Rather than naming specific conditions in the bundle, CMS could be given a charge to determine the top 5 conditions for volume/intensity/high cost considerations for inclusion in the bundle
Determination of performance on benchmarks	Benchmarks could be based on a number of factors to include fiscal and quality performance. Providers could be treated as a group for the purpose of measuring quality relative to a benchmark and distributing subsequent incentives / penalties. Providers could be treated individually for the purpose of measuring performance relative to benchmarks and distributing subsequent payment incentives / penalties.	One variation would base incentive / penalty payments on the aggregate performance of all providers participating in the virtual bundle, relative to a group benchmark.
Timeline	12 months for NCQA / NQF to establish quality metrics and CMS to develop the demonstration project 2-4 years of testing/piloting, followed by an HHS report to Congress. A Congressional evaluation would be triggered prior to any final adoption or implementation of any permanent, new post acute payment system.	

	In addition, GAO should be directed to report to Congress on whether pilot achieved cost savings, improved quality, and how it impacted beneficiaries and providers. GAO report due at the same time as Secretary report to Congress.	
Regulatory barriers	See separate list. In addition, give the Secretary the discretion to eliminate additional barriers as appropriate.	
Scope	Include different geographic markets (e.g., rural vs. urban). Understanding that this is just one of potentially three or more suggested demos (CCH and site neutral payment being the other two), include 10% of the current Medicare population collectively in the various demonstrations; focusing initially on high volume, high cost patients.	
Definition of success	Achieves cost savings, improves quality and does not negatively impact beneficiaries and providers	

Rules for Elimination under Post Acute Care Bundling

IRF RULES

RULE	REFERENCE and LINK	RATIONAL FOR ELIMINATION
60 Percent Rule **CMS 13** **IRF Co-Morbidity Inclusion**	42 CFR Part 412 Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2009; Final Rule Page 46388 http://edocket.access.gpo.gov/2008/pdf/e8-17797.pdf Statutory	• Under a bundled payment system there is a predetermination of both payment and disposition. While a post-acute assessment tool is still required the need for admission rules are unnecessary. • Elimination of these regulations would be advantageous as patients would be discharged to a post-acute setting based on their basic needs and not on an arbitrary percentage of patients in certain diagnostic categories. • Elimination would result in significant reduction in the burden of providers managing the complex and ever-changing rules related to which patient qualifies under the CMS 13 or a qualifying co-morbid condition. • Patients benefit with the elimination of these regulations by being able to receive services in a post-acute setting at the time of their specific need. For example, currently a patient may be admitted to an IRF in one month, but that same patient could be denied admission in any other given month if the IRF is nearing their 60% compliance threshold.
3-Hour Rule	Medicare Benefit Policy Manual Chapter One, Section 110.4.3 http://www.cms.hhs.gov/manuals/Downloads/bp102c01.pdf Regulatory	• Conditions of Participation require therapy to be delivered at a high level of intensity interpreted by Medicare as being at least 3 hours of therapy per day. • Monitoring this unsubstantiated provision serves no purpose if the goal is to return the patient to their home in an efficient, quality oriented manner while reducing re-hospitalizations.

IRF-PAI
CMG
	42 CFR § 412.614
	Inpatient Rehabilitation Facility Patient Assessment Instrument
	Case Mix Group
	
	http://law.justia.com/us/cfr/title42/42-2.0.1.2.12.15.51.8.html
	
	Regulatory
		• Currently there are numerous setting-specific post acute assessment tools that are required for reimbursement purposes (MDS, OASIS and IRF-PAI). A common assessment tool under a bundled payment system eliminates the need for multiple assessment tools. Post-acute bundling would in essence require one standardized assessment instrument. Currently a post acute assessment instrument is in demonstration with CMS.
		• Standardization of assessment instruments across the post-acute continuum would be cost-effective for CMS and providers.
		    o Future rule making relative to updates would be required for one instrument rather than the current three.
		    o Providers would have a significantly reduced burden in maintaining compliance with the complicated and ever-changing rules with only one standardized assessment instrument.
		• Patients would benefit by having a single assessment tool that could be part of the electronic health record, reducing error rates when attempting to incorporate multiple assessment documents.

SNF RULES

RULE	REFERENCE and LINK	RATIONAL FOR ELIMINATION
SNF PPS **3-Day Hospitalization** **30-Day Transfer Rule**	Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance § 20 and 20.2 http://www.cms.hhs.gov/manuals/Downloads/bp102c08.pdf Statutory	• Under a post-acute bundled payment system, compliance with regulations such as qualifying 3-day hospitalization and 30-day transfer become irrelevant. • Elimination of these regulations would be advantageous to both patients and providers. Patients would be discharged to the post-acute setting based on their immediate clinical need and not based on an arbitrary acute stay requirement.
SNF Resource Utilization Groups **MDS Consolidated Billing**	42 CFR Part 413 Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2009; Final Rule http://edocket.access.gpo.gov/2008/pdf/e8-17948.pdf Statutory	• Under a bundled payment system and similar to the rationale above for IRF-PAI, the Resource Utilization Group payment policies would be unnecessary under a single post-acute assessment tool. • Compliance with a rigid and complicated MDS assessment schedule that raises administrative costs would be eliminated. • Consolidated billing regulations requiring the provider to bill for all services would be irrelevant in a post-acute model as all services would be bundled in one payment.

LTAC RULES

RULE	REFERENCE and LINK	RATIONAL FOR ELIMINATION
25% Threshold Rule **Short Stay Outlier Payment** **Six Month Demonstration Requirement**	42 CFR § 412.534 Special payment provisions for long-term care hospitals within hospitals and satellites of long-term care hospitals. http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr412.534.pdf 42 CFR § 412.529 http://edocket.access.gpo.gov/cfr_2005/octqtr/pdf/42cfr412.529.pdf 42 CFR §412.23 http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr412.23.pdf Statutory	• Under a bundled payment system all of these admission policies payment requirements and pre-qualifying requirements become obsolete. • Elimination of admission criteria based on arbitrary percentages would be beneficial to patients as their immediate needs would not be hamstrung to regulatory admission restrictions.
25 Day Length Of Stay	42 CFR §412.23 http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr412.23.pdf Statutory	• Compliance with regulations such as maintenance of an arbitrary average length of stay would irrelevant. Elimination of these regulations would be advantageous as patients would be discharged to the post-acute setting based on their immediate clinical need without being required to remain in a setting for a specified period of time, further escalating costs. • Patients benefit by not being subjected to post-acute settings compliance percentage For example, a patient may be easily admitted due to medical necessity criteria one month, but that same patient could be denied admission if that LTAC is encroaching the 25% threshold.

OTHER ADMINISTRATIVE RULES

RULE	REFERENCE and LINK	RATIONAL FOR ELIMINATION
Recovery Audit Contractor (RAC)	Tax Relief and Healthcare Act of 2006 §302 http://www.cms.hhs.gov/RAC/Downloads/Legislation%20for%20Permanent%20RACs.pdf Statutory	• The costly ($4.4B over 10 years) and complicated Recovery Audit Contractor (RAC) project would need refinement in a bundled post-acute payment system. While medical necessity reviews would continue as they exist in the acute care hospital, payment is now predetermined and the need for retrospective reviews in addition to medical necessity is redundant and costly.
Medical Necessity Requirements	Various decisions at the regional CMS contractor level	• Medical necessity requirements are currently inconsistent across region and contractor and action may be necessary in order to establish a clear and consistent standard for medical necessity